Florida External Quality Review Organization

April 2021

2020 Annual

EQRO Technical Report

HealthyKids™

Qsource

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Acknowledgements, Acronyms, and Initialisms[1]

A..... All
AAAHC...Accreditation Association for Ambulatory Health Care
ACA.....Annual Compliance Assessment
ADD.....Follow-Up Care for Children Prescribed ADHD Medication
ADHD .....Attention-Deficit/Hyperactivity Disorder
ADV.....Annual Dental Visit
AHCA ..... Agency for Health Care Administration
AMB-ED ..... Ambulatory Care: Emergency Department Visits
AMR ..... Asthma Medication Ratio
ANA.....Annual Network Adequacy
AOD .....Alcohol and Other Drug
AON .....Area of Noncompliance
APC..... Use of Multiple Concurrent Antipsychotics in Children and Adolescents
APM .. Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP .....Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
AWC.....Adolescent Well-Care Visits
BMI.....Body Mass Index
BR .....Biased Rate
C..... Critical/Clinical
CAP .....Corrective Action Plan (ACA)
CAP ...Children and Adolescents' Access to Primary Care Practitioners (PMV)
CFR ..... *Code of Federal Regulations*
CHIP..... Children's Health Insurance Program
CHL .....Chlamydia Screening in Women
CMS ..... Centers for Medicare & Medicaid Services
CPT .....Current Procedural Terminology
CWP ..... Appropriate Testing for Children with Pharyngitis
DBM ..... Dental Benefit Manager
DEA.....Drug Enforcement Agency
Den. ..... Denominator
DSC..... Dental Services Contract
ED .....Emergency Department
EDV..... Encounter Data Validation
ENT ..... Otolaryngology (ear, nose, and throat)
EQR/EQRO ..... External Quality Review/EQR Organization
F .....Female
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.*

FHM ..... Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older
FUA ..... Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
FUM ..... Follow-Up After Emergency Department Visit for Mental Illness
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of the NCQA
HHS..... U.S. Department of Health and Human Services
HPV..... Human Papillomavirus
IAD ..... Identification of Alcohol and Other Drug Services
ICD ..... International Classification of Diseases
ID..... Identification
IDSS..... Interactive Data Submission System
IET..... Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
IHI..... Institute for Healthcare Improvement
IMA..... Immunizations for Adolescents
IRO..... Independent Review Organization
IRR ..... Inter-Rater Reliability
IS..... Information System(s)
ISCAT..... Information Systems Capability Assessment Tool
M ..... Male
MCO..... Managed Care Organization
MCP ..... Managed Care Plan
MMA..... Managed Medical Assistance/Medication Management for People with Asthma
MPT..... Mental Health Utilization
MRR ..... Medical Record Review
MSC ..... Medical Services Contract
N..... No/Number
NA ..... Not Applicable (ACA)
NA ..... Small Denominator (PMV)
NA ..... Not Assessed (PIP)
NC ..... Nonclinical
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ .. a trademark of NCQA
No..... Number
NPDB ..... National Practitioner Data Bank
NPI ..... National Provider Identifier
NPPES . National Plan and Provider Enumeration System
NR ..... Non-Reportable Rate
Num..... Numerator
OB/GYN ..... Obstetrician/Gynecologist
OIG..... Office of the Inspector General
P&P ..... Policy and Procedure
PCP ..... Primary Care Provider/Physician
PDENT ..... Dental Preventive Services
PDP ..... Primary Dental Provider
PDSA..... Plan-Do-Study-Act
PIP..... Performance Improvement Project
PMV..... Performance Measure Validation
PPC ..... Prenatal and Postpartum Care
Q..... Quarter
Qsource® ..... a registered trademark
R..... Reportable Rate

Roadmap.....Record of Administrative Data Management and Processes
SAM .....System for Award Management
SCP..... Specialty Care Provider
SEA.....Enrolled Children Receiving Dental Sealants on Permanent Molars
SHOTS..... State Health Online Tracking System
SQL.....Structured Query Language
SSA.....Social Security Administration
Td.....Tetanus and Diphtheria Toxoids Vaccine
Tdap.....Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT .....Dental Treatment Services
UB-04 .....Uniform Bill (CMS-1450 form)
UCRP ..Uniform Credentialing and Recredentialing Policy
UM..... Utilization Management
URAC® .....a registered trademark
URI ..... Appropriate Treatment for Children with Upper Respiratory Infection
URL .....Uniform Resource Locator
W34.....Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC..Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents
Y .....Yes

Overview

Qsource serves as Florida Healthy Kids Corporation's (FHKC's) external quality review organization (EQRO) and prepared this *2020 Annual EQRO Technical Report* for FHKC to document Florida Healthy Kids managed care organization (MCO) and dental benefit manager (DBM) performance in regard to quality, timeliness, and access to care for FHKC enrollees, as well as to identify areas for improvement and recommend interventions to improve the process and outcomes of care. This section provides a brief history of FHKC, its Quality Strategy Plan, the guidelines for this report, and external quality review (EQR) activities conducted in 2020.

Background

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

In 2019, five MCOs and three DBMs operated in Florida. The MCOs included Aetna Better Health of Florida (Aetna), Simply Healthcare Plans, Inc. (Simply Healthcare; formerly Amerigroup Community Care [Amerigroup] in the *2018 Annual EQRO Technical Report*), WellCare Health Plans, Inc., doing business as Staywell Kids (Staywell), Sunshine Health (Sunshine), and UnitedHealthcare of Florida, Inc. (UnitedHealthcare). The DBMs were Argus Dental Plan (Argus), DentaQuest of Florida, Inc. (DentaQuest), and Managed Care of North America, Inc., doing business as MCNA Dental Plans (MCNA). FHKC released an invitation to negotiate for MCOs in 2019, awarding contracts starting in 2020 to incumbents Aetna and Simply Healthcare and one new MCO, Community Care Plan (Community Care). The DBMs remained the same for 2020.

As of December 2020, nearly 170,000 children were enrolled in the Florida Healthy Kids program, more than 150,000 in the subsidized program and over 19,000 in the full-pay option. At the same time last year, more than 209,000 children were enrolled in the program.

FHKC Quality Strategy Plan Goals

FHKC's goals and vision and mission statements align with the three aims of the National Quality Strategy[2]: better care, improved health for people and communities, and affordable healthcare. Its Quality Strategy Plan includes two primary areas of focus, access to quality care and quality assurance.

FHKC's vision and mission statements serve as a guide for ensuring quality remains a top priority. These statements are a strong foundation for FHKC and the services it provides the Florida Healthy Kids population:

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

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

1. **Quality:** Ensure child-centered standards of healthcare excellence in all Florida Healthy Kids health plans.
2. **Satisfaction:** Fulfill child healthcare 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 healthcare in Florida.
6. **Advancement:** Maintain necessary resources and authority to achieve the mission.

EQR Activities

EQR includes four mandated activities and can include six optional activities. Each state (in this case, FHKC) may also assign other responsibilities to its designated EQRO, such as the provision of ongoing technical assistance. This section summarizes the activities that Qsource performed for FHKC in 2020, according to Centers for Medicare & Medicaid Services (CMS) EQR Protocols.

EQR Mandatory Activities

As set forth in Title 42 *Code of Federal Regulations* (CFR) Section 438, Part 358 (42 § 438.358), incorporated by 42 CFR § 457.1250, four mandatory EQR activities must be conducted to assess the performance of the MCOs and DBMs:

- Validation of performance improvement projects (PIPs) – Part of the PIP validation for FHKC MCOs and DBMs involves rapid Plan-Do-Study-Act (PDSA) cycles, which are also included in this report.
- Validation of performance measures (PMV)

[2] *Agency for Healthcare Research and Quality. n.d.* Working for Quality. *https://www.ahrq.gov/workingforquality/index.html*

- Review of compliance with Medicaid and CHIP managed care regulations (annual compliance assessment, ACA)
- Validation of network adequacy (ANA)

In addition to EQR mandatory activities, 42 CFR § 438.358 outlines six optional activities, one of which FHKC has elected for Qsource to conduct, *Protocol 5: Validation of Encounter Data*.

For those activities for which the review period was calendar or federal fiscal year 2019, Qsource followed the CMS protocols published in September 2012 (PIP, PMV, and ACA). No protocol had yet been published at the time of conducting ANA activities for 2020, so Qsource, in cooperation with its subcontractor, Quest Analytics, followed internally developed standards. For encounter data validation (EDV), which involved 2020 data, Qsource followed the CMS protocol published in October 2019. In addition, Qsource provided FHKC and its MCOs and DBMs with technical assistance—an EQR-related activity also defined by 42 CFR § 438.358. In this capacity, Qsource maintained ongoing, collaborative communication with FHKC and supported the MCOs and DBMs in their EQR activities. Most notably, Qsource worked closely with the Plans to assist them as they assessed their claims and encounter data collection and reporting systems following FHKC's collaboration with the Agency for Healthcare Administration (AHCA) to develop new data submission guidelines. These efforts aimed to create more standardized reporting between the two agencies. Qsource and FHKC met virtually on multiple occasions with individual MCOs and DBMs to help staff determine capacity to meet the new guidelines with existing systems and transition to the new layout in an effort to reduce potential errors on initial data submission.

Finally, Qsource conducted two health and dental All-Plan meeting(s) that were attended by FHKC, MCO, and DBM staff. The two virtual 2020 meeting(s) featured technical assistance sessions facilitated by Qsource on upcoming 2021 EQR activities, changes from the 2012 ERQ Protocols to the 2019 EQR Protocols, and a more in-depth case study training for the PIP activity. Although three All-Plan meetings were planned for 2020, the in-person meeting was initially postponed and then canceled to accommodate federal guidelines in response to Coronavirus Disease 2019 (COVID-19). The virtual meetings were held in October and December.

Qsource is responsible for the creation and production of this *2020 Annual EQRO Technical Report*, which compiles the results of these EQR activities. Qsource's efforts are a primary means of assessing the quality, timeliness, and accessibility of services provided by FHKC's MCOs and DBMs. Qsource performed annual EQR activities for 2020 to determine each MCO's and DBM's compliance with federally mandated activities.

This report includes the following results of these activities:

- Technical methods for data collection and analysis, data description, and conclusions drawn from data analysis for each of the EQR compliance activities
- Strengths and weaknesses demonstrated by each MCO and DBM in providing healthcare services to Florida Healthy Kids enrollees
- Recommendations for improving the quality of these services, including how FHKC can target goals and objectives in the Quality Strategy Plan to better support improvement
- Methodologically appropriate, comparative information about all FHKC's MCOs and DBMs, consistent with CMS EQR protocol guidance
- The degree to which each MCO/DBM has effectively addressed the recommendations for quality improvement made during the 2019 EQR

This *2020 Annual EQRO Technical Report* is based on detailed findings that can be examined in the individual EQR activity reports provided to FHKC. Comparative analyses from 2018, the first year Qsource served as FHKC's EQRO, to 2019 and 2020 are included in this report where possible.

Technical Report Guidelines

To assist both EQROs and state agencies, CMS supplemented the requirements of 42 CFR § 438.364 and provided guidelines in the 2012 and 2019 EQR Protocols for producing annual technical reports. In addition to this Overview, this year's technical report includes the following EQR-activity-specific sections:

- Performance Improvement Project (PIP) Validation
- Plan-Do-Study-Act (PDSA)
- Performance Measure Validation (PMV)
- Annual Compliance Assessment (ACA)
- Annual Network Adequacy (ANA)
- Encounter Data Validation (EDV), optional

The appendices provide additional EQR activity information:

- Appendix A includes more detailed, MCO/DBM-specific results.
- Appendix B provides the tools used to conduct the 2020 EQR activities.

FHKC Utilization of the EQRO Technical Report

The annual technical report provides FHKC with substantive, unbiased data for the MCOs and DBMs as well as recommendations for action toward far-reaching performance improvement. As mandated by 42 CFR § 438.364, these data enable benchmarking of performance statewide and nationally.

The data also depict the healthcare landscape for the state's Florida Healthy Kids population, which assists FHKC in its collaborations with other state agencies to address common health issues—particularly those that are prevalent, chronic, and

preventable. FHKC can use these data to measure progress toward goals and objectives of its Quality Strategy Plan and better support improvement in the quality and timeliness of, and access to, healthcare services.

Performance Improvement Project (PIP) Validation

Assessment Background

The primary objective of PIP validation is to determine the compliance of each MCO and DBM with the requirements set forth in 42 CFR § 438.330(d). MCOs and DBMs must conduct PIPs that are designed to achieve, through ongoing measurements and interventions, significant and sustained improvement in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIP study topics must reflect Florida Healthy Kids enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease. Each PIP must be completed in a reasonable timeframe to allow PIP success-related data in the aggregate to produce new information on quality of care every year. In addition to PIP completion, each MCO and DBM was expected to implement rapid-cycle improvement activities using the Institute for Healthcare Improvement (IHI) Model for Improvement's PDSA model as appropriate for each PIP. PIPs are further defined in 42 CFR § 438.330(d) to include all of the following:

- Performance measurement using objective quality indicators
- Implementation of interventions to achieve improvement in the access to and quality of care
- Evaluation of intervention effectiveness
- Planning and initiation of activities to increase or sustain improvement

The 2020 PIP validation process evaluated one clinical and one nonclinical PIP each for three MCOs (Aetna, Community Care, and Simply Healthcare) and three DBMs (Argus, DentaQuest, and MCNA). The clinical PIP topics were selected by FHKC; the nonclinical topics were proposed by the MCOs/DBMs and approved by FHKC. To validate PIPs, Qsource assembled a validation team of experienced clinicians specializing in quality improvement and a healthcare data analyst with expertise in statistics. The validation process included a review of each PIP's study design and approach, an evaluation of each PIP's compliance with the analysis plan, and an assessment of the effectiveness of MCO and DBM interventions.

Technical Methods for Data Collection and Analysis

Each MCO and DBM is contractually required to submit its PIP studies annually to FHKC as requested. Submitted PIPs should include the necessary documentation for data collection, data analysis plans, and an interpretation of all results. MCOs and

DBMs should also address threats to validity regarding data analysis and include an interpretation of study results.

The 2020 PIP validation was based on CMS's *EQR Protocol 3: Validating Performance Improvement Projects (PIPs)*, (Version 2.0; September 2012). Qsource developed a PIP Summary Form and a PIP Validation Tool to standardize the process by which each MCO and DBM provides PIP information to FHKC and how that information is assessed. Using Qsource's PIP Summary Form, each MCO and DBM submitted its PIP studies and supplemental information in July 2020.

Each PIP validation assessed MCO and DBM performance on 10 activities, and each activity consisted of multiple elements essential to the successful completion of a valid PIP. The actual number of activities validated for each PIP varied depending on how far the MCO or DBM had progressed with an individual study or whether the activity was applicable to the study's methodology. For example, Activity V was not validated when a study did not use sampling, used an administrative-only data collection methodology, or used HEDIS Technical Specifications for sampling.

The elements within each activity were scored as Met, Not Met, or Not Assessed. To ensure a valid and reliable review, 13 elements across eight activities were designated as "critical" (i.e., necessary) to be Met, if applicable, in order for the MCO or DBM to produce an accurate and reliable PIP. Given the importance of the critical elements to this scoring methodology, any applicable critical element that received a Not Met status resulted in an overall validation rating of Not Met and required future revisions of the PIP. More specific information on validation methodology is available in the individual *2020 PIP Validation Report* for each MCO and DBM.

Description of Data Obtained

Table 1 summarizes the 10 CMS protocol activity requirements and the 13 critical elements addressed in the PIP Summary Form.

Table 1. CMS PIP Activities and Critical Elements

I. State the Study Topic(s)
Has the potential to affect enrollee health, functional status, or satisfaction
II. Define the Study Question(s)
♦ States the problem to be studied in simple terms ♦ Is answerable
III. Use a Representative and Generalizable Study Population
♦ Is accurately and completely defined ♦ Captures all enrollees to whom the study question applies
IV. Select the Study Indicators
♦ Are well-defined, objective, and measurable ♦ Allow for the study questions to be answered ♦ Have available data that can be collected on each indicator
V. Use Sound Sampling Methods
Ensure a representative sample of the eligible population

Table 1. CMS PIP Activities and Critical Elements
VI. Use Valid and Reliable Data Collection Procedures
Include a manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications (only applicable if manual data collection conducted)
VII. Analyze Data and Interpret Study Results
♦ Are conducted according to the data analysis plan in the study design ♦ Allow for generalization of results to the study population if a sample was selected
VIII. Include Improvement Strategies
Related to causes/barriers identified through data analysis and quality improvement processes
IX. Assess for Real Improvement
No critical elements
X. Assess for Sustained Improvement
No critical elements

Comparative Findings

Table 2 presents the type, validation status, overall score for all elements, and critical element score of each MCO's and DBM's PIPs. The MCOs' clinical PIP was new and selected by FHKC, *Screening for Depression and Follow-Up Plan: Ages 12–17*. MCO nonclinical PIPs focused on behavioral health topics. The DBMs' clinical PIP focused on preventive dental services. The nonclinical PIP focused on access and availability of services.

For the 2020 PIP review, 4 of the 12 PIP studies received a Met Status. Seven of the eight PIPs with a Not Met status earned both critical element and overall scores below defined thresholds for a Met status. The one remaining PIP was not met due to the critical element score only. Additional details about each PIP study are provided in Appendix A.

Table 2. 2020 PIP Validation Status and Performance Scores by MCO/DBM

MCO/DBM	PIP Type	Met/Not Met	Overall Score	Critical Element Score
Aetna	Clinical	Met	100%	100%
	Nonclinical	Met	100%	100%
Argus	Clinical	Not Met	70.7%	80.0%
	Nonclinical	Not Met	40.4%	36.4%
Community Care	Clinical	Not Met	72.7%	75.0%
	Nonclinical	Not Met	81.8%	75.0%
DentaQuest	Clinical	Not Met	76.9%	70.0%
	Nonclinical	Not Met	65.0%	70.0%
MCNA	Clinical	Met	100%	100%
	Nonclinical	Met	100%	100%
Simply Healthcare	Clinical	Not Met	72.7%	87.5%
	Nonclinical	Not Met	67.5%	80.0%

Strengths and Weaknesses

Table 3 includes strengths and Table 4 includes weaknesses exhibited by the MCOs and DBMs for the 2020 PIP validation.

Strengths for the PIP validation indicate that the MCO or DBM demonstrated particular proficiency on a given activity and can be identified regardless of validation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCO or DBM. Areas of noncompliance (AONs), or weaknesses, arise from evaluation elements that receive a Not Met score, indicating that those elements are not in full compliance with CMS protocols. AONs are expressed in terms of what the MCO/DBM should do to meet all requirements. This information is useful for determining whether to continue or retire a specific PIP. Qsource also identifies suggestions where an element is fully compliant but a revision or update could further strengthen that element's compliance. The MCOs and DBMs are not held accountable for addressing suggestions; therefore, suggestions are not monitored or included in this report. Any PIPs not listed in **tables 3** and 4 had no strengths and/or weaknesses identified.

Table 3. PIP Strengths by MCO/DBM

Aetna	
C*	Characteristics of methodology for calculating study indicator; complete discussion of data collection process
NC*	Clearly organized data analysis and interpretation of results
Argus	
C	External research and DBM-specific data supporting topic relevance; detailed analysis of historic measure rates; how study indicators addressed outcomes; complete discussion of data collection process
DentaQuest	
C	External research supporting topic relevance with demographic analysis; how study indicators addressed outcomes
MCNA	
C	External research supporting topic relevance with demographic analysis; how study indicators addressed outcomes; complete discussion of data collection process; clear description of study results; how improvement strategies impacted study indicator rates
NC	Comprehensive research supporting topic relevance; complete discussion of data collection process; clear description of study results; specific data related to interventions most attributable for improvement; how improvement strategies impacted study indicator rates
Simply Healthcare	
C	External research supporting topic relevance with demographic analysis; comprehensive discussion of data completeness estimation

Table 3. PIP Strengths by MCO/DBM	
NC	Analysis of membership gender, age, ethnic, and spoken language distribution to address racial and cultural impacts on the study topic in the future

* *C=clinical; NC=nonclinical*

Table 4. PIP Weaknesses (AONs) by MCO/DBM	
Argus	
C*	Address data available to calculate study indicators, comprehensive interpretation of study findings and evaluation of study's success to date, whether baseline and remeasurement methodologies were the same, study indicator improvements over time, statistical evidence of true improvement, and improvements over PIP measurement periods in terms of sustained improvement; include accurate baseline rates and measurement periods and comparison of study indicator results to benchmark and goal rates; limit factors impacting comparability of baseline and remeasurement results to one measurement period; describe change in revised intervention
NC*	Include analysis of access grievances (instead of enrollee survey responses), accurate remeasurement results, comprehensive interpretation of study findings, evaluation of study's success to date, modifications made in PIP approach, systematic process for administrative data collection and description of data collection process; update study question to reflect modified approach to PIP and study population to reflect all applicable enrollees; eliminate one study indicator and focus on the dental measure as the outcome measure; eliminate sampling description; address administrative data completeness, whether baseline and remeasurement methodologies were the same, study indicator improvements over time, statistical evidence of true improvement, and improvements over PIP measurement periods in terms of sustained improvement; describe data analysis plan, how study indicator rates will be calculated and compared, and change in revised intervention; identify factors that could threaten internal or external validity of findings or that could affect study indicator measurement comparison
Community Care	
C	Address how all enrollees who meet study criteria are to be included, whether any enrollees will be excluded based on special healthcare needs, how study indicator measures changes in health or functional status, and data elements to be collected for measure calculation; rephrase study question
NC	Describe eligible population and availability of data for calculation of study indicator; address any exclusion of enrollees with special healthcare needs and specific source of study indicator

Table 4. PIP Weaknesses (AONs) by MCO/DBM	
DentaQuest	
C	Address data available to calculate study indicator, comparison of baseline and remeasurement rates to benchmark and goal rates, factors impacting ability to compare baseline and remeasurement rates, and whether baseline and remeasurement methodologies were the same; ensure accurate and consistent rates and baseline and remeasurement rate cycles; calculate statistical significance of study indicator rate declines and statistical significance of rate differences; further discuss barriers addressed by interventions and statistically significant declines over measurement periods
NC	Address eligible populations, data available to calculate study indicators, and whether baseline and remeasurement methodologies were the same; include appropriate systematic process for data collection; analyze data and interpret results according to annual measurement periods; provide details for identified barriers and change in revised intervention; calculate statistical significance of rate differences
Simply Healthcare	
C	Address how all enrollees who meet study criteria are included, whether any enrollees will be excluded based on special healthcare needs, how study indicator measures changes in health or functional status, and availability of data to be collected for indicator; describe systematic process of administrative data collection; include flowchart or algorithm describing data flow process for calculation of study indicator
NC	Identify benchmark rate as actual percentage rate, factors that could threaten internal or external validity or affect ability to compare baseline measurement with remeasurement(s); provide interpretation of extent to which study was successful; address activities for which no responses were provided

** C=clinical; NC=nonclinical*

Improvements Since the 2019 PIP

Table 5 includes the MCOs' and DBMs' improvements made based on last year's PIP. The clinical PIP for the MCOs was new in 2019; thus, all clinical PIPs for the MCOs were in the baseline year and comparisons cannot be made between the 2019 and 2020 clinical PIPs. In addition, Community Care's medical services contract (MSC) with FHKC was effective January 1, 2020. As such, the MCO has not undergone PIP evaluation for FHKC prior to this year, and there are no improvements to report for Community Care. Any other MCO or DBM not appearing in Table 5 had no identified AONs for PIPs in 2019.

Table 5. Improvements Since the 2019 PIP by MCO/DBM			
MCO/DBM	**C/NC***	**2019 AON**	**MCO/DBM's Action**
Argus	NC*	The DBM should include the basis for the Any Dental Services data completeness estimate.	The DBM provided the basis for data completeness estimates for both study indicators.
DentaQuest	C*	The DBM should address the source of data available for measurement of each study indicator (e.g., dental administrative claims data include all necessary elements to calculate the indicator).	This area also was noted as a deficiency in the 2020 PIP; thus, the AON has not been addressed.
	NC	1. The DBM should specifically define the benchmark rate (noted as the national benchmark). 2. The DBM should include the appropriate systematic process for data collection for the Any Dental Services study indicator.	1. The DBM specifically defined the benchmark rate in the 2020 PIP; thus, the AON has been satisfied. 2. This area also was noted as a deficiency in the 2020 PIP; thus, the AON has not been addressed.

** C=clinical; NC=nonclinical*

Plan-Do-Study-Act (PDSA)

Assessment Background

In addition to the 10-step PIP evaluation and validation outlined in EQR Protocol 3, FHKC requested that the MCOs and DBMs implement rapid-cycle improvement techniques for the current PIPs in 2018, using the IHI Model for Improvement's PDSA model. The MCOs and DBMs were expected to implement new interventions using the PDSA model as appropriate for the PIP. These efforts focused on developing an appropriate aim; planning for and running small tests of change; identifying and collecting data to measure results; analyzing short-term results compared to set goals; and adopting, modifying, or abandoning interventions to maximize improvement. The PDSA model of successive tests of change leading to sustained improvement over the long term corresponds well with the CMS protocol structure.

Technical Methods for Data Collection and Analysis

For the PDSA evaluation, the MCOs and DBMs submitted information for Plan-Do in 2019 quarter 3 (2019Q3) and Study-

Act in 2019Q4. This information was combined into one Q3 and Q4 report for each PIP. Evaluation for Q3 and Q4 reports included scoring elements for each activity as Met (complies with PDSA principles), Opportunity (implementation of PDSA principles not evident or needs to be strengthened), or Not Assessed (NA; could not be evaluated due to lack of data or other factors).

For 2020, the requirement for submission of Q1 and Q2 interval PDSA reports from the MCOs and DBMs was waived by FHKC due to difficulties implementing interventions given the COVID-19 pandemic. The MCOs and DBMs still were required to submit information for 2020Q3, the evaluation of which is included in this report. The 2020Q4 evaluation will be conducted as part of the standard 2021 PIP submission as required by the updated CMS Protocol 3 (October 2019) and will be included in the *2021 Annual EQRO Technical Report*.

Description of Data Obtained

Table 6 summarizes the four PDSA activities and elements.

Table 6. PDSA Activities and Elements
I. Plan
♦ Set aim of the project
♦ Define measure
♦ State measure baseline
♦ Develop driver diagram
♦ Select specific change ideas and rationale for selection
♦ Describe planned data collection process
♦ Develop initial sustainability plan
II. Do
♦ Describe the change implemented and the scale of the test
♦ Describe the results of the test
III. Study
♦ Analyze and compare results
♦ Describe what was learned from test of change
IV. Act
♦ Describe action to be taken
♦ Complete sustainability plan
♦ Describe plan for next PDSA cycle

Strengths and Weaknesses

Strengths for the PDSA evaluation indicate that the MCO or DBM demonstrated particular proficiency on a given activity and can be identified regardless of evaluation status. The lack of an identified strength should not be interpreted as a shortcoming on the part of an MCO or DBM. Weaknesses can be identified when documentation for an evaluation element indicated that the basic components of the PDSA model were not adequately demonstrated or need to be strengthened. The recommended corrective actions for these opportunities are identified as suggestions in the PDSA reports. Identified strengths are provided in Table 7 and weaknesses are provided in Table 8 by individual MCO/DBM and by PIP study for 2019 Q3 and Q4 combined. Additional information about each PIP is provided in Appendix A.

Table 7. PDSA Strengths by MCO/DBM	
Aetna	
C*	Relevant, comprehensive driver diagram; appropriate data collection for first two quarters
NC*	Process measure included in project plan to drive improvement interventions; comprehensive driver diagram; change ideas described in detail, provider focused, and addressed critical issues in driving improvement for measure; behavioral health liaison test of change expanded to additional geographic area, allowing for continued analysis of change's success and potential spread to other areas; facility-level analysis allowed for specific follow-up activities to improve results; detailed monthly data
Argus	
C	Monthly short-term goals that facilitate rapid-cycle improvement activity
NC	Impact of COVID-19 on project described in detail; comprehensive lessons learned
Community Care	
C	Quarter-based goal achievement timeframe toward rapid-cycle improvement
NC	Short-term timeframe for improvement toward rapid-cycle improvement
DentaQuest	
C	Control group to help establish true success
MCNA	
C	Comprehensive description of aim and measures
Simply Healthcare	
C	Comprehensive, relevant driver diagram
NC	Innovative change ideas; thorough, relevant barrier analysis

** C=clinical; NC=nonclinical*

Table 8. PDSA Weaknesses (Suggestions) by MCO/DBM	
Aetna	
C*	Quarterly rate collection and monitoring and redefinition of baseline for rapid-cycle improvement
NC*	Updated goal rate to address most recent results; baseline and goal rates that are clear; data collection processes relative to interventions; description of network consultant intervention, its scale, and test results; documentation of test results and lessons learned
Argus	
C	Driver diagram drivers that clearly address reasons for needed improvement in indicator results
NC	Numeric goals included in project aim; use of more appropriate measure; change ideas included in driver diagram and rationale for their selection; data collection process included
Community Care	
C	Rationale for selection of change idea
NC	Numeric baseline for all months
DentaQuest	
NC	Sustainability plan for adapted change

Table 8. PDSA Weaknesses (Suggestions) by MCO/DBM	
MCNA	
NC	Scale of test identified; analysis and comparison of results and lessons learned; action to be taken, sustainability plan, and plan for next PDSA cycle
Simply Healthcare	
C	Reconsideration of baseline and goal rates; inclusion of all components in sustainability plan
NC	Inclusion of all components in sustainability plan

** C=clinical; NC=nonclinical*

Improvements Since the 2019 PDSA

Table 9 provides improvements made in PDSA processes since last year's PDSA cycle by MCO/DBM. The clinical PIP for the MCOs was new in 2019; thus, all clinical PIPs for the MCOs were in the baseline year and comparisons cannot be made between the 2019 and 2020 PDSA cycles. In addition, Community Care's MSC with FHKC was effective January 1, 2020. As such, the MCO has not undergone PIP evaluation for FHKC prior to this year, and there are no improvements to report in PDSA processes for Community Care. Any other MCO or DBM not appearing in **Table 9** had no identified AONs for PIPs in 2019.

Table 9. Improvements Since the 2019 PDSA by MCO/DBM		
C/NC*	**2019 Opportunity**	**MCO/DBM's Action**
Argus		
C	Plan: Factors that influence indicator rates should be included in the primary and secondary driver section of the driver diagram. Element 5 should only include the actual change idea implemented and the rationale for selection of this change idea. Monitoring of outreach call completion rates, a process measure, should be defined under element 2 of this activity. The sustainability plan should reference all required components. Do: Additional detail on how the change tests were actually implemented should be included. Act: The sustainability plan should reference all required components.	The DBM resolved most issues from last year's PDSA, with the exception of the drivers in the driver diagram in the Plan activity. The drivers in the driver diagram could more clearly address the reasons for improvement needed in the indicator results.

Table 9. Improvements Since the 2019 PDSA by MCO/DBM		
C/NC*	**2019 Opportunity**	**MCO/DBM's Action**
NC	Plan: For the aim, a numeric rate for the desired outcome (enrollee satisfaction) and timeframe for achievement based on survey question (indicator) scores should be developed. For the study measures, how improvement will be demonstrated (change in survey question scores) should be discussed. In addition, using the survey response rate as a process measure should be considered. The driver diagram should be updated to include appropriate information for the aim, primary and secondary drivers, and change ideas. The data collection process description should include the survey method and the number of survey attempts planned. The sustainability plan should reference all required components. Act: The sustainability plan should reference all required components.	The DBM resolved some issues from last year's PDSA, including addressing the aim and primary and secondary drivers in the driver diagram and updating the sustainability plan to reference all required components. However, some areas of weakness were still identified in the 2020 PDSA. Numeric goals should be included in the aim of the project. The DBM should consider using the "any dental services" measure to most accurately reflect access to dental services. All change ideas should be included in the driver diagram, and the rationale for selection of the change ideas should be addressed. The data collection process for the TDENT measure should be included.
MCNA		
C	Plan: The sustainability plan should reference all required components. Study: General observations regarding the implementation of the change test could be useful, e.g. successful components of the change test and whether any barriers were encountered. Act: The sustainability plan should reference all required components.	The DBM resolved some issues from last year's PDSA, including referencing all required components in the sustainability plan for the Plan activity. However, some areas of weakness were still identified in the 2020 PDSA. The scale of the test should be identified. An analysis and comparison of results and lessons learned from the test of change should be addressed. The action to be taken, sustainability plan, and plan for next PDSA cycle should be addressed in the Act activity.
NC	Plan: The sustainability plan should reference all required components.	The DBM resolved some issues from last year's PDSA, including referencing all required components in the sustainability plan for the Plan activity. However, some areas of weakness were still identified in the 2020

Table 9. Improvements Since the 2019 PDSA by MCO/DBM		
C/NC*	**2019 Opportunity**	**MCO/DBM's Action**
	Study: General observations regarding the implementation of the change test could be useful, e.g. successful components of the change test and whether any barriers were encountered. Act: The sustainability plan should reference all required components.	PDSA. The scale of the test should be identified. An analysis and comparison of results and lessons learned from the test of change should be addressed. The action to be taken, sustainability plan, and plan for next PDSA cycle should be addressed in the Act activity.
Simply Healthcare		
NC	Plan: The sustainability plan should reference all required components. Act: Potential adaptations to the change test should be considered, based on the lessons learned and observations from the study phase. The sustainability plan should reference all required components.	The MCO resolved the Plan activity issue from last year's PDSA and addressed the potential adaptations to the change test. However, the MCO did not address the sustainability plan in the Act activity.

** C=clinical; NC=nonclinical*

Performance Measure Validation (PMV)

Assessment Background

To satisfy CMS protocol for MCOs/DBMs and to meet the requirements set forth in 42 CFR § 438.330(c), FHKC selected a process for an objective, comparative review of quality-of-care outcomes performance measures. The primary aims of PMV are to evaluate the accuracy of MCO- and DBM-reported measures and to determine whether those measures were calculated according to required technical specifications, enabling FHKC to monitor MCO/DBM performance at a point in time, track performance over time, and compare performance among MCOs and DBMs.

The 2020 PMV included validation of performance measures for the five MCOs—Aetna, Simply Healthcare, Staywell, Sunshine, and UnitedHealthcare—and three DBMs—Argus, DentaQuest, and MCNA—providing care services for Florida Healthy Kids enrollees in 2019.

Qsource's PMV team consisted of members selected for their various skill sets, including statistics, analysis, managed care operations, clinical expertise, performance measure reporting, information system assessments, and computer programming capabilities.

Technical Methods of Data Assessment for MCOs

FHKC identified for validation 21 Healthcare Effectiveness Data and Information Set (HEDIS®) measures, defined by the National Committee for Quality Assurance (NCQA) and validated through an NCQA HEDIS Compliance Audit™, and one Agency for Health Care Administration (AHCA) Medicaid Managed Medical Assistance measure. One of the 21 HEDIS measures was retired by NCQA for 2020, Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC); however, FHKC opted to require the MCOs to report results for this measure using 2019 HEDIS specifications. In addition, for HEDIS measures reported using only the hybrid methodology, NCQA allowed Plans to report their audited HEDIS 2019 hybrid rate if it was better than the HEDIS 2020 hybrid rate as a result of low chart retrieval due to the COVID-19 pandemic. FHKC approved this reporting methodology for its MCOs. Aetna elected to report its 2019 HEDIS results for the Adolescent Well-Care Visits (AWC) measure. Simply Healthcare elected to reports its 2019 HEDIS results for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), and AWC measures. Staywell, Sunshine, and UnitedHealthcare elected to report all 2020 hybrid rates. No exceptions were made by NCQA or FHKC for measures using administrative rates.

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). CMS's *Protocol 2: Validation of Performance Measures Reported by the MCO* (Version 2.0; September 2012) outlines activities for validation of performance measures. Per the protocol, completion of the HEDIS Roadmap is an acceptable substitute for the Information Systems Capability Assessment Tool (ISCAT), and all MCOs used NCQA HEDIS-certified software for measure calculation. As a result of the MCOs' successful completion of the HEDIS audit process, onsite audits and source code review (also components of the protocol) by Qsource were not necessary.

Based on all validation activities, results were determined for each performance measure. For the MCOs, NCQA's HEDIS Compliance Audit protocol was followed. For the 2020 PMV, this entailed a report of preliminary findings; a review of the final rates; and the production of a final report stating whether the MCO had a Reportable Rate (R), Non-Reportable Rate (NR), Biased Rate (BR), or Small Denominator (NA).

Technical Methods of Data Assessment for DBMs

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

FHKC identified eight dental performance measures to be calculated and reported by the contracted DBMs. Six of these were CMS-416 dental service measures, one was a modified CMS-416 dental service measure, and the last was the HEDIS Annual Dental Visit (ADV) measure. Qsource followed EQR Protocol 2, which identifies key data sources that should be reviewed as part of the validation process:

- **ISCATs:** Completed ISCATs received from the DBMs were reviewed to ensure all sections were complete and all attachments were available. The validation team reviewed all ISCAT documents, noting issues or items needing follow-up.
- **Source Code (Programming Language) for Performance Measures:** The validation team completed line-by-line code review and observation of program logic flow to ensure compliance with measure technical specifications. Areas of deviation were identified to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- **Performance Measure Reports:** Qsource reviewed calculated rates for the current measurement period to assess rate reasonability.
- **Supportive Documentation:** Qsource reviewed additional information to complete the validation process, including, but not limited to, policies and procedures (P&Ps), file layouts, system flow diagrams, system log files, and data collection process descriptions. Issues or areas needing further clarification were flagged for further follow-up.

For the DBMs, validation included the following basic steps:

1. **Pre-Virtual-Review Activities:** In addition to scheduling the virtual reviews and developing the agenda, the team prepared a data collection tool based on established validation protocols. Additionally, each DBM was required to complete the ISCAT. Qsource responded directly to ISCAT-related questions from the DBMs during the pre-virtual-review phase. The validation team conducted a review of the ISCAT and supportive documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.
2. **Virtual Reviews:** The virtual review lasted one day and included the following:
   - Opening session
   - Evaluation of system compliance, specifically the processing of claim, encounter, and enrollment data where applicable
   - Overview of data integration and control procedures, including discussion and observation of source code logic where applicable

- Review of how all data sources were combined and the method used to produce the analytical file for performance measure reporting
- Interviews with DBM staff members involved with any aspect of the performance measure reporting
- Closing session summarizing preliminary findings and recommendations

Description of Data Obtained

Table 10 lists the audited measures for MCOs, and Table 11 lists the audited measures for DBMs. Some measure definition age stratifications that do not apply to the Florida Healthy Kids population (ages 5–18 years) have been omitted. In the case that a measure has an overlapping age stratification that does apply to Florida Healthy Kids enrollees, data for that category are reported. However, due to enrollment data aberrations, total rates reported for measures that include overlapping age stratifications may include a minimal number of enrollees outside the Florida Healthy Kids population age range of 5–18 years.

Table 10. 2020 PMV: MCO HEDIS Performance Measures

Access and Availability of Care
♦ Children and Adolescents' Access to Primary Care Practitioners
♦ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
♦ Prenatal and Postpartum Care
♦ Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Table 10. 2020 PMV: MCO HEDIS Performance Measures

Utilization
♦ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
♦ Ambulatory Care: Emergency Department Visits
♦ Adolescent Well-Care Visits
♦ Identification of Alcohol and Other Drug Services
♦ Mental Health Utilization
Effectiveness of Care – Prevention and Screening
♦ Chlamydia Screening in Women
♦ Immunizations for Adolescents
♦ Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents
Effectiveness of Care – Respiratory Condition
♦ Appropriate Testing for Children with Pharyngitis
♦ Medication Management for People with Asthma
♦ Asthma Medication Ratio
Effectiveness of Care – Behavioral Health
♦ Follow-Up Care for Children Prescribed ADHD [Attention-Deficit/Hyperactivity Disorder] Medication
♦ Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older (FHM)*
♦ Follow-Up After Emergency Department Visit for Mental Illness
♦ Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
♦ Metabolic Monitoring for Children and Adolescents on Antipsychotics

Table 10. 2020 PMV: MCO HEDIS Performance Measures
Overuse/Appropriateness
♦ Appropriate Treatment for Children with Upper Respiratory Infection
♦ Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)†

** FHM is an AHCA-defined measure.*
† Although APC is a retired HEDIS measure, FHKC required that MCOs report data for this measure.

Table 11. 2020 PMV: DBM Performance Measures
♦ Enrolled Children Receiving Any Dental Services
♦ Enrolled Children Receiving Dental Preventive Services
♦ Enrolled Children Receiving Dental Treatment Services
♦ Enrolled Children Receiving Dental Sealants on Permanent Molars
♦ Enrolled Children Receiving Dental Sealants on Permanent Molars – With Exclusions*
♦ Enrolled Children Receiving Diagnostic Dental Services
♦ Enrolled Children Receiving Any Dental or Oral Health Service
♦ Annual Dental Visit (ADV)†

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

Comparative Findings

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

Charts 1 and 2 present overall trending for each MCO and DBM, respectively, by including the total number of performance measures for which rates increased (or decreased positively when lower measure rates are better), decreased, or remained the same from 2019 to 2020.

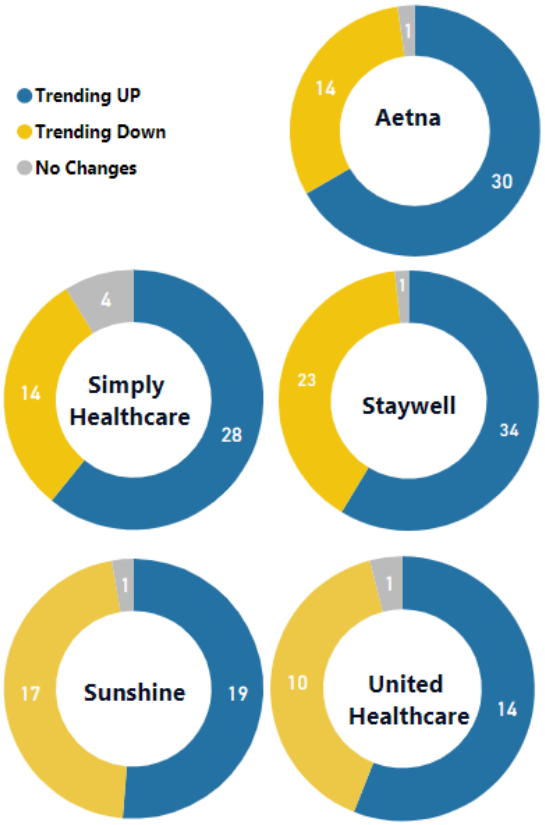

Chart 1. MCO Measure Trending from 2019 to 2020

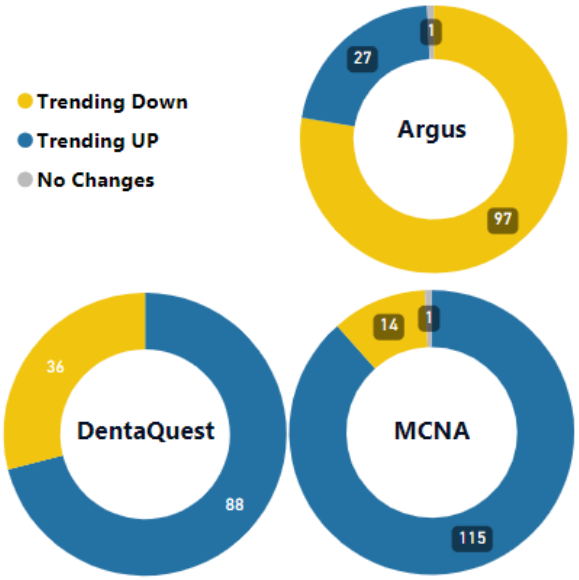

Chart 2. DBM Measure Trending from 2019 to 2020

Strengths and Weaknesses

Table 12 includes strengths identified in the 2020 PMV for the DBMs. The MCOs all were noted as fully compliant with all NCQA-defined Information System Standards for HEDIS-applied data and processes. Each of the MCOs was also recognized as having undergone an NCQA Compliance Audit, and the final opinion indicated that all performance measures were prepared in accordance with the appropriate technical specifications—HEDIS or AHCA MMA.

Likewise, Qsource did not identify any areas for improvement related to any of the DBMs' processes for data collection and

performance measure reporting during the 2020 PMV, as with the 2019 and 2018 PMV activities.

Table 12. 2020 PMV: Strengths by DBM
Argus
Team well prepared for review, demonstrated by documentation and identifying subject-matter experts necessary for each area contributing to performance measure data reporting; key leadership included and resources dedicated to FHKC contract during the review, noted as a high level of engagement and commitment to the Florida Healthy Kids program; consistent performance across required dental measures with rates consistent to prior year's results
DentaQuest
Continued demonstration of commitment to the Florida Healthy Kids program; increase in many performance measures, noted as commendable; performance measurement team's unique understanding of its role and how it contributes to overall results
MCNA
Exceptional strengths demonstrated with internally developed system, DentalTrac™ (identified as a best practice), which captured all data required for performance measure reporting, including claims, enrollment, and provider data; supported seamless data integration; and inherently maintained necessary controls to support data completeness and accurately produce measures under scope of the validation

Improvements Since the 2019 PMV

As no weaknesses were identified for the MCOs or DBMs in the 2019 PMV, there are no improvements to report for 2020. However, Qsource has provided trending for the MCOs' and DBMs' performance measure results in Appendix A.

Annual Compliance Assessment (ACA)

Assessment Background

Qsource conducted the ACA reviews pursuant to the requirements in (1) 42 CFR § 438, Subparts D and E, as incorporated by 42 CFR § 457 Subpart L; (2) CMS's *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations* (Version 2.0; September 2012); and (3) FHKC MSCs and dental services contracts (DSCs). The survey team consisted of clinicians with expertise in quality improvement. FHKC has chosen to review approximately one-third of the compliance standards annually, resulting in all standards being reviewed within the required three-year time period, as noted in **Table 13**. Standards reviewed for the MCOs for 2020 include Enrollee Information, Enrollee Rights and Protections and Confidentiality, and Credentialing (Provider Selection). This year's ACA also included credentialing and recredentialing file reviews.

Table 13. Compliance Assessment Standards

Standard	Review Year
Access and Availability of Services and Assurances of Adequate Capacity and Services	2018
Grievances and Appeals	2018
Quality Assessment and Performance Improvement, Practice Guidelines, and Health Information Systems	2018
Program Integrity	2018

Table 13. Compliance Assessment Standards

Standard	Review Year
Coverage and Authorization of Services	2019
Coordination and Continuity of Care	2019
Subcontractual Relationships and Delegation	2019
Enrollee Information	2020
Enrollee Rights and Protections and Confidentiality	2020
Credentialing (Provider Selection)	2020

In addition, the 2020 ACA reports included results from the 2019 and 2018 assessments as well as the 2020 results. The overall results for the compliance assessments for 2018, 2019, and 2020 are included for each MCO and DBM in the Comparative Findings section, where discussion of results from the 2020 ACA is also provided. More detailed results from the 2020 ACA are included in Appendix A.

Technical Methods for Data Collection and Analysis

For each MCO and DBM, the ACA normally includes pre-onsite reviews, an onsite visit, and post-onsite analyses. Due to the COVID-19 pandemic, however, all regularly scheduled onsite reviews were migrated to virtual reviews through the use of online meeting software. All other protocols for the ACA review

remained the same. Qsource developed evidence-based oversight tools in consultation with FHKC and by referencing the MSCs and DSCs and the requirements included in 42 CFR § 438, Subparts D and E, as incorporated by 42 CFR § 457, Subpart L. Qsource provided the ACA tools and a list of documents needed to support compliance to each MCO and DBM prior to pre-assessment, giving the MCOs and DBMs opportunities to ask questions, complete documentation reviews, and prepare for the virtual review. During the review, MCO and DBM staff answered questions and provided information to help surveyors determine the MCO/DBM's degree of compliance with federal and contract requirements, explore any issues not fully addressed in the document review, and increase overall understanding of the MCO/DBM's operations. Qsource surveyors used the tools, along with personal observations, interviews with MCO/DBM staff, virtual system demonstrations, and file/document reviews to facilitate analyses and compilation of findings. Each MCO and DBM also provided additional P&Ps and other documents for surveyors during the virtual review. The 2020 virtual reviews took place May through June 2020.

To reduce duplication of assessment activities, FHKC chose to allow certain standard elements to be deemed compliant in cases where an MCO/DBM, accredited by a nationally recognized accreditation organization—NCQA, the Accreditation Association for Ambulatory Health Care (AAAHC), or URAC®—has achieved a full score on an element with similar requirements to the regulatory or contractual element. Both Aetna and Simply Healthcare elected to provide full documentation for all elements for 2020, just as in 2019 and 2018. Argus elected to provide full documentation for some elements available for deeming for the 2020 review and for all elements available for deeming for the 2019 review. One element, Enrollee Handbook Content – 3, in the Enrollee Information standard was deemed compliant for Argus per the DBM's AAAHC fully compliant scores related to this element. Two elements were deemed for MCNA based on the DBM's URAC and NCQA fully compliant scores: Provider Incentive Plan in the Enrollee Information standard and Provider Selection Process – 1 in the Credentialing standard. DentaQuest had no deeming opportunities for the 2020 ACA.

In addition to compliance standards, the ACA included reviews of a random sample of provider credentialing and recredentialing cases to evaluate how the MCO or DBM applied the processes and procedures required in 42 CFR § 438, Subpart D and in the Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP; March 2018) in its operational practice. Qsource asked that MCOs and DBMs provide the universe of 2019 credentialing and recredentialing files, from which Qsource abstracted a random sample and an oversample. Files in this selection included 15 credentialing files and 15 recredentialing files (10 sample and 5 oversample). For the 2020 review, several elements of the credentialing and recredentialing file reviews were deemed compliant based on NCQA accreditation. These elements are highlighted 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 regarding the MCO's or DBM's compliance with regulatory and contractual standards through a review of P&Ps, quality studies, reports, medical records/files, and other related MCO and DBM documentation. Each standard element had an assigned point value of 1, and Qsource analyzed every element in the survey tools. Qsource determined MCO and DBM performance scores by adding the total points earned for each standard element on a scale of 0 to 1. Scores for each standard were calculated by dividing the total points earned for all elements in the standard by the total points possible for all elements in the standard.

The Enrollee Information standard included 22 elements for the MCOs and 20 for the DBMs. The MCOs were assessed on 17 elements and the DBMs for 12 for the Enrollee Rights and Protections and Confidentiality standard. The Credentialing (Provider Selection) standard had 21 elements for the MCOs and 18 for the DBMs.

Comparative Findings

Chart 3 includes overall compliance scores for all standards evaluated over the past three-year period (2018–2020). Detailed discussion of the 2020 review is included in this section. Additional results are provided in Appendix A.

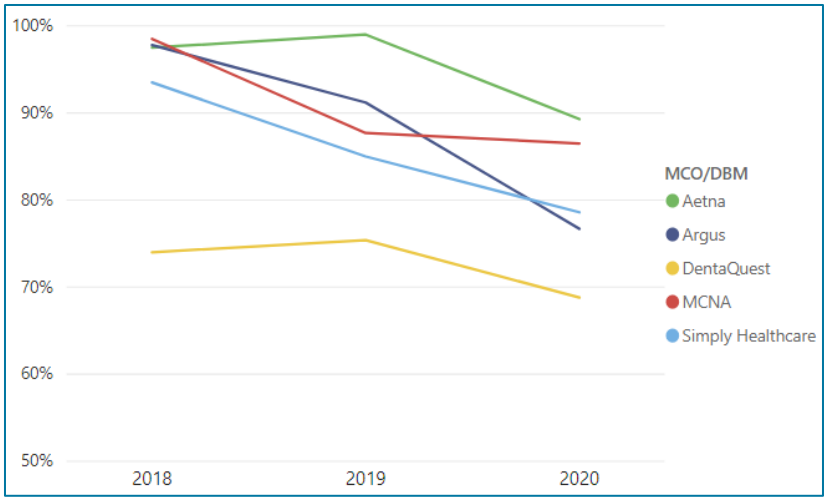

Chart 3. MCO/DBM Overall Compliance Score Trending 2018–2020

Strengths and Weaknesses

Table 14 provides each MCO's and DBM's strengths by compliance standard for the 2020 ACA, while the AONs, or weaknesses, identified for the MCOs and DBMs are in Table 15. AONs are expressed in terms of what the MCO/DBM should do to be in full compliance. Where an MCO or DBM does not appear in Table 14 or Table 15, the Plan had no identified strengths or weaknesses in those areas, respectively. Qsource also identifies suggestions where an element is fully compliant but a revision/update could further strengthen that element's compliance. The MCOs and DBMs are not held accountable for addressing suggestions; therefore, suggestions are not monitored or included in this report.

Table 14. 2020 ACA Strengths by Standard and MCO/DBM	
MCO/DBM	**Strength**
Enrollee Information	
Aetna	Provider Directory Content and Provider Directory Updates: Referencing and cross-referencing of CFR, NCQA, and FHKC requirements
DentaQuest	Information Format: Inclusion of evaluation component for health literacy of enrollee communication materials Culturally Competent Communication: Thorough training slide deck with definitions and explanations of laws related to cultural competency Provider Termination Notice: Quality check step by Provider Relations team Enrollee Handbook Content: Step-by-step instructions for accessing and using online provider search tool
MCNA	Culturally Competent Communication: Thorough, detailed report of welcome packet requests for FHKC enrollees Electronic Information: Website inclusion of pertinent enrollee information clearly identified, organized, and accessible Provider Termination Notice: More stringent notification requirement than CFR and contractual requirement Enrollee Handbook: "About This Handbook" section's inclusion of helpful explanation of the handbook Notice of Changes: Inclusion of date for enrollee notification records Provider Directory Content: Inclusion of "How to Read the Provider Listings" section
Simply Healthcare	Electronic Information: Easy website navigation through organized, non-cluttered design Provider Directory Content: Inclusion of "Symbols Index" section
Enrollee Rights and Protections and Confidentiality	
Aetna	Provider–Enrollee Communication: Encouragement to providers to advocate on behalf of enrollees
DentaQuest	Enrollee Rights: Enrollee handbook "Member Rights and Responsibilities" section's references to specific CFR requirements
MCNA	Emergency and Post-Stabilization Services: Clear, detailed information on provider reimbursement for emergency care claims and citing of applicable state and federal law
Simply Healthcare	Emergency and Post-Stabilization Services: Specific CFR and Florida Statute regulations Enrollee Confidentiality: Specific CFR and Florida Statute regulations

Table 14. 2020 ACA Strengths by Standard and MCO/DBM	
Credentialing (Provider Selection)	
Aetna	Mental Healthcare and Substance Abuse Providers: Specific reference to types of mental health and substance abuse providers in networks; specific Florida statutes and Florida Healthy Kids Uniform Credentialing and Recredentialing Policy
DentaQuest	Provider Contract Compliance: Appointment access quarterly Quality Monitoring Survey that was thorough and demonstrated active ongoing monitoring of provider access; comprehensive provider demographic validation process, including quarterly outreach to certain providers and annual outreach to all providers
Simply Healthcare	Delivery Network – Provider Credentialing: Annual review of provider denials and terminations for consistency in nondiscrimination and nondiscrimination statement distributed to Credentialing Committee Facility Standards: Comprehensive, easily understood table of accrediting bodies by type of health delivery organization

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
MCO/DBM	**AON**
Enrollee Information	
Aetna	Electronic Information: Policy update to ensure enrollee materials from website are provided in paper form to enrollees within five business days of request Notice of Changes: Requirement for notifying enrollees of changes in enrollee handbook missing for review year
Argus	Language and Format: Policy update to include requirement for prevalent non-English-language taglines Provider Termination Notice: Policy update to reflect written notification and 15-calendar-day requirement
DentaQuest	Electronic Information: Update so requirement that enrollee materials are to be provided in paper form free of charge upon request within five business days of request is clearly communicated to enrollees; include requirements specific for Florida Healthy Kids Language and Format: Policy update to include 12-point-font requirement for enrollee materials and make clear that all written materials for enrollees must include taglines in prevalent non-English languages in service area Certificates of Creditable Coverage: Policy update to include requirement for issuing certificates of creditable coverage to enrollees, upon enrollee request

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
	Enrollment with Primary Dental Care Provider: Policy update to include requirement to provide new enrollee materials within five business days of enrollment Enrollee Handbook Content: Update to enrollee handbook to include information about potential required enrollee payment during enrollee-requested external review if final decision is adverse to enrollee Notice of Changes: Policy update to include requirement to provide notice to each enrollee of any change that FHKC defines as significant in enrollee handbook, at least 30 days before effective date of change
MCNA	Enrollee Handbook Content: Update to enrollee handbook to include information about potential required enrollee payment during enrollee-requested external review if final decision is adverse to enrollee Provider Directory Content: Requirement for inclusion of age limitations missing from provider directory for part of review year
Simply Healthcare	Provider Termination Notice: Policy update to include requirement to provide notice within 15 calendar days for terminating network provider Physician Incentive Plan: Policy update to address requirement to make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i) Enrollee Handbook: Requirement for providing new enrollee materials within five business days in enrollee handbook missing for review year Enrollee Handbook Content: Updates to enrollee handbook to include explanation that a referral is not needed to choose a family planning provider and to include information about enrollee continuation of benefits or potential required enrollee payment during enrollee-requested external review Notice of Changes: 30-day notification requirement missing from policy for part of review year Provider Directory Content: Provider directory updates for all service areas to include providers' website uniform resource locators (URLs)
Enrollee Rights and Protections and Confidentiality	
Aetna	Compliance with Federal and State Laws: Policy update to include references to all applicable laws cited in 42 CFR 438.100(d) Emergency Service Limitations: Policy update to clarify that emergency services payment will not be denied based on the provider not notifying enrollee's PCP of enrollee's screening and treatment within 10 calendar days

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
	Responsibility for Emergency Coverage and Payment: Policy update to clarify that no matter which provider—emergency physician or treating provider—makes a determination that the enrollee is stabilized for transfer or discharge, MCO must be responsible for payment of services
Argus	Enrollee Rights: Updates to policy and enrollee handbook to include enrollee's rights to be free from restraint or seclusion used as means of coercion, discipline, convenience, or retaliation; and to be furnished healthcare services in accordance with 42 CFR 438.206 through 438.210 Freedom to Exercise Rights: Enrollee handbook update to include enrollee's freedom to exercise rights without adversely affecting treatment by DBM, its providers, or State agency Compliance with Federal and State Laws: Policy update to include references to all applicable laws cited in 42 CFR 438.100(d) Provider–Enrollee Communication: Provider agreement missing requirement during review year Marketing Material Requirements: Policy update to include provision to not engage directly or indirectly in marketing activities
DentaQuest	Freedom to Exercise Rights: Enrollee handbook update to include enrollee's freedom to exercise rights without adversely affecting treatment by DBM, its providers, or State agency Compliance with Federal and State Laws: Policy update to include references to all applicable laws cited in 42 CFR 438.100(d) Marketing Material Requirements: Policy update to include requirements regarding marketing materials Marketing Material Assurances: Policy update to include DBM's assurances to FHKC regarding marketing materials Enrollee Confidentiality: Policy update to include specific reference to contract with FHKC
MCNA	Compliance with Federal and State Laws: Language specific to Florida Healthy Kids missing from policy for review year DBM Non-Refusal to Cover Benefits or Services: Language specific to Florida Healthy Kids missing from policy for review year Liability for Payment: Language specific to Florida Healthy Kids missing from policy for review year Protections from Collection: Language specific to Florida Healthy Kids missing from policy for review year
Simply Healthcare	Compliance with Federal and State Laws: Policy update to address requirement of compliance with Section 654 of *Omnibus Budget Reconciliation Act of 1981* and Title XXI of the federal *Social Security Act*

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
	Liability for Payment: Florida Healthy Kids Provider Addendum that included requirements not effective for review year Protections from Collection: Florida Healthy Kids Provider Addendum that included requirements not effective for review year
Credentialing (Provider Selection)	
Aetna	At-Risk Providers: Update to provider agreement or provider manual to include requirement for unannounced site visits by CMS, FHKC, their agents, and designated contractors Disclosures: Update to provider agreement to include provision of required disclosures within 35 days of date requested by CMS, AHCA, or FHKC Education and Training: Assurance that documentation of all required primary source verification elements and copies of licenses are stored in credentialing system
Argus	At-Risk Providers: Policy development to address that criminal background checks and risk level adjustments are conducted by AHCA and verified by active, enrolled Medicaid ID; provider agreement missing provision requiring compliance with site visits for review period; update to provider agreement to include denying or terminating provider enrollment if site visit access is denied Exclusions: Policy update to confirm status of provider and disclosed parties in Social Security Agency's death master file Appropriate Actions: Policy update to include imposing sanctions, suspensions, restrictions, and terminations of providers as result of inability to verify provider identity Recredentialing: Policy update to reference requirement for repeat background checks at least every five years Verifications: Policy update to address suspension of prescribing rights by AHCA Disclosures: Policy update to address denial of enrollment based on specific circumstances; provider agreement provision requiring compliance with disclosure requirements missing for review period Criminal Background Checks: Policy update to include requirements that providers and those with ownership interest in provider must consent to criminal background checks, including fingerprinting within 30 days of request; update to provider manual or provider agreement to include this language Education and Training: Credentialing system update to include verification of Social Security Agency death master file

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
DentaQuest	Facility Standards: Policy update to address specific ACHA facility accreditation and licensure and how they are verified At-Risk Providers: Policy update to include AHCA process of establishing categorical risk levels for providers; criminal background checks, including fingerprints; and adjustments of risk levels, and that these activities are confirmed by validation of current, unrestricted Medicaid ID; Dental Participating Practice Agreement update to include requirements to allow unannounced site visits by CMS, FHKC, their agents, and designated contractors, and denial or termination of enrollment if access for site visits is denied; policy to address denying or terminating provider participation if access to unannounced visits by appropriate agencies is not allowed Appropriate Actions: Policy update to address when provider's identity cannot be confirmed Recredentialing: Policy update to reference requirement for repeat background checks at least every five years Verifications: Policy update to address verification of Medicaid prescribing rights and providers terminated under *Social Security Act* or Medicaid or CHIP program in any other state Disclosures: Update to Dental Participating Practice Agreement to include provision that disclosure information must be provided within 35 days from the date of request from CMS, AHCA, or FHKC Criminal Background Checks: Dental Participating Practice Agreement update to include requirement for consenting to criminal background checks, including fingerprinting and timeframe for submitting requested fingerprints for providers and persons with practice ownership interest Verifications and Attestations: Policy updates to include verification of adequate supplies and smoke-free facilities as well as attestations for history of chemical dependency/substance use disorder and history of misdemeanor convictions Provider Nondiscrimination: Policy update to address nondiscrimination based solely on license or certification
MCNA	Exclusions: Policy update to address verification of identity and exclusion status of appropriate persons with ownership or control interest or who are agents or managing employees of provider Verifications: Policy update to address suspension of prescribing rights by AHCA Disclosures: Policy update to include when providers must be denied enrollment based on ownership and management disclosures

Table 15. 2020 ACA Weaknesses (AONs) by Standard and MCO/ DBM	
Simply Healthcare	Mental Healthcare and Substance Abuse Providers: Policy update to address individuals or entities who meet minimal licensure and credentialing standards set forth in statutes and rules License: Policy update to specify that, for participation in Florida Healthy Kids network, providers must have no current limitations on their license At-Risk Providers: Florida Healthy Kids Provider Addendum update to include provision to allow unannounced onsite inspections of provider locations; policy update to include that providers must be denied enrollment or terminated from network if provider fails to provide access for any site visits Exclusions: Policy update to address verification of exclusion status for all providers and disclosed parties and to include verification through National Plan and Provider Enumeration System Provider Contract Compliance: Appropriate documentation development for how accurate directory information is maintained Appropriate Actions: Policy update to reference action to be taken when provider's identity cannot be verified or when provider falsifies information on application Recredentialing: Policy update to include repeat background checks at least every five years as conducted by AHCA Verifications: Policy update to address verification of suspension of Medicaid prescribing rights by AHCA Disclosures: Provider agreement update to include that provider must provide disclosures within 35 days of request by CMS, AHCA, or FHKC Verifications and Attestations: Policy update to include attestations for misdemeanor convictions

Improvements Since the 2019 ACA

As part of the ACA, Qsource documents the quality improvements the MCOs and DBMs have made since the previous year's survey. Table 16 summarizes the AONs identified during the 2019 ACA and the corrective actions accomplished to address the AONs. While AONs were identified during the 2019 ACA for Staywell, Sunshine, and UnitedHealthcare, these MCOs' contracts with FHKC ended December 31, 2019; therefore, no improvements are included for these three. Any other MCO or DBM not appearing in Table 16 had no identified AONs during the 2019 ACA. Standards assessed as part of the 2019 ACA included Coverage and Authorization of Services, Coordination and Continuity of Care, and Subcontractual Relationships and Delegation.

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
Argus	
Coverage and Authorization of Services, Element 1, Service Protections: The DBM should ensure that the appropriate document includes the provision that the DBM does not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.	Verbiage updated in P&P UM59d_APS03 Practice Guidelines to clarify provisions that Argus does not deny or reduce service to any enrollee based on diagnosis, type of illness, or condition. **This action satisfied the 2019 CAP.**
Coverage and Authorization of Services, Element 2, Service Limitations: The DBM should ensure that the appropriate document reflects that services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services.	Verbiage updated in UM59d_APS0 Practice Guidelines to clarify that services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need. **This action satisfied the 2019 CAP.**
Coordination and Continuity of Care, Element 1, Appropriate Source of Care: The DBM should develop procedures and processes to ensure each enrollee has an ongoing source of primary dental care and communicate how enrollees can contact this source of care.	1. Actions currently in place will continue as documented in the Argus P&Ps submitted for this ACA and further documentation presented and reported during the on-site as documented in the ACA Report Argus Dental Plan August 2019. Verbiage in the initial new enrollee outreach information will remain until approval updated verbiage submitted to FHKC for approval 08/27/2019 is received. 2. Every enrollee will be assigned to a primary dental provider/dental home and be notified in writing via a letter currently pending approval by FHKC. The notification will be sent to the enrollee's mailing address provided by FHKC in the monthly enrollment files. The Primary Dental Provider will be a network general or pediatric dentist accepting patients and located closest to the enrollee's home address as reported via the full and/or supplemental enrollment data files received from FHKC.

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
	a. Those having received dental care will be notified of their primary dental provider – this will be the Argus network general practice provider who most recently provided dental care to the enrollee. b. Those without a history of receiving dental care will be assigned to a network dental provider in close proximity to their home. c. New enrollees will be assigned to a network dental provider closest to their home when Argus receives notice of new enrollees via the monthly full or supplemental enrollment files received from FHKC. Our expected completion date for this process to be fully operational is 01/01/2020. This expected date is due to the IT resources required to GEO code the enrollees and providers, program system updates to "read" member and provider demographics to pull the assigned provider to each enrollee's system profile, accommodate the 834 file layout changes for 2020 (test file scheduled to be transmitted from FHKC on 12/06/2019). After the initial issuance of the existing membership, letters will be generated after the supplemental file is received and timed with the mailing of the Welcome Letter and ID card. Argus' Compliance Department is currently reviewing 42 CFR 438.208(b)(1), DSC between FHKC and AGDVI effective 0701/2016 and amendment #3 to that contract effective 07/01/2019 relative to DCS 3-2-1 and our requirements to assign each enrollee to a network provider. **These actions satisfied the 2019 CAP.**

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
DentaQuest	
Coverage and Authorization of Services, Element 1, Service Protections: While the UM Program Description 2018 indicated that the DBM complied with all federal and state regulations, the requirements of the applicable regulations and contract provisions should be specifically documented in the appropriate policy or program document.	Policy & Procedure (P&P) #UM01-INS: Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines was updated to include appropriate information. **This action satisfied the 2019 CAP.**
Coverage and Authorization of Services, Element 14, Decisions Exceeding Timeframes: For denial authorization decisions not reached within required timeframes, the DBM should provide notice on the date the timeframe expires.	Ticket, TASK0215972 and REQ0148754 was opened to create system optimizations that would allow us to identify prior authorizations eclipsing their contractual turnaround time, adjudicate, and trigger the appropriate correspondence letter thus satisfying the Federal regulatory requirement 42 CFR 438.210(d) and 42 CFR 438.404(c)(5). This is a multi-faceted system enhancement that due to its overarching scope does not have a tangible completion date yet assigned. System optimizations in progress to allow DBM to identify prior authorizations eclipsing their contractual turnaround time, adjudicate, and trigger the appropriate correspondence letter thus satisfying the federal regulatory requirement 42 *Code of Federal Regulations* (CFR) 438.210(d) and 42 CFR 438.404(c)(5). **This action satisfied the 2019 CAP.**
Coordination and Continuity of Care, Element 1, Appropriate Source of Care: The DBM should implement P&Ps to fulfill the four required activities as agreed upon with FHKC to ensure each enrollee has an ongoing source of care and care coordination and as well as information on how to contact the designated provider.	Draft P& P has been created and is in the review status with the committee. **This action satisfied the 2019 CAP**, with the understanding that network dental provider outreach to enrollees to assure an ongoing source of care and care coordination and contact information is carefully monitored by the DBM.

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
MCNA	
Coverage and Authorization of Services, Element 10, Extension of Decision Timeframe: The DBM should update P&P #3.203 to indicate that, for the Florida Healthy Kids program, the extension period is 14 calendar days and that the determination must be carried out by the date the extension expires.	Policy 3.203 updated. **This action satisfied the 2019 CAP.**
Coverage and Authorization of Services, Element 15, Elements of Adverse Benefit Determination Notice: The DBM should update P&P #3.203a to include that all documents relevant to the adverse benefit determination are available to the enrollee free of charge and should also update the denial letter template to include similar language.	Policy 3.203a updated. Denial letter template updated. **These actions satisfied the 2019 CAP.**
Coordination and Continuity of Care, Element 1, Appropriate Source of Care: While the process of assigning a PDP [primary dental provider] for enrollees was implemented, the DBM should provide the enrollee with the assigned PDP name and contact information.	Submit new template to Florida Healthy Kids for approval. Submit updated template to vendor. **This action satisfied the 2019 CAP.**
Simply Healthcare	
Coverage and Authorization of Services, Element 3, Medically Necessary Services: The MCO should specifically include the three conditions under criterion b.2 in its definition of medical necessity.	Updated P&P. Per our notes from the onsite the P&P should be updated to include that the provider is notified of a determination by fax within 24 hours. The member is notified of a denial by letter. Letters are mailed to the member and provider within three business days. Please refer A08 Pharmacy Prior Authorization, page 3. **This action satisfied the 2019 CAP.**
Coverage and Authorization of Services, Element 11, Covered Outpatient Drug Decisions: P&P #A08:	Updated P&P. Per our notes from the onsite the P&P should be updated to include that the provider is notified of a

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
Pharmacy Prior Authorization should be updated to specifically indicate that enrollees and providers receive denial notification by telephone or other telecommunication device within 24 hours of a request for prior authorization. In addition, the definition of 24 hours as a business day or non-holiday should be removed.	determination by fax within 24 hours. The member is notified of a denial by letter. Letters are mailed to the member and provider within three business days. Please refer A08 Pharmacy Prior Authorization, page 3. **This action satisfied the 2019 CAP.**
Coverage and Authorization of Services, Element 14, Denial of Payment: P&P: Health Care Management Denial – Core Process should be updated to ensure that this provision is applicable to Florida Healthy Kids enrollees.	Updated P&P. Per our notes from the onsite the P&P should be updated to include that the provider is notified of a determination by fax within 24 hours. The member is notified of a denial by letter. Letters are mailed to the member and provider within three business days. Please refer A08 Pharmacy Prior Authorization, page 3. **This action satisfied the 2019 CAP.**
Coordination and Continuity of Care, Element 3, Initial Screening: The MCO should ensure that relevant P&Ps are effective for the entire review period and that they are specific to the Florida Healthy Kids population.	Updated P&P. **This action satisfied the 2019 CAP.**
Coordination and Continuity of Care, Element 8, Treatment or Service Plan: The MCO should update P&P #FL-CM: Care Coordination and Case Management to include that plans of care are reviewed and revised at the request of the enrollee.	Updated P&P. **This action satisfied the 2019 CAP.**
Subcontractual Relationships and Delegation, Element 1, Contract Compliance: The MCO should ensure all vendor contracts related to Florida Healthy Kids delegated activities include the requirement that the MCO will maintain responsibility for complying with its contract with FHKC.	Updated Subcontractor Addendum. We have reviewed this finding with our legal counsel and she has provided the following guidance: All of our contracts contain a general compliance of law provision with all federal and state laws. Even though not expressed Subcontractors will comply with state and federal regulatory laws—it is not narrowly construed only for fraud. For our 1/1/2020 contract, this

Table 16. Improvements Since the 2019 ACA by MCO/DBM	
2019 AON	**MCO/DBM's Action Accomplished**
	matter has been mitigated with an amendment that reflects the right to inspect. **This action satisfied the 2019 CAP.**
Subcontractual Relationships and Delegation, Element 2, Delegation of Activities: The MCO should ensure all contracts and amendments with all vendors that provide services for Florida Healthy Kids are effective for the entire review year.	Updated Subcontractor Addendum. We have reviewed this finding with our legal counsel and she has provided the following guidance: All of our contracts contain a general compliance of law provision with all federal and state laws. Even though not expressed Subcontractors will comply with state and federal regulatory laws—it is not narrowly construed only for fraud. For our 1/1/2020 contract, this matter has been mitigated with an amendment that reflects the right to inspect. **This action satisfied the 2019 CAP.**
Subcontractual Relationships and Delegation, Element 4, Subcontractor Audit: The MCO should include a description of the right to inspect, evaluate, and audit if possible fraud were determined by FHKC, CMS, or the HHS.	Updated Subcontractor Addendum. We have reviewed this finding with our legal counsel and she has provided the following guidance: All of our contracts contain a general compliance of law provision with all federal and state laws. Even though not expressed Subcontractors will comply with state and federal regulatory laws—it is not narrowly construed only for fraud. For our 1/1/2020 contract, this matter has been mitigated with an amendment that reflects the right to inspect. **This action satisfied the 2019 CAP.**

Annual Network Adequacy (ANA)

Assessment Background

For the ANA reviews, directed by FHKC, Qsource evaluated each MCO and DBM to determine if it had a provider network adequate to ensure the effective and efficient delivery of healthcare to enrollees, pursuant to 42 CFR § 438.68. Prior to 2018, reviews for the MCOs were done for primary care providers, but beginning in 2018, the network validation process expanded to include certain pediatric and adult specialists as well as hospitals. For the DBMs, the 2018 review included certain dental specialists in addition to primary dental providers. The 2019 review included further changes, as contracts between FHKC and the MCOs and DBMs were amended effective July 1, 2018. This amendment included changes in provider and specialty type requirements in addition to separate time and distance standards for urban and rural areas by provider/specialty type. The 2020 review included an updated list of specialties and specialty roll-up categories for MCOs. Dental reviews remained the same. As in 2019, roll-up category access scores reflect access to any specialty within the category.

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

- Pediatric and family physician primary care providers (PCPs)
- Certain high-volume specialty care providers (SCPs), including allergists and immunologists, dermatologists, obstetricians/gynecologists, optometrists, and otolaryngologists as required by the contracts between FHKC and the MCOs
- Categories of behavioral health providers, including pediatric behavioral health providers and other behavioral health providers
- Hospitals and pharmacies
- Other providers, for informational purposes only, including various physician specialties, urgent care centers, laboratories, and free-standing psychiatric facilities

After the enrollee and provider data were standardized and geocoded, county-level (urban and rural) calculations established the travel time and distance from each enrollee location to each of the provider types identified above. If the enrollee location had at least one provider location within the established criteria, that enrollee was factored into the percentage-with-access category. The access percentages for provider categories that included multiple provider types, such as behavioral health – pediatric, reflect the percentage of enrollees who had access to any provider within the category.

For DBM enrollees, geographical access to services was determined by calculating the travel time and distance from each

enrollee—in both urban and rural categories—to each of the primary care dentist, specialty dentist, and orthodontist provider types, as specified in the DBM contracts. The access percentages for provider categories that included multiple provider types, such as dental specialists, reflect the percentage of enrollees who had access to any provider within that category.

Qsource also reviewed each MCO's and DBM's P&Ps, provider manual, and enrollee handbook to ensure that appointment availability standards were in place during 2020 and consistent with contract standards. The ANA reviews were conducted in November 2020.

Technical Methods for Data Collection and Analysis

The 2020 ANA evaluation included MCO and DBM provider networks as of October 2020. MCO and DBM relevant P&Ps and provider and enrollee communication materials were assessed. The surveyors focused on the following areas:

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

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

Description of Data Obtained

The data used in the quantitative analyses were derived from provider files supplied by the MCOs and DBMs and enrollment data supplied by FHKC. Once extracted from their respective source files, provider and enrollment data were prepared by Quest Analytics using a software application called DataCleaner from GeoAccess, Inc. Provider and enrollee address information was first validated, then cleaned and standardized to United States Postal Service specifications. Next, data were geocoded using these updated, standardized addresses. The files generated from this process were analyzed to assess network adequacy for all MCOs and DBMs. Further details can be found in each MCO's and DBM's *2020 Annual Network Adequacy Report*. Analyses were conducted for the provider and specialty types listed in **Table 17** for the MCOs and **Table 18** for the DBMs.

Table 17. ANA Provider/Specialty Categories for MCOs

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

Table 18. ANA Provider/Specialty Categories for DBMs

- Primary Care Dentists
- Orthodontists
- Dental Specialists

Comparative Findings

Although comparisons were not included in last year's technical report due to contract amendments during the 2018 review year, comparisons from last year to this year are included where possible.

Charts 4 and **5** present overall trending for each MCO and DBM, respectively, by providing the number of required provider/specialty categories for which the MCO/DBM's compliance percentage increased, decreased, or remained consistent from 2019 to 2020. Community Care is not included as its contract with FHKC was not executed until January 2020. Plan-specific results for the MCOs and DBMs are presented in Appendix A.

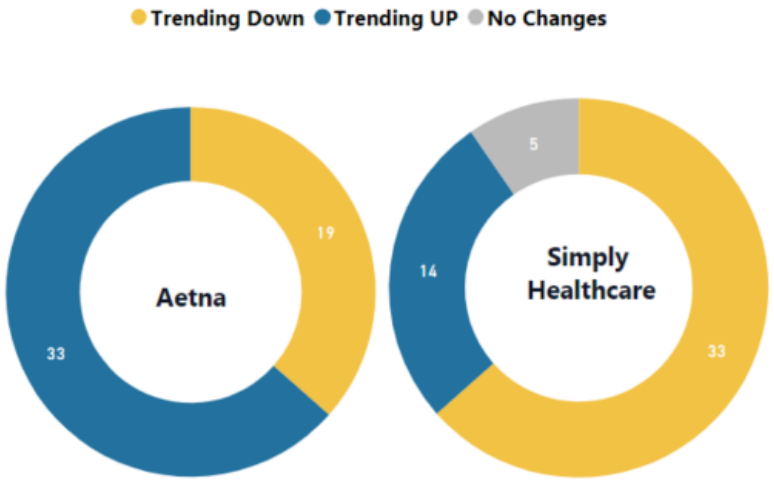

Chart 4. ANA Provider/Specialty Categories Trending from 2019 to 2020 by MCO

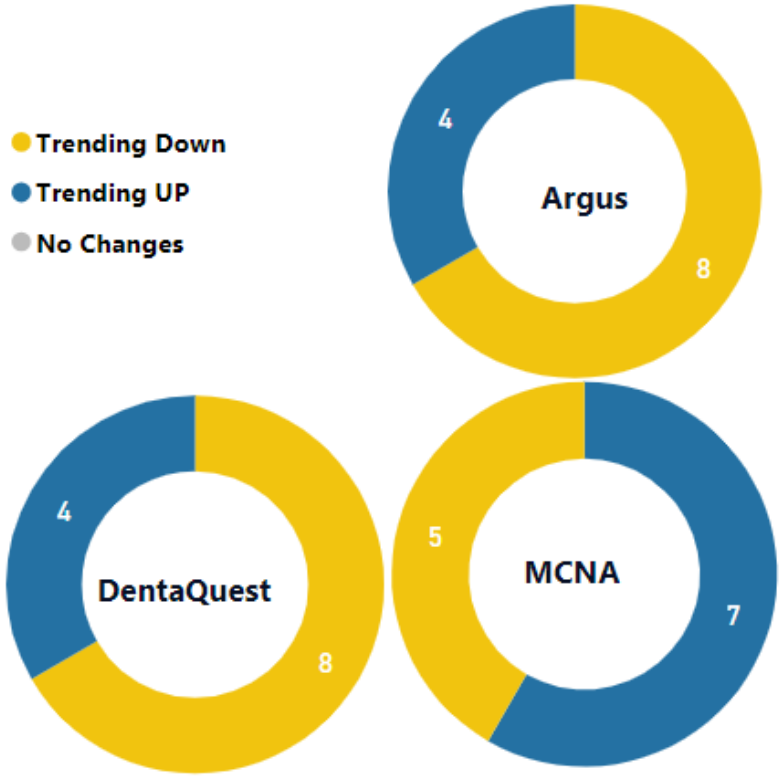

Chart 5. ANA Provider/Specialty Categories Trending from 2019 to 2020 by DBM

Strengths and Weaknesses

Table 19 includes strengths and **Table 20** identifies opportunities for improvement, or weaknesses, by MCO/DBM.

Table 19. ANA Strengths by MCO/DBM	
MCO/DBM	**Strength**
Aetna	Over 93.0% time and distance access for all provider categories for urban enrollees
Argus	Over 90.0% access within both time and distance standards for urban enrollees for primary care dentists, orthodontists, and dental specialists; over 99.0% access within time and distance standards for rural enrollees to primary care dentists
Community Care	Over 96.0% time and distance access for all provider categories for urban enrollees
DentaQuest	Over 96.0% access within both time and distance standards for urban enrollees for primary care dentists, orthodontists, and dental specialists; over 95.0% access within time and distance standards for rural enrollees to primary care dentists
MCNA	Over 95.0% access within both time and distance standards for urban enrollees for primary care dentists, orthodontists, and dental specialists; over 98.0% access within time and distance standards for rural enrollees to primary care dentists
Simply Healthcare	Over 96.0% time and distance access for all provider categories for urban enrollees

Table 20. ANA Weaknesses (Opportunities) by MCO/DBM	
MCO/DBM	**Opportunity**
Aetna	Improve rural access to allergy and immunology, obstetrics and gynecology, and hospital services; include standards for well-child visits and follow-up care as medically appropriate in provider manual
Argus	Improve access to orthodontists and dental specialists for rural enrollees
Community Care	Improve rural access to allergy and immunology, dermatology, obstetrics and gynecology, otolaryngology, specialist – pediatric, specialist – other, and hospital
DentaQuest	Improve access to orthodontists and dental specialists for rural enrollees
MCNA	Improve access to orthodontists and dental specialists for rural enrollees
Simply Healthcare	Improve access to otolaryngology, specialist – pediatric, and pharmacy for rural enrollees

Improvements Since the 2019 ANA

Table 21 includes MCO/DBM improvements since last year's ANA.

Table 21. Improvements Since the 2019 ANA by MCO/DBM

MCO/DBM	2019 Opportunity for Improvement	MCO/DBM's Action
Aetna	Improve access to allergy and immunology specialists and pharmacy providers in rural areas; improve rural and urban access to providers in the Behavioral Health – Pediatric and Specialist – Pediatric categories; consider adding detailed revision history to P&Ps	The MCO improved rural access to pharmacy providers and significantly improved rural and urban access to providers in the Behavioral Health – Pediatric and Specialist – Pediatric categories. While the MCO improved rural access to allergy and immunology specialists, the same opportunity was identified in the 2020 ANA.
Argus	Improve access to orthodontists for rural enrollees for distance standards and dental specialists for rural enrollees for both time and distance standards	The DBM had the same opportunities for enrollee access identified in the 2020 ANA.
DentaQuest	Improve access to dental specialists and orthodontists for rural enrollees; consider updating P&P to include all four appointment availability standards	The DBM had the same opportunities for enrollee access identified in the 2020 ANA. The recommendation to update the P&P was addressed prior to the 2020 ANA.
MCNA	Improve access to dental specialists and orthodontists for rural enrollees	The DBM had the same opportunities for enrollee access identified in the 2020 ANA.
Simply Healthcare	Improve access to allergy and immunology and dermatology specialists in rural areas; improve accessibility to pediatric specialists	The MCO improved rural access for the allergy and immunology and dermatology specialists. The same opportunity to improve enrollee access to pediatric specialists was also identified in the 2020 ANA.

Validation of Encounter Data (EDV)

Assessment Background

FHKC contracted with Qsource to conduct one optional EQR activity, EDV. CMS encourages the use of EQROs to validate encounter data to ensure that data used for activities related to payments and delivery of care are valid and reliable. Validation determines the accuracy and completeness of encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, and determine capitation payment rates. The importance of MCOs and DBMs collecting encounter data that are complete and accurate has only increased with value-based payment models, and this information is vital for effective operation and oversight of FHKC's MCOs and DBMs.

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

1. Review of FHKC requirements for collecting and submitting encounter data
2. Review of MCO/DBM capacity for producing encounter data that are accurate and complete
3. Analyses of the accuracy and completeness of MCO/DBM-submitted encounter data
4. Medical record review (MRR) to confirm EDV findings
5. Submission of EQRO findings

Using the 2019 CMS protocol for 2020 EDV created changes in Qsource's EQRO process for conducting EDV as did lessons learned during validation of encounter data in 2018 and 2019. The evolving nature of this activity also altered EDV reporting structure—from one quarterly service dates report each quarter to an individual quarterly service dates report for each MCO and DBM, one quarterly paid dates report each quarter, and one annual service dates report.

In addition, based on the objective of creating standardized reporting for FHKC and AHCA, FHKC collaborated with AHCA to develop new data submission guidelines implemented with submissions beginning in 2020Q1. The guidelines included the data layout, field definitions, lengths, valid values, and data types and relevant instructions. EDV activities for the 2019Q4 report followed the previous EQR Protocol 4 (2012) as well as the previous data submission guidelines and report structure. The numerous changes between the 2018 and 2019 EDV and the 2020 EDV hinder trending capabilities. Without being able to trend, Qsource has included data and results related only to the 2020 EDV in this report. Further, there are no improvements to report from last year's EDV.

Qsource also will conduct a medical record review for capitated physician encounters to fulfill Activity 4 for conducting EDV. MRR will be conducted for encounters with dates of service in 2020Q1. At

the time of this report submission, the MRR was not complete; thus, no MRR results are included for this year. As the DBMs do not utilize capitation, no encounters are reported for them.

Technical Methods for Data Collection and Analysis

The *2020Q1 Paid Dates Report* submission included new medical claims and encounters, pharmacy claims, and adjustments submitted by each MCO and DBM and in aggregate for all MCOs and DBMs, where applicable, addressing claims and encounters with service dates between January 1, 2020, and March 31, 2020. The purpose of the EDV Paid Dates Report was to provide aggregate-level claim, encounter, pharmacy, and adjustment data on a time-sensitive basis, allowing for monitoring of the volume of data in each category submitted by each MCO and DBM, identifying any aberrations in terms of expected volume, and timely follow-up on and resolution of any irregularities noted. The FHKC MCOs whose contracts ended at the end of 2019 were included in paid date EDV reporting for quarters 1 and 2 in 2020 to capture claims for services rendered prior to January 1, 2020, but not paid for until 2020, along with adjustments to prior claims that occurred in 2020.

Each quarterly EDV Paid Dates Report was intended to be supplemented by an MCO/DBM-specific *2020 Quarterly Service Dates Encounter Data Validation Report* (EDV Service Dates Report), which presented claims, encounters (MCOs only), and pharmacy claims (MCOs only) by service date for each quarter of the year. However, due to new data reporting requirements for the MCOs and DBMs, individual Plan data could not be analyzed for 2019Q4 dates of service. Reporting on each quarter was conducted once data for the review quarter and the subsequent quarter had been submitted. This three-month delay in reporting allowed for more complete service date reporting by accounting for claims lag. The EDV Service Dates reports included comprehensive data analysis guided by the activities presented in EQR Protocol 5 (2019).

The 2020Q1 EDV Service Dates reports addressed claims and encounter data with service dates between January 1 and March 31, 2020, for all claims and encounters adjudicated between January 1 and June 30, 2020 (to address claim payment lag).

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

To assess the capacity of the MCOs and DBMs to produce accurate and complete claims and encounter data, each MCO underwent an annual HEDIS Compliance Audit during 2020, examining encounter and claims processing for measurement year 2019. This audit assessed the MCOs' information systems and capacity to

process claims and encounters accurately. For the DBMs, this activity was based on review of the ISCATs submitted.

Qsource used SQL [Structured Query Language] Server Management Studio for both data maintenance and querying and to statistically determine frequencies and rates in health services data on specific fields or variables created explicitly for data validation to indicate potential concerns. Analyzing claims and encounter data obtained from MCO- and DBM-submitted data, Qsource conducted basic integrity checks to determine if the data existed, if they met expectations, and if they were of sufficient basic quality to proceed with more complex analyses.

For MRR, Qsource will select a statistically valid stratified random sample of statewide encounters for service dates between January 1 and March 31, 2020, from Aetna and Simply Healthcare. Community Care reported no capitated physician encounters for this time period and thus will not be included in the MRR. A sample of 411 encounter records will be selected with an oversample of 40 records, for a total of 451 distinct encounters. Qsource will request that the MCOs secure medical records associated with these encounters. The records will be reviewed to confirm that key electronic encounter data are supported by the appropriate medical record. Qsource will first identify if the appropriate medical record is available, then validate the following data in each medical record as compared to the electronic encounter data:

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

For this validation, Qsource will address the following:

- Are all the procedure/diagnosis codes in the electronic record documented in the medical record and all procedures/diagnoses documented in the medical record coded in the electronic record (Correctly Coded)?
- Are there procedure/diagnosis codes in the electronic record that are not documented in the medical record (Undocumented Codes)?
- Are there procedures/diagnoses documented in the medical record that are not coded in the electronic record (Missing Codes)?

Description of Data Obtained

CMS protocol for EDV defines encounter data as "the information related to the receipt of any item or service by an enrollee in a managed care plan (MCP). It is often thought of as the managed care equivalent of fee-for-service (FFS) claims. Encounter data reflect that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider" (EQR Protocol 5). Encounter data are typically the detailed service data for providers whose services are covered under a capitation

financial arrangement (i.e., per enrollee per month payments) and, therefore, are not billed as individual claims to MCOs.

Encounter data include most of the same information that appears on claim forms; however, encounter data may be less complete or accurate than claim data due to some provider payments via capitation or episodes of care versus a claim for individual services provided. Encounter data are used to assess and improve quality, monitor program integrity, determine capitation payment rates, inform policy and operational decision-making, conduct risk adjustments, and incorporate alternative payment methods (EQR Protocol 5).

CMS protocol defines potential areas of concern with encounter data validity and acceptable error rates. Encounter data determined to be *Missing* involve encounters that occurred but were not represented by an encounter record. Missing encounters were not evaluated in the quarterly EDV reports specifically, but analysis of data volume was included. Encounters that did occur but have records with incorrect data elements are classified as *Erroneous*. The *Acceptable Error Rate* is the maximum percentage of these record types (i.e., Missing, Erroneous) that FHKC will accept.

For the 2020 EDV Reports, Qsource identified the number of MCO and DBM records with accurate data out of the number examined with data present (completeness) for fields FHKC agreed upon, as detailed in Appendix B.

Comparative Findings

For EDV Activity 2, review of data production capacity, all three MCOs and both DBMs received an acceptable rating for the ability to produce accurate and complete claims and encounter data for the period covered in the 2020 EDV reports. These ratings were based on an evaluation of:

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

Volume and Consistency

Per CMS protocol, EDV should include an analysis of the volume and consistency of encounter data. To assess if claims and encounter data volume among the MCOs/DBMs was within expectations, Qsource analyzed frequencies of submitted claims and encounter records, frequencies of claim and encounter lines; percentages of enrollees with at least one claim/encounter; and the percentage of enrollment versus claims and encounter data. Qsource also analyzed medical and dental claim data percentages by service type and by provider type, average days from last service date to distinct claim paid date and average days from billing date to distinct claim paid date as well as frequencies of new medical claims and encounters, pharmacy claims, and adjustments. Table 22 includes total claims and encounters submitted by all MCOs and DBMs for 2020Q1 and 2020Q2 dates of service. Other more detailed results are included in Appendix A. The total number of claims may differ from the totals in tables A-22 and A-23 due to some claims having more than one provider type.

Table 22. Total Claims and Encounters Submitted by MCOs and DBMs						
2020Q1 Dates of Service	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total***	**Pharmacy Claims**
	Institutional	**Professional**	**Institutional**	**Professional**		
Total MCOs	30,055 (10.07%)	268,018 (89.93%)	6 (0.02%)	26,940 (99.98%)	325,018	410,756
Total DBMs					70,069	
2020Q2 Dates of Service	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total***	**Pharmacy Claims**
	Institutional	**Professional**	**Institutional**	**Professional**		
Total MCOs	12,031 (7.01%)	159,499 (92.99%)	59 (0.29%)	20,021 (99.71%)	191,505	294,624
Total DBMs					35,735	

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

MCO data for Q1 service dates demonstrated that professional claims accounted for the vast majority of distinct medical claims at 89.93%, within normal expectations. Professional encounters accounted for 99.98% of total encounters, consistent with expectations that most capitated payment arrangements are with professional providers. Data for Q2 service dates demonstrated a reduction from Q1 of 41% in total claims and encounters, a result of the COVID-19 pandemic and limited services available and sought in Q2. The distribution of professional versus institutional was similar to Q1 experience. DBM data for Q2 service dates demonstrated a similar reduction (49%) in services from Q1, again attributable to the COVID-19 pandemic.

Similar to MCO claims and encounters, MCO claim and encounter lines decreased significantly from Q1 to Q2. The same was true for DBM claim lines.

The percentage of enrollees with at least one medical claim or encounter also decreased significantly from Q1 to Q2, ranging from 48.88% (Community Care) to 58.31% (Simply Healthcare) in Q1 and from 34.85% (Community Care) to 41.96% (Simply Healthcare) in Q2. For the DBMs, the percentage of enrollees with at least one claim decreased from Q1 to Q2, ranging from 22.22% (Argus) to 27.16% (DentaQuest) in Q1 and from 13.29% (Argus) to 16.32% (DentaQuest) in Q2.

The relative distribution of medical claims and encounters and dental claims to MCO and DBM enrollment was consistent in Q1 and Q2.

Q1 and Q2 demonstrated consistent distribution of medical claims by services type, with the majority of claims being for evaluation and management, medicine, and pathology and laboratory services. The majority of medical encounters were for evaluation and management, medicine, and other services (mostly therapy encounters). Dental claims were consistent from Q1 to Q1, with the majority of claims for dental preventative services, dental radiographs and diagnostic imaging, and dental clinical oral evaluations. Medical claims by provider type were also consistent from Q1 to Q2, with the majority of claims from physicians, independent laboratories, and general hospitals. For medical encounters, the most frequent provider types were physician and therapist.

The average number of days from last service date to claim paid date for professional and institutional claims was within expectations for Q1 and Q2. The same was true for average number of days from billing date to last claim paid date, with the exception of Simply Healthcare, for which an accurate, systematic average number of days could not be calculated due to a number of blank billing dates. For the DBMs, the average number of days from last service date and billing date to claim paid date was within expectations, with the exception of Argus. Argus had a number of claim paid dates of 01/01/1900, which made an accurate systematic calculation of the two values impossible.

Completeness and Validity

Qsource determined completeness and validity rates for critical data fields for the MCOs and DBMs agreed upon by FHKC, included in Appendix B. The accuracy rates were calculated as the number of valid data points as a percentage of those with data present (completeness). **Chart 6** includes the percentage of fields for which each MCO and DBM scored between 90.0% and 100% completeness. The percentage of fields with 90.0% to 100% accuracy are included in Chart 7.

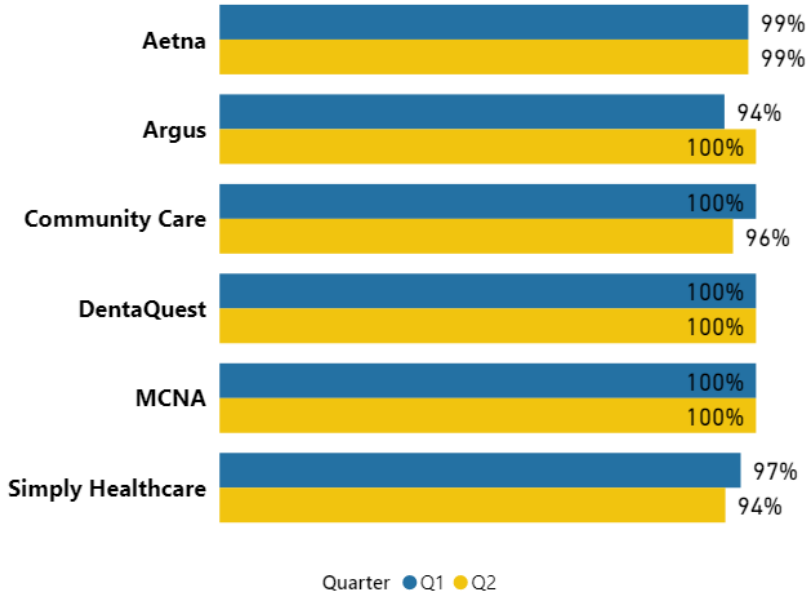

Chart 6. Percentage of Fields with 90.0-100% Completeness Rating

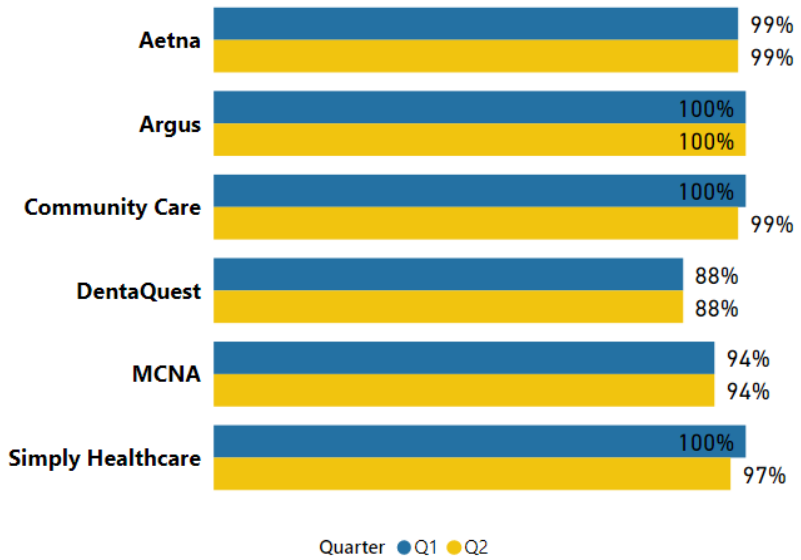

Chart 7. Percentage of Fields with 90.0-100% Validity Rating

For the MCOs, the majority of completeness and validity rates for critical data fields were between 90.0% and 100%. Exceptions included Aetna's Admit Date, for which completeness was 88.2% in Q1 and 43.39% in Q2. For encounters, Place of Service validity for Community Care was below 90.0% in Q2 at 76.52% compared to 94.53% in Q1. For Simply Healthcare, Place of Service validity was 69.76% in Q2, down from 98.83% in Q1.

For MCO pharmacy claims, Aetna's validity of the Class data field was 0% for Q1, increasing to 3.27% in Q2. Community Care completeness rates for Treating Provider Type, Treating Provider Medicaid ID, and Treating Provider Specialty were 85.03% in Q2, a decrease from 100% rates in Q1. For Simply Healthcare, National Drug Code and Class completeness rates were 89.93% in Q1 and 84.86% in Q2. Primary Pharmacy ID and Days' Supply completeness rates for Q2 were 85.02%, compared to 90.11% in Q1.

For the DBMs, the majority of completeness and validity rates for critical data fields were between 90.0% and 100%. Exceptions included Argus Treating Provider NPI completeness at 84.66% for Q2, compared to 91.49% in Q1. DentaQuest Treating Provider Medicaid ID validity rates for Q1 and Q2 were low, at 40.76% and 45.54%, respectively. MCNA's Member ID validity rates were 76.93% and 77.57% for Q1 and Q2, respectively. Specific results by MCO and DBM are provided in Appendix A.

Paid Date Reporting

In addition to service date reporting, Qsource conducted quarterly aggregate analysis of claim/encounter data based on claims/encounters adjudicated in that quarter to provide timely information on the volume of claims/encounters and adjustments occurring in each quarter. Analysis for 2020 Q1, Q2, and Q3 for the MCOs (Aetna, Community Care, and Simply Healthcare) and DBMs is included in this report. Chart 8 includes claim, encounter, and pharmacy data by MCO. Chart 9 includes adjustment data by MCO. Chart 10 includes claim data by DBM, and Chart 11 includes adjustment data by DBM.

Medical claims and encounters adjudicated in Q1 were close to 300,000. This decreased to approximately 219,000—a 26% reduction—in Q2, likely due to the COVID-19 pandemic. For Q3, claims and encounters increased significantly, to approximately 278,000. Pharmacy claims decreased from close to 369,000 in Q1 to 281,000 (down by 24%) in Q2 and 278,000 in Q3. One issue with claims submission was underreporting of Community Care pharmacy claims, for Q1 in particular. Dental claims decreased from about 75,000 in Q1 to 34,000 in Q2 (down by 56%), but went back up in Q3, to approximately 64,000.

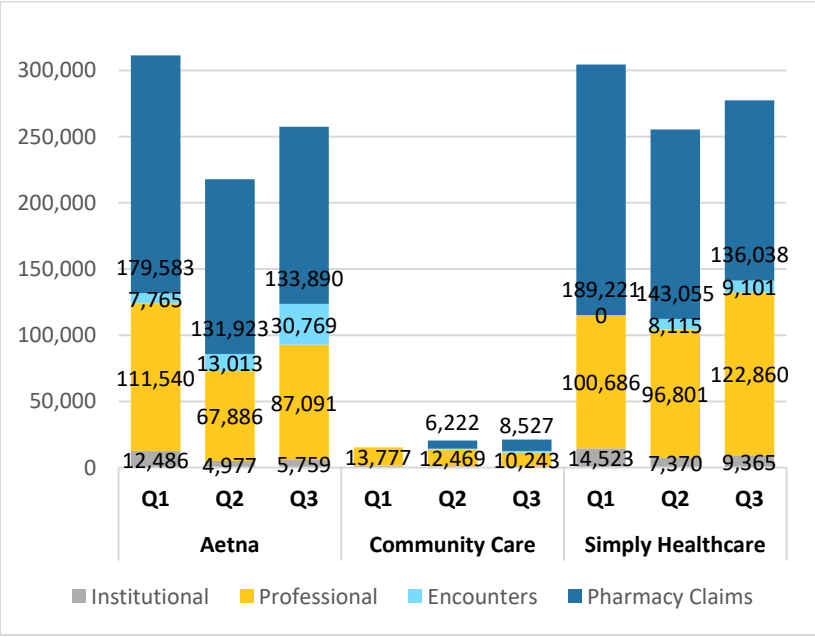

Chart 8. 2020 Q1, Q2, and Q3 Claim, Encounter, and Pharmacy Data by MCO

Adjustment varied among the MCOs for medical claims, with institutional adjustments accounting for between 9% and 19% of total adjustments and professional adjustments accounting for between 81% and 91%. Pharmacy adjustments were relatively consistent across all three quarters as were dental claim adjustments.

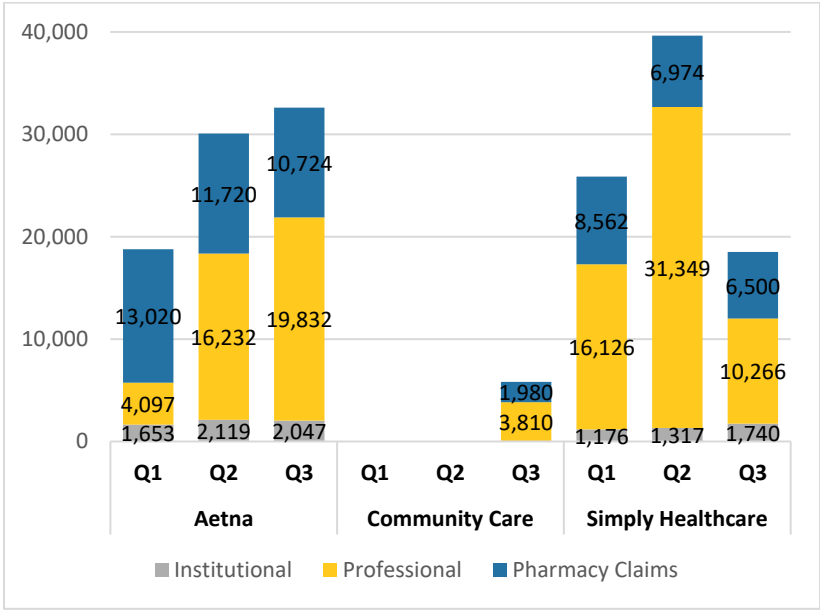

Chart 9. 2020 Q1, Q2, and Q3 Adjustments by MCO

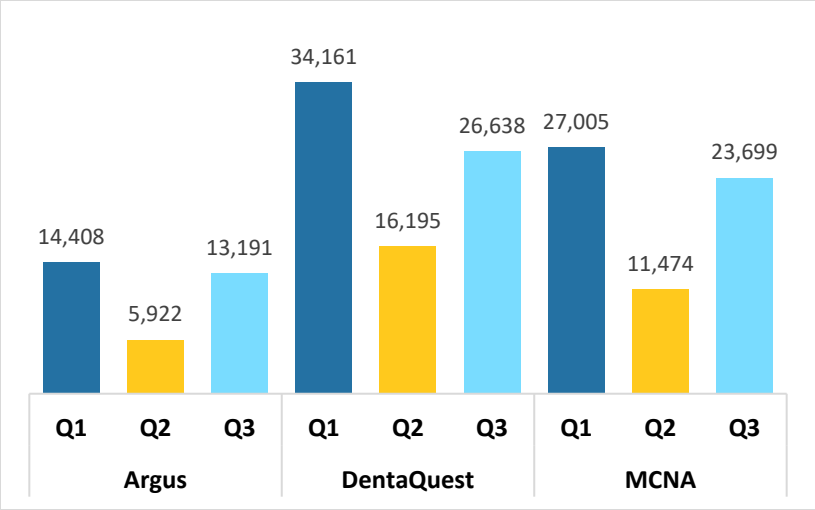

Chart 10. 2020 Q1, Q2, and Q3 Claim Data by DBM

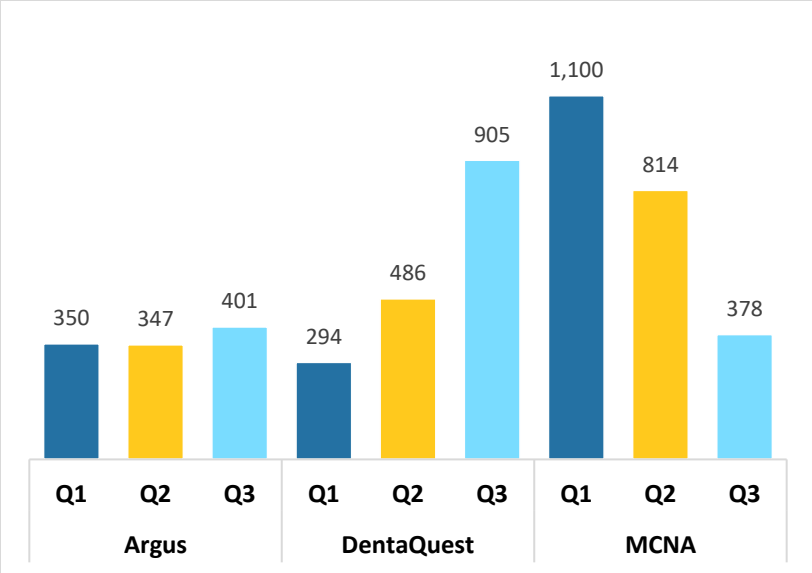

Chart 11. 2020 Q1, Q2, and Q3 Adjustments by DBM

Conclusions and Recommendations

Qsource conducted mandatory and optional EQR activities for the Florida Healthy Kids program for calendar year 2019. From the aggregation and analyses of data across activities for all MCOs and DBMs providing health and dental services for Florida Healthy Kids enrollees, Qsource provides the following conclusions and recommendations for improving enrollee access to care as well as the timeliness and quality of care received.

PIP/PDSA

FHKC's Quality Improvement and Data Analytics Committee approves PIP topics annually. The FHKC-selected PIP topics required the MCOs to focus on improving quality health outcomes by increasing the number of enrollees screened for depression and, if screened positive, received follow-up care. Only one of the three MCOs met the criteria to enable a Met status for this PIP (Aetna), and, with this PIP being in its baseline year, no measurements results were reported by the MCOs. Interventions implemented for this PIP should support improved quality health outcomes as well as improve CDF-CH measure performance.

Of the two MCO nonclinical PIPs in remeasurement years, both demonstrated improvements achieved through various

interventions. Aetna reported an increase of follow-up appointments being scheduled as well as an increase in the FUH 7-Day study indicator over the year, attributed to the MCO's Behavioral Health Liaison conducting inservice trainings with behavioral health facility discharge planning teams. Simply Healthcare also reported an increase for both ADD study indicators. While the MCO did not provide intervention descriptions, the PIP strategy involved improving care coordination for enrollees. Community Care's nonclinical PIP, in its baseline year, aims to increase the number of enrollees completing an HRA. These PIPs should support improved quality outcomes while also focusing on HEDIS measure performance improvement toward that aim.

DBM performance was more varied for the clinical PIPs, but similar to the MCOs, only one DBM earned a Met PIP validation status (MCNA). Argus reported a slight increase for one of two PDENT study indicators and a decrease for the other. Argus standardized two interventions addressing enrollee lack of education. DentaQuest reported a decrease for its clinical PIP study indicator and abandoned both interventions after determining them to be ineffective. MCNA reported increases for all three clinical PIP study indicators, by an average of 1.36 percentage points, and standardized and monitored all four interventions. These PIPs should continue to assist enrollees in accessing preventive dental services and thereby increase DBM PDENT measure performance.

For the nonclinical PIPs, only one of the DBMs reported improvement. Argus demonstrated a significant decrease of 15.1 percentage points for one of its *Access and Availability of Services – Enrollee Satisfaction* PIP indicators, abandoned two interventions, and revised a third; the DBM did not report results for the other indicator. Likewise, DentaQuest demonstrated a decrease for one of its *Access & Availability/Non-Compliant Geo Directory* PIP study indicators, abandoned one intervention, and revised a second; the DBM did not report results for the other indicator. MCNA reported an increase in its *Annual Dental Visit* PIP study indicator, and standardized and monitored all five interventions. Appropriate revised interventions for these PIPs, based on 2019 results, should be implemented and monitored to maximize access to and quality and timeliness of dental services for enrollees.

With the revised CMS EQR protocol for PIPs, Qsource recommends that the MCOs and DBMs continue to implement rapid-cycle PDSA improvement techniques as these PIPs progress in support of Quality Strategy Plan goals 1 and 4, quality and effectiveness.

PMV

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

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

- Access and Availability of Care
- Utilization
- Effectiveness of Care
  - Prevention and Screening
  - Respiratory Conditions
  - Behavioral Health
  - Overuse/Appropriateness

Overall trending for these measures indicates that the MCOs' and DBMs' measure rates are primarily increasing, with one exception (Argus); however, a large portion of measures trended down from 2019 to 2020 for all six Plans. Of note, both MCOs evaluated in the 2020 PMV, Aetna and Simply Healthcare, demonstrated improved rates for all three CAP submeasures, both AMB-ED submeasures, all but one FUM submeasure (Aetna's 30-day follow-up total), and two APP submeasures. Some significant decreases also were reported by the MCOs for the IET Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years, Other Drug Abuse or Dependence: Initiation of AOD Treatment Total, and Initiation of AOD Treatment Total submeasures. Both Aetna's and Simply Healthcare's FHM (an MMA performance measure) submeasure rates showed declines from last year's reported results. For the DBMs, Argus' biggest rate decline was for the Any Dental Service measure for five-year-olds enrolled for at least six months.

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

ACA

FHKC's compliance assessment is stratified based on risk and importance, with the higher risk compliance standards assessed in the first year and the lowest risk compliance standards assessed in the last year. The latest three-year review cycle spanned from 2018 to 2020. Overall trending shows a decline in compliance scores for both MCOs evaluated, Aetna and Simply Healthcare, and all three DBMs. Despite the decreasing compliance score trend, three of the five Plans achieved overall three-year aggregated ACA scores above 90.0%. The program-wide score for the MCOs was 91.6% and for the DBMs was 85.5%. These scores indicate that the MCOs and DBMs have in place the policies, procedures, and systems to meet federal and contractual requirements. In addition, all Plans scored higher on the standards assessed in the first year, meaning that performance was better for those standards deemed higher risk, including those related to access and availability of services

(100% scores for all five Plans), grievances and appeals, QAPI programs, and program integrity.

Qsource recommends the MCOs and DBMs conduct internal quality checks to ensure program processes align with the most recent federal regulations as well as all contract and contract amendment requirements toward FHKC's Quality Strategy goals 1 and 4, quality and effectiveness. They also should make sure those processes are in place for all rather than partial time periods under review. The Plans all successfully resolved deficiencies identified in the 2018 and 2019 ACA, demonstrating a commitment to the Florida Healthy Kids program.

ANA

As noted in FHKC's Quality Strategy Plan, ensuring enrollees have adequate and timely access is key to quality care but also can be challenging given the rural nature of the state, provider hesitancy to contract with publicly funded insurance programs, and a nationwide shortage of pediatric subspecialists. FHKC mitigates these challenges by requiring its MCOs and DBMs to meet certain network adequacy standards.

Across all provider/specialty types for which access standards have been defined contractually by FHKC, the MCOs met compliance requirements for 134 of 156 possible areas. The MCOs did not meet minimum standard requirements for the remaining 22 of 156 (11 for time and 11 for distance) possible areas, disaggregated by MCO, provider/specialty type, urban and rural status of enrollee residence, and time and distance standards required by FHKC.

Trending of provider/specialty categories from 2019 to 2020 shows nearly an even split between the two MCOs' compliance score trending, with 33 category scores increasing for Aetna and 33 decreasing for Simply Healthcare. Many of the deficiencies identified in the 2020 ANA also were present in the 2019 review, demonstrating continued need for expanded provider networks, especially for rural populations. Toward achievement of Quality Strategy Plan goals 1, 2, 3, and 6—quality, satisfaction, growth, and advancement—Qsource recommends that the MCOs and DBMs take action where possible to ensure a robust provider and specialist network to provide services for Florida Healthy Kids enrollees. Specifically, the focus for the MCOs should be on increasing rural access to the following healthcare provider types:

- allergy and immunology,
- obstetrics and gynecology,
- pediatric specialists,
- otolaryngology
- hospital, and
- pharmacy.

Although minimum access thresholds are not defined as a percentage of FHKC enrollees in the DBMs' contracts with FHKC, 2020 ANA results included scores above 90.0% for 24 of 36 possible areas (12 each for time and distance). The DBMs

should focus efforts on increasing access to orthodontists and dental specialists for rural enrollees.

EDV

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

All MCOs and DBMs assessed for EDV in 2020Q1 and 2020Q2 achieved completeness ratings above 90.0%, with the lowest being 94.0%; four of the five achieved validity ratings above 90.0%. One DBM, DentaQuest, had 88.0% validity ratings for both quarters. Similarly, most volume and consistency distribution rates were within expectations.

In support of Quality Strategy Plan goals 1 and 4, quality and effectiveness, Qsource recommends that FHKC consider defining acceptable error rates (e.g., a maximum of 5.0%) for aggregate MCO and DBM data. In addition, Qsource recommends that FHKC and Qsource continue to collaborate closely with the Plans to ensure complete and accurate claim and encounter data submission.

APPENDIX A | EQR Activity Findings

In accordance with CMS guidelines for EQRO technical reporting provided in the October 2019 CMS EQR Protocols to provide comparative information in tables presenting performance measure scores and PIP ratings and scores for all Plans, this appendix presents MCO- and DBM-specific results for the 2020 **PIP**, PMV, ACA, ANA, and EDV activities.

PIP Validation

Table A-1 includes each MCO/DBM's full PIP title, study population, study indicator(s), interventions, and measurement results. Interventions do not apply to PIPs in the baseline year and are not included in such cases. The overall validation status, type of PIP, summary of performance, and strengths and weaknesses are provided in the PIP section of the report for each MCO and DBM. More detailed individual MCO and DBM scores are provided for the clinical PIPs in Table A-2 and for the nonclinical PIPs in Table A-3.

Table A-1. 2020 PIP Details for MCOs and DBMs	
MCOs	
Aetna: Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	
Study Population	All Florida Healthy Kids enrollees 12–17 years of age (on date of encounter) with an outpatient visit during the measurement year
Study Indicator(s)	Screening for Depression and Follow-Up Plan: Ages 12–17
Measurement Results	The goal rate will be determined based on the baseline rate (based on data from calendar year 2020) to be reported in the next submission of this PIP in 2021. Remeasurement results are not included as this is the baseline year of the PIP.
Aetna: Timely Follow-Up for Patients After They Have Been Hospitalized for Mental Illness – 7-Day (FUH 7-Day)	
Study Population	All continuously enrolled Florida Healthy Kids enrollees (6 years of age or older as of the date of discharge) with an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm during the measurement year
Study Indicator(s)	Follow-Up After Hospitalization for Mental Illness (FUH 7-day)
Interventions	The MCO's Behavioral Health Liaison conducts inservice trainings with the Discharge Planning team at 3 behavioral health facilities (identified for the pilot project) in Miami-Dade (Region 11). During these trainings,

Table A-1. 2020 PIP Details for MCOs and DBMs	
	the liaison: (1) educates the discharge planning staff on the HEDIS measures for FUH, and the recommended follow-up visits at 7 and 30-days post discharge; (2) identifies barriers to scheduling follow-up appointments with enrollees prior to discharge; and (3) discusses options and best practices to promote scheduling the recommended follow-up appointments and address barriers to care. Throughout 2019, Plan-Do-Study-Act (PDSA) processes were applied to this intervention, resulting in an increase of follow-up appointments being scheduled within 7 days of discharge and an increase in the study indicator over the prior year.
Measurement Results	The baseline goal was 44.0%, and the baseline result was 33.77%. The remeasurement 1 rate was 35.58%.
Community Care: Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)	
Study Population	FHKC enrollees between the ages of 12 and 17 that have an outpatient visit during the measurement year. An enrollee is excluded from the study population if the enrollee has an active diagnosis of depression or bipolar disorder. An active diagnosis is defined as a diagnosis before the outpatient visit and is still active during the outpatient visit. There are no enrollment criteria.
Study Indicator(s)	CDF-CH Screening for Depression and Follow-Up Plan
Measurement Results	The goal rate, yet to be calculated, will be determined based on the CMS benchmark rate to be published and reported for the 2021 PIP validation. Remeasurement results are not included as this is the baseline year of the PIP.
Community Care: Health Risk Assessment (HRA) Response Rate	
Study Population	All Community Care FHKC enrollees regardless of enrollment timeframe
Study Indicator(s)	The percentage of Community Care FHKC enrollees that complete the HRA within 90 days of enrollment
Measurement Results	The goal rate, yet to be calculated, will be determined based on the CMS benchmark rate to be published and reported for the 2021 PIP validation. Remeasurement results are not included as this is the baseline year of the PIP.
Simply Healthcare: Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)	
Study Population	Florida Healthy Kids enrollees ages 12–17 years who had an outpatient visit during the measurement year
Study Indicator(s)	Screening for Depression and Follow-Up Plan Ages 12 to 17 (CDF-CH)

Table A-1. 2020 PIP Details for MCOs and DBMs	
Measurement Results	The goal rate, yet to be calculated, will be determined based on the CMS benchmark rate to be published and reported for the 2021 PIP validation. Remeasurement results are not included as this is the baseline year of the PIP.
Simply Healthcare: Improving Care Coordination to Improve Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Study Population	1. Florida Healthy Kids ages 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year 2. Florida Healthy Kids ages 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year, with no more than one 45-day gap in enrollment after the IPSD for the maintenance phase
Study Indicator(s)	1. Follow-Up Care for Children Prescribed ADHD Medication (ADD) Initiation Phase 2. Follow-Up Care for Children Prescribed ADHD Medication (ADD) Continuation and Maintenance (C&M) Phase
Interventions	The MCO did not provide interventions in its PIP submission for 2020.
Measurement Results	1. The baseline goal was the NCQA 75th percentile, and the baseline result was 42.28%. The remeasurement 1 rate was 45.73%. 2. The baseline goal was the NCQA 75th percentile, and the baseline result was 58.54%. The remeasurement 1 rate was 66.25%.
DBMs	
Argus: Children Receiving Preventive Services	
Study Population	This PIP includes all children in the age group 6–18 as the measurement outcome, but all age groups are to be included in the outreach and intervention processes.
Study Indicator(s)	1. The percent of Florida Healthy Kids enrollees, aged 6–18 years as of September 30 of the measurement year, enrolled for at least one month in the dental plan and who receive dental preventive services (per CMS Form-416 specifications) 2. The percent of Florida Healthy Kid enrollees, aged 6–18 years as of September 30 of the measurement year, enrolled continuously for at least six months in the dental plan, who receive dental preventive services

Table A-1. 2020 PIP Details for MCOs and DBMs	
	(per CMS Form-416 specifications)
Interventions	♦ Welcome to Argus and Healthy Kids: Provide educational material for use of enrollee portal/temporary ID card and website benefit information. ♦ Outreach to close care gaps for those in need of care who have not received treatment for six months ♦ Outreach to close gaps in care for those who have not received care in seven months and/or from the initial effective date of coverage ♦ Outreach call to new enrollees whose ID cards are returned to sender ♦ Engage providers to conduct outreach. ♦ Staff to make follow-up phone calls to non-compliant enrollees to facilitate communication between the providers and enrollees
Measurement Results	1. The baseline goal was 41.0%, and the baseline result was 35.62%. The remeasurement 1 rate was 36.68%, and the remeasurement 2 rate was 37.44%. 2. The baseline goal was 43.0%, and the baseline result was 48.75%. The remeasurement 1 rate was 49.45%, and the remeasurement 2 rate was 46.85%.
Argus: Access and Availability of Services – Enrollee Satisfaction (Children) with Argus Dental	
Study Population	Florida Healthy Kids enrollees who are active at the time of the survey, including new enrollees, those with continuous coverage as of 1/1/19, those who have not had more than a 30-day lapse in coverage, are between the ages of 6 and 18 years at the time the survey population pool is pulled, and who reside in any of the 67 Florida counties
Study Indicator(s)	1. An enrollee satisfaction survey sent to a sound sampling of the entire population ages 6–18 years and the results of those surveys will be used to measure satisfaction with access to care. Enrollees who, in the survey, express dissatisfaction with both access to care and availability of services will be addressed via interventions. 2. CMS-416 Oral Health Initiative Form – 416 ESPDT - TDENT
Interventions	♦ Targeted outreach to those expressing dissatisfaction (survey question 4) ♦ Distribute surveys in another survey platform

Table A-1. 2020 PIP Details for MCOs and DBMs	
	♦ Issue surveys more often than quarterly and to smaller membership pools
Measurement Results	1. The baseline goal was 20.0%. The remeasurement 2 rate was 2.9% (English) and 3.07% (Spanish). The DBM did not report the baseline result or remeasurement 1 rates for study indicator 1. 2. The baseline goal was 21.0%, and the baseline result was 23.42%. The remeasurement 1 rate was 24.19%, and the remeasurement 2 rate was 22.80%.
DentaQuest: Preventive Dental Services	
Study Population	FHKC enrollees under the age of 21 with at least 90 days continuous enrollment during the federal fiscal year who received one preventive dental service
Study Indicator(s)	Preventive Visits for Children
Interventions	♦ Orthodontic offices will handout an RX pad that educates on preventive dental care to enrollees aged 13–18 years in specified counties. ♦ Enrollees aged 17–18 who had not had a preventative visit in the last year received live scheduling assistance.
Measurement Results	The baseline goal was 50.94%, and the baseline result was 48.94%. The remeasurement 1 rate was 41.49%, and the remeasurement 2 rate was 33.70%.
DentaQuest: Access & Availability/Non-Compliant Geo Directory	
Study Population	1. Study Population for Extended Hours Dental Care: Extended hours include provider offices that offer dental services during non-standard hours and non-standard times. Non-standard hours include providers that offer dental services outside of 8:00 a.m.-5:00 p.m. Non-standard days include providers that offer services on Saturdays and/or Sundays. 2. Study Population for Any Dental Visit: FHKC enrollees meeting the CMS-416 Any Dental Visit measure, which includes enrollees under age 21 with 90 days continuous enrollment during the federal fiscal year who received at least one dental service
Study Indicator(s)	1. Providers offering evening or weekend hours (outside of 8:00 a.m.-5:00 p.m. Monday-Friday) 2. Percentage of enrollees utilizing services (Any Dental Visit)
Interventions	♦ Geo-coded directory letter providing enrollees with contact information of three providers in their area as

Table A-1. 2020 PIP Details for MCOs and DBMs	
	well as oral health tips and education; sent to enrollees with no service in six months that lived in a county with less than 10 DentaQuest providers ♦ DentaQuest providers will receive a roster of patients in which the providers are responsible for their care. This is referred to as dental home assignment. Providers are expected to contact the enrollees to encourage utilization. This was implemented statewide.
Measurement Results	1. The baseline goal was 50.50%, and the baseline result was 45.50%. The DBM did not report a remeasurement 1 result for study indicator 1. 2. The baseline goal was 53.70%, and the baseline result was 51.70%. The remeasurement 1 result was 36.60%.
MCNA: Preventive Dental Visit	
Study Population	1. Study Population for Preventive Dental Services: Enrollees ages 5–18 years as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year 2. Study Population for Dental Sealants Ages 6–9 (with exclusions): Enrollees ages 6–9 years as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year 3. Study Population for Dental Sealants Ages 10–14 (with exclusions): Enrollees ages 10–14 years as of 12/31 of the reporting year, continuously enrolled at least 90 days during the reporting year
Study Indicator(s)	1. Preventive Dental Services 2. Dental Sealants Ages 6–9 (with exclusions) 3. Dental Sealants Ages 10–14 (with exclusions)
Interventions	♦ 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 enrollee is overdue for a preventive dental visit. The MSR offers to locate a provider if the enrollee does not already have one and performs a three-way call if necessary, with the provider office to schedule an appointment. When the enrollee's preferred language is other than English, the MSRs are trained to assist them in locating a dentist who speaks the language of their choice. In the event MCNA's network does not have a provider that can accommodate the enrollee's preferred language choice, our MSRs are trained to offer and coordinate translation services. ♦ Text Messages – Text messages will be sent once a month to enrollees who have no claims history on file. Enrollees will continue to receive a text message until an encounter is received. This intervention was

Table A-1. 2020 PIP Details for MCOs and DBMs

	included in the PDSA activities where claims data was evaluated monthly to assess if enrollees who received a text message also received a dental visit within 60 days. Results indicated that 79,862 text messages were disseminated and 20,343 (25.5%) enrollees received a preventive service and 3,000 (3.8%) enrollees received a dental sealant post receipt of a text message. ♦ Member Outreach Forms – MCNA created a Member Outreach Form, which allows providers to communicate with MCNA when an enrollee 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 enrollee and provides the assistance needed. This intervention was included in the PDSA activities where the Member Outreach forms are received from provider offices and logged internally. Claims data was evaluated monthly to assess if enrollees had a dental visit within 60 days of contact by a Care Connections agent. Results include a total of 86 outreach forms were received from 07/01/19 -12/31/19 and 23.7% of enrollees received a preventive dental service within 60 days of outreach by a Care Connections agent. ♦ 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.
Measurement Results	1. The baseline goal was 48.91%, and the baseline result was 46.91%. The remeasurement 1 result was 48.95%. 2. The baseline goal was 18.34%, and the baseline result was 16.34%. The remeasurement 1 result was 16.83%. 3. The baseline goal was 14.33%, and the baseline result was 12.33%. The remeasurement 1 result was 13.84%.
MCNA: Annual Dental Visit	
Study Population	Enrollees ages 5–18 years old as of 12/31 of the reporting year and continuously enrolled 12 months during the reporting year with no more than a one-month break in coverage
Study Indicator(s)	Annual dental visit (ADV)
Interventions	♦ 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 enrollee is overdue for a preventive dental visit. The MSR offers to locate a provider if the enrollee does not already have one and performs a three-way call if necessary, with the provider office to schedule an appointment. When the enrollee's preferred language is other than English, the MSRs are trained to assist

Table A-1. 2020 PIP Details for MCOs and DBMs

	them in locating a dentist who speaks the language of their choice. In the event MCNA's network does not have a provider that can accommodate the enrollee's preferred language choice, our MSRs are trained to offer and coordinate translation services. ♦ Text Messages – Text messages will be sent once a month to enrollees who have no claims history on file. Enrollees will continue to receive a text message until an encounter is received. This intervention was included in the PDSA activities where claims data was evaluated monthly to assess if enrollees who received a text message also received a dental visit within 60 days. Results indicated that 79,862 text messages were disseminated and 20,343 (25.5%) enrollees received a preventive service and 3,000 (3.8%) enrollees received a dental sealant post receipt of a text message. ♦ Member Outreach Forms – MCNA created a Member Outreach Form, which allows providers to communicate with MCNA when an enrollee 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 enrollee and provides the assistance needed. This intervention was included in the PDSA activities where the Member Outreach forms are received from provider offices and logged internally. Claims data was evaluated monthly to assess if enrollees had a dental visit within 60 days of contact by a Care Connections agent. Results include a total of 86 outreach forms were received from 07/01/19 -12/31/19 and 40.7% of enrollees had a dental visit within 60 days of outreach by a Care Connections agent. ♦ ADV Outbound Call Campaign – Conduct outbound calls to enrollees 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 enrollees who have not a dental visit to encourage enrollees to schedule an appointment.
Measurement Results	The baseline goal was 61.31%, and the baseline result was 59.31%. The remeasurement 1 result was 60.62%.

For each applicable activity, tables A-2 and A-3 summarize overall PIP validation scores, including the total number of evaluation elements assessed and Met, the number of critical elements assessed and Met, the percentage of elements that were Met, as well as the overall validation status. The actual number of activities validated for each MCO and DBM depended on various factors, including the progress of the PIP study and sampling methods. Table A-2 includes scores for the MCOs' and DBMs' clinical PIPs, and Table A-3 includes scores for the MCOs' and DBMs' nonclinical PIPs.

Table A-2. 2020 Clinical PIP Validation Scores by Review Activity

Review Activities	All (A) and Critical (C) Elements Met/Assessed											
	Aetna		Argus		Community Care		DentaQuest		MCNA		Simply Healthcare	
	A	C	A	C	A	C	A	C	A	C	A	C
I. Choose the Study Topic(s)	5/5	1/1	6/6	1/1	3/5	1/1	6/6	1/1	6/6	1/1	3/5	1/1
II. Define the Study Question(s)	2/2	2/2	2/2	2/2	0/2	0/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicator(s)	6/6	3/3	5/6	2/3	5/6	3/3	5/6	2/3	6/6	3/3	4/6	2/3
V. Use Sound Sampling Methods	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures	6/6	0/0	6/6	0/0	5/6	0/0	6/6	0/0	6/6	0/0	4/6	0/0
VII. Analyze and Interpret Study Results	0/0	0/0	2/8	0/1	0/0	0/0	4/8	0/1	8/8	1/1	0/0	0/0
VIII. Include Improvement Strategies	0/0	0/0	4/5	1/1	0/0	0/0	3/4	0/1	4/4	1/1	0/0	0/0
IX. Assess for Real Improvement	0/0	0/0	1/4	0/0	0/0	0/0	1/3	0/0	4/4	0/0	0/0	0/0
X. Assess for Sustained Improvement	0/0	0/0	0/1	0/0	0/0	0/0	0/1	0/0	0/0	0/0	0/0	0/0

Table A-2. 2020 Clinical PIP Validation Scores by Review Activity													
Review Activities		All (A) and Critical (C) Elements Met/Assessed											
		Aetna		Argus		Community Care		DentaQuest		MCNA		Simply Healthcare	
		A	C	A	C	A	C	A	C	A	C	A	C
Overall Score		22/22	8/8	29/41	8/10	16/22	6/8	30/39	7/10	39/39	10/10	16/22	7/8
Percentage of Elements Met	Total	100%		70.7%		72.7%		76.9%		100%		72.7%	
	Critical	100%		80.0%		75.0%		70.0%		100%		87.5%	
Validation Status		Met		Not Met		Not Met		Not Met		Met		Not Met	

Table A-3. 2020 Nonclinical PIP Validation Scores by Review Activity												
Review Activities	All (A) and Critical (C) Elements Met/Assessed											
	Aetna		Argus		Community Care		DentaQuest		MCNA		Simply Healthcare	
	A	C	A	C	A	C	A	C	A	C	A	C
I. Choose the Study Topic(s)	6/6	1/1	5/6	1/1	4/6	1/1	5/6	1/1	6/6	1/1	6/6	1/1
II. Define the Study Question(s)	2/2	2/2	0/2	0/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
III. Use a Representative and Generalizable Study Population	3/3	2/2	0/3	0/2	3/3	2/2	3/3	2/2	3/3	2/2	3/3	2/2
IV. Select the Study Indicator(s)	6/6	3/3	5/6	2/3	3/5	1/3	6/7	2/3	7/7	3/3	5/6	2/3

Table A-3. 2020 Nonclinical PIP Validation Scores by Review Activity

Review Activities		All (A) and Critical (C) Elements Met/Assessed											
		Aetna		Argus		Community Care		DentaQuest		MCNA		Simply Healthcare	
		A	C	A	C	A	C	A	C	A	C	A	C
V. Use Sound Sampling Methods		0/0	0/0	0/6	0/1	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
VI. Use Valid and Reliable Data Collection Procedures		6/6	0/0	3/6	0/0	6/6	0/0	5/6	0/0	6/6	0/0	6/6	0/0
VII. Analyze and Interpret Study Results		8/8	1/1	1/8	0/1	0/0	0/0	1/8	0/1	8/8	1/1	5/8	1/1
VIII. Include Improvement Strategies		4/4	1/1	4/5	1/1	0/0	0/0	2/4	0/1	4/4	1/1	0/5	0/1
IX. Assess for Real Improvement		4/4	0/0	1/4	0/0	0/0	0/0	2/4	0/0	4/4	0/0	0/4	0/0
X. Assess for Sustained Improvement		0/0	0/0	0/1	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Overall Score		**39/39**	**10/10**	**19/47**	**4/11**	**18/22**	**6/8**	**26/40**	**7/10**	**40/40**	**10/10**	**27/40**	**8/10**
Percentage of Elements Met	**Total**	**100%**		**40.4%**		**81.8%**		**65.0%**		**100%**		**67.5%**	
	Critical	**100%**		**36.4%**		**75.0%**		**70.0%**		**100%**		**80.0%**	
Validation Status		**Met**		**Not Met**		**Not Met**		**Not Met**		**Met**		**Not Met**	

PMV

MCO-specific results appear in tables **A-4**, A-5, and A-6. The green and red arrows in **Table A-4** indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Trending for some measures is not possible, as measures reported for the 2018 PMV are not all the same as those reported for 2019 or 2020. Others are not able to be trended due to different designations from year to year; for example, a measure with a percentage result one year has an NA (small denominator) designation the other year. Where measure results appear without green or red arrows, trending was not possible. Table cells with a blue background indicate rates that did not change from 2019 to 2020 for that measure.

Table A-4. 2020 PMV Measure Results: MCOs

Measure	Aetna	Simply Healthcare	Staywell	Sunshine	United Healthcare
Primary Care Access and Preventive Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Body Mass Index (BMI) Percentile: 3–11 Years	85.48%⬆	95.96%*	78.46%⬇	81.96%⬆	85.71%⬇
BMI Percentile: 12–17 Years	89.33%⬆	94.84%	80.11%⬇	81.98%⬆	86.57%⬆
BMI Percentile Total	87.59%⬆	95.38%	79.29%⬇	81.97%⬆	86.13%⬇
Chlamydia Screening in Women (CHL)					
16–20 Years	57.72%⬆	52.93%⬇	56.12%⬆	55.69%⬆	40.18%⬇
Immunizations for Adolescents (IMA)					
Meningococcal	75.43%⬆	85.40%⬆	77.25%⬇	82.44%⬆	72.26%⬆
Tdap	91.24%⬇	93.43%⬇	88.74%⬇	94.31%⬇	90.02%⬇
HPV	31.87%⬇	44.04%⬆	37.22%⬇	41.97%⬆	28.95%⬇
Combination #1 (Meningococcal and Tdap/Td)	74.21%⬆	83.70%⬆	75.46%⬇	81.27%⬆	71.29%⬆
Combination #2 (Meningococcal, Tdap/Td, and HPV)	29.68%⬆	41.85%⬆	33.72%⬇	40.64%⬆	26.76%⬇

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	76.95%↑	82.97%	76.40%↓	75.0%↓	75.91%↑
Adolescent Well-Care Visits (AWC)	66.91%	73.48%	69.85%↓	68.48%↑	63.50%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
25 Months – 6 Years	92.15%↑	94.84%↑	92.18%↑	91.27%↑	89.67%↓
7–11 Years	94.59%↑	97.23%↑	96.20%↑	96.25%↑	93.40%↓
12–19 Years	92.18%↑	95.74%↑	94.67%↑	93.96%↓	92.31%↑
Maternal and Perinatal Health					
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	NA†	80.0%	NA	NA	NA
Care of Acute and Chronic Conditions					
Asthma Medication Ratio (AMR)					
5–11 Years	85.21%↑	89.91%↓	85.97%↓	91.67%↑	91.11%↑
12–18 Years	78.05%↓	78.95%↑	73.04%↓	81.58%↑	70.0%
Total	81.89%↓	85.07%↑	80.44%↓	87.21%↑	81.18%↑
Medication Management for People with Asthma (MMA)					
Medication Compliance 50%: 5–11 Years	52.94%↑	54.15%↓	56.50%↑	63.83%↓	54.76%↑
Medication Compliance 75%: 5–11 Years	27.21%↑	33.54%↓	24.93%↓	46.81%↑	28.57%↑
Medication Compliance 50%: 12–18 Years	46.43%↑	51.63%↑	53.17%↓	65.71%↑	52.94%
Medication Compliance 75%: 12–18 Years	25.0%↑	28.05%↑	25.79%↓	31.43%↓	32.35%

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Medication Compliance 50% Total	50.0%↑	53.06%↓	55.17%↑	64.63%↓	53.95%↑
Medication Compliance 75% Total	26.21%↑	31.17%↓	25.28%↓	40.24%↓	30.26%↑
Appropriate Testing for Pharyngitis (CWP)					
3 Months – 17 Years	84.52%	84.12%	83.66%	82.67%	72.66%
18–64 Years	74.64%	70.90%	77.40%	50.0%	51.22%
Total	84.17%↓	83.64%↑	83.42%↑	81.67%↓	71.39%↑
Appropriate Treatment for Children with Upper Respiratory Infection (URI)					
3 Months – 17 Years	87.78%	91.10%	89.42%	91.62%	83.23%
18–64 Years	78.88%	79.90%	82.68%	NA	63.64%
Total	87.54%↓	90.79%↓	89.21%↓	91.61%↑	82.39%↑
Ambulatory Care: Emergency Department Visits (AMB-ED) – Visits / 1,000 Enrollee Months					
1–9 Years	30.56↑	32.92↑	31.81↑	23.0↑	34.64↑
10–19 Years	24.94↑	25.72↑	26.81↑	19.18↓	29.11↓
Behavioral Healthcare					
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	47.30%↑	45.73%↑	50.0%↑	48.57%↑	41.35%↓
Continuation and Maintenance Phase	60.53%↓	66.25%↑	64.18%↑	NA	34.64%
Follow-Up After Hospitalization for Mental Illness: Ages 6 and Older (FHM [MMA])					
7-Day Follow-Up: 6–17 Years	36.73%↑	8.76%↓	43.71%↑	33.68%↓	**
30-Day Follow-Up: 6–17 Years	55.10%↓	18.98%↓	68.43%↑	63.16%↓	**

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up: 6–17 Years	26.67%↑	26.0%↑	43.71%↑	NA	NA
30-Day Follow-Up: 6–17 Years	45.0%↑	44.0%↑	68.43%↑	NA	NA
7-Day Follow-Up: 18–64 Years	NA	NA	26.53%	NA	NA
30-Day Follow-Up: 18–64 Years	NA	NA	53.06%	NA	NA
7-Day Follow-Up Total	49.28%↑	29.82%↑	42.03%↑	NA	NA
30-Day Follow-Up Total	26.09%↓	49.12%↑	66.93%↑	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)					
7-Day Follow-Up: 13–17 Years	NA	NA	2.27%↓	NA	NA
30-Day Follow-Up: 13–17 Years	NA	NA	2.27%↓	NA	NA
7-Day Follow-Up: 18+ Years	NA	NA	NA	NA	NA
30-Day Follow-Up: 18+Years	NA	NA	NA	NA	NA
7-Day Follow-Up Total	NA	NA	3.64%↑	NA	NA
30-Day Follow-Up Total	NA	NA	3.64%↑	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
1–11 Years	NA	NA	56.25%	NA	NA
12–17 Years	54.69%↑	78.95%↑	56.70%↓	NA	NA
Total	54.05%↑	79.25%↑	56.59%↓	NA	43.75%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose Testing: 1–11 Years	NA	NA	44.16%	NA	NA

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Cholesterol Testing: 1–11 Years	NA	NA	33.77%	NA	NA
Blood Glucose and Cholesterol Testing: 1–11 Years	NA	NA	29.87%	NA	NA
Blood Glucose Testing: 12–17 Years	70.0%	58.89%	59.57%	68.89%	51.52%
Cholesterol Testing: 12–17 Years	43.75%	45.56%	44.68%	53.33%	39.39%
Blood Glucose and Cholesterol Testing: 12–17 Years	42.50%	42.22%	39.89%	53.33%	39.39%
Blood Glucose Testing Total	67.62%	59.46%	55.09%	63.79%	48.94%
Cholesterol Testing Total	40.95%	45.95%	41.51%	51.72%	34.04%
Blood Glucose and Cholesterol Testing Total	40.0%	43.24%	36.98%	50.0%	34.04%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)					
1–5 Years	NA	NA	NA	NA	NA
6–11 Years	NA	NA	0%	NA	NA
12–17 Years	0%⬇	1.61%⬆	0%⬇	0%⬇	NA
Total	0%⬇	1.37%⬆	0%⬇	0%⬇	NA
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)					
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Opioid Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 13–17 Years	25.93%⬇	33.33%⬇	44.96%⬇	NA	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 13–17 Years	5.56%⬆	12.96%⬆	5.43%⬆	NA	NA
Initiation of AOD Treatment: 13–17 Years Total	26.56%⬇	36.67%⬇	42.86%⬇	46.88%	NA
Engagement of AOD Treatment: 13–17 Years Total	4.69%⬆	15.0%⬆	5.71%⬆	6.25%	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment: 18+ Years	30.56%	34.21%	44.07%⬆	NA	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment: 18+ Years	11.11%	10.53%	8.47%⬆	NA	NA

Table A-4. 2020 PMV Measure Results: MCOs					
Measure	**Aetna**	**Simply Healthcare**	**Staywell**	**Sunshine**	**United Healthcare**
Initiation of AOD Treatment: 18+ Years Total	32.61%	34.09%	41.18%↑	NA	NA
Engagement of AOD Treatment: 18+ Years Total	10.87%	9.09%	7.35%↑	NA	NA
Alcohol Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA	45.45%↑	NA	NA
Alcohol Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA	3.03%↑	NA	NA
Opioid Abuse or Dependence: Initiation of AOD Treatment Total	NA	NA	NA	NA	NA
Opioid Abuse or Dependence: Engagement of AOD Treatment Total	NA	NA	NA	NA	NA
Other Drug Abuse or Dependence: Initiation of AOD Treatment Total	27.78%↓	33.70%↓	44.68%↑	56.41%↓	NA
Other Drug Abuse or Dependence: Engagement of AOD Treatment Total	7.78%↑	11.96%↑	6.38%↑	15.38%↓	NA
Initiation of AOD Treatment Total	29.09%↓	35.58%↓	42.31%↑	50.0%↓	NA
Engagement of AOD Treatment Total	7.27%↑	12.50%↑	6.25%↑	13.04%↓	NA

** Table cells with a blue background indicate rates that did not change from 2019 to 2020 for that measure.*
† NA = Small Denominator: The MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. For utilization measures that count enrollee months, this result is reported when the denominator is <360 enrollee months.
*** The FHM measure was not calculated by the MCO.*

Table A-5 provides the MCOs' PMV results for the IAD measure. Because the results for this measure are typically less than one percent of the MCOs' enrollees, trending is not included.

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Alcohol										
Any Services: Male										
0–12 Years	1	0.01%	0	0%	1	0%	0	0%	0	0%
13–17 Years	13	0.14%	7	0.07%	27	0.19%	13	0.49%	2	0.12%
18–24 Years	5	0.30%	3	0.18%	4	0.17%	0	0%	1	0.34%
Any Services: Female										
0–12 Years	1	0.01%	0	0%	1	0%	0	0%	0	0%
13–17 Years	10	0.11%	9	0.09%	21	0.16%	1	0.04%	1	0.06%
18–24 Years	5	0.30%	3	0.18%	8	0.34%	4	0.98%	1	0.35%
Any Services: Total										
0–12 Years	2	0.01%	0	0%	2	0%	0	0%	0	0%
13–17 Years	23	0.12%	16	0.08%	48	0.17%	14	0.28%	3	0.09%
18–24 Years	10	0.30%	6	0.18%	12	0.25%	4	0.47%	2	0.34%
Inpatient: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	5	0.05%	1	0.01%	10	0.07%	2	0.08%	0	0%
18–24 Years	0	0%	1	0.06%	2	0.08%	0	0%	0	0%
Inpatient: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	2	0.02%	1	0.01%	6	0.04%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
18–24 Years	1	0.06%	0	0%	1	0.04%	2	0.49%	0	0%
Inpatient: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	7	0.04%	2	0.01%	16	0.06%	2	0.04%	0	0%
18–24 Years	1	0.03%	1	0.03%	3	0.06%	2	0.24%	0	0%
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	2	0.02%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	1	0.01%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	3	0.02%	1	0.01%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	0	0%	0	0%	1	0%	0	0%	0	0%
13–17 Years	4	0.04%	4	0.04%	8	0.06%	5	0.19%	1	0.06%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	2	0.12%	0	0%	2	0.08%	0	0%	1	0.34%
Outpatient/Medication Treatment: Female										
0–12 Years	1	0.01%	0	0%	1	0%	0	0%	0	0%
13–17 Years	3	0.03%	4	0.04%	11	0.08%	1	0.04%	0	0%
18–24 Years	1	0.06%	1	0.06%	1	0.04%	1	0.24%	1	0.35%
Outpatient/Medication Treatment: Total										
0–12 Years	1	0%	0	0%	2	0%	0	0%	0	0%
13–17 Years	7	0.04%	8	0.04%	19	0.07%	6	0.12%	1	0.03%
18–24 Years	3	0.09%	1	0.03%	3	0.06%	1	0.12%	2	0.34%
Emergency Department: Male										
0–12 Years	1	0.01%	0	0%	0	0%	0	0%	0	0%
13–17 Years	6	0.06%	2	0.02%	13	0.09%	6	0.23%	1	0.06%
18–24 Years	3	0.18%	2	0.12%	0	0%	0	0%	0	0%
Emergency Department: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	6	0.06%	3	0.03%	7	0.05%	0	0%	1	0.06%
18–24 Years	3	0.18%	2	0.12%	6	0.26%	1	0.24%	0	0%
Emergency Department: Total										
0–12 Years	1	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	12	0.06%	5	0.03%	20	0.07%	6	0.12%	2	0.06%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	6	0.18%	4	0.12%	6	0.13%	1	0.12%	0	0%
Telehealth: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Opioid										
Any Services: Male										
0–12 Years	0	0%	1	0.01%	1	0%	0	0%	0	0%
13–17 Years	3	0.03%	2	0.02%	1	0.01%	4	0.15%	2	0.12%
18–24 Years	3	0.18%	0	0%	2	0.08%	0	0%	0	0%
Any Services: Female										
0–12 Years	1	0.01%	0	0%	1	0%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	3	0.03%	2	0.02%	4	0.03%	0	0%	0	0%
18–24 Years	2	0.12%	1	0.06%	1	0.04%	1	0.24%	0	0%
Any Services: Total										
0–12 Years	1	0%	1	0%	2	0%	0	0%	0	0%
13–17 Years	6	0.03%	4	0.02%	5	0.02%	4	0.08%	2	0.06%
18–24 Years	5	0.15%	1	0.03%	3	0.06%	1	0.12%	0	0%
Inpatient: Male										
0–12 Years	0	0%	1	0.01%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	1	0.01%	0	0%	1	0.04%	1	0.06%
18–24 Years	0	0%	0	0%	2	0.08%	0	0%	0	0%
Inpatient: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	1	0.01%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	1	0.24%	0	0%
Inpatient: Total										
0–12 Years	0	0%	1	0%	0	0%	0	0%	0	0%
13–17 Years	2	0.01%	1	0.01%	1	0%	1	0.02%	1	0.03%
18–24 Years	0	0%	0	0%	2	0.04%	1	0.12%	0	0%
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	0	0%	0	0%	1	0%	0	0%	0	0%
13–17 Years	2	0.02%	1	0.01%	1	0.01%	3	0.11%	1	0.06%
18–24 Years	3	0.18%	0	0%	0	0%	0	0%	0	0%
Outpatient/Medication Treatment: Female										
0–12 Years	1	0.01%	0	0%	1	0%	0	0%	0	0%
13–17 Years	2	0.02%	2	0.02%	3	0.02%	0	0%	0	0%
18–24 Years	1	0.06%	1	0.06%	1	0.04%	1	0.24%	0	0%
Outpatient/Medication Treatment: Total										
0–12 Years	1	0%	0	0%	2	0%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	4	0.02%	3	0.02%	4	0.01%	3	0.06%	1	0.03%
18–24 Years	4	0.12%	1	0.03%	1	0.02%	1	0.12%	0	0%
Emergency Department: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	2	0.02%	0	0%	0	0%	0	0%	0	0%
18–24 Years	1	0.06%	0	0%	0	0%	0	0%	0	0%
Emergency Department: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	1	0.06%	0	0%	0	0%	0	0%	0	0%
Emergency Department: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	2	0.01%	0	0%	0	0%	0	0%	0	0%
18–24 Years	2	0.06%	0	0%	0	0%	0	0%	0	0%
Telehealth: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	0	0%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Other										
Any Services: Male										
0–12 Years	1	0.01%	0	0%	1	0%	2	0.04%	2	0.08%
13–17 Years	88	0.93%	1	0.01%	153	1.09%	29	1.10%	26	1.50%
18–24 Years	16	0.97%	0	0%	39	1.63%	9	2.07%	4	1.36%
Any Services: Female										
0–12 Years	2	0.01%	0	0%	5	0.02%	0	0%	0	0%
13–17 Years	49	0.53%	0	0%	124	0.92%	34	1.42%	16	1.03%
18–24 Years	13	0.77%	0	0%	31	1.32%	7	1.71%	5	1.73%
Any Services: Total										
0–12 Years	3	0.01%	0	0%	6	0.01%	2	0.02%	2	0.04%
13–17 Years	137	0.73%	1	0.01%	277	1.01%	63	1.26%	42	1.28%
18–24 Years	29	0.87%	0	0%	70	1.47%	16	1.90%	9	1.55%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Inpatient: Male										
0–12 Years	0	0%	1	0.01%	0	0%	0	0%	0	0%
13–17 Years	12	0.13%	14	0.14%	37	0.26%	12	0.46%	2	0.12%
18–24 Years	2	0.12%	3	0.18%	12	0.50%	0	0%	0	0%
Inpatient: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	11	0.12%	3	0.03%	41	0.30%	11	0.46%	4	0.26%
18–24 Years	1	0.06%	6	0.36%	10	0.43%	2	0.49%	2	0.69%
Inpatient: Total										
0–12 Years	0	0%	1	0%	0	0%	0	0%	0	0%
13–17 Years	23	0.12%	17	0.09%	78	0.28%	23	0.46%	6	0.18%
18–24 Years	3	0.09%	9	0.27%	22	0.46%	2	0.24%	2	0.34%
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	3	0.03%	3	0.03%	0	0%	0	0%	1	0.06%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	2	0.02%	2	0.01%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	4	0.02%	5	0.03%	2	0.01%	0	0%	1	0.03%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Outpatient/Medication Treatment: Male										
0–12 Years	0	0%	5	0.03%	1	0%	1	0.02%	2	0.08%
13–17 Years	56	0.59%	63	0.65%	94	0.67%	17	0.65%	14	0.81%
18–24 Years	7	0.43%	16	0.96%	13	0.54%	7	1.61%	2	0.68%
Outpatient/Medication Treatment: Female										
0–12 Years	2	0.01%	1	0.01%	3	0.01%	0	0%	0	0%
13–17 Years	23	0.25%	26	0.27%	55	0.41%	20	0.84%	10	0.64%
18–24 Years	5	0.30%	9	0.54%	14	0.60%	4	0.98%	2	0.69%
Outpatient/Medication Treatment: Total										
0–12 Years	2	0.01%	6	0.02%	4	0.01%	1	0.01%	2	0.04%
13–17 Years	79	0.42%	89	0.46%	149	0.54%	37	0.74%	24	0.73%
18–24 Years	12	0.36%	25	0.75%	27	0.57%	11	1.30%	4	0.69%
Emergency Department: Male										
0–12 Years	1	0.01%	0	0%	0	0%	1	0.02%	0	0%
13–17 Years	30	0.32%	23	0.24%	40	0.29%	4	0.15%	16	0.92%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	10	0.61%	8	0.48%	17	0.71%	2	0.46%	2	0.68%
Emergency Department: Female										
0–12 Years	0	0%	0	0%	3	0.01%	0	0%	0	0%
13–17 Years	19	0.20%	23	0.24%	38	0.28%	9	0.38%	4	0.26%
18–24 Years	7	0.42%	11	0.66%	11	0.47%	1	0.24%	2	0.69%
Emergency Department: Total										
0–12 Years	1	0%	0	0%	3	0.01%	1	0.01%	0	0%
13–17 Years	49	0.26%	46	0.24%	78	0.28%	13	0.26%	20	0.61%
18–24 Years	17	0.51%	19	0.57%	28	0.59%	3	0.36%	4	0.69%
Telehealth: Male										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	0	0%	1	0.01%	0	0%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Female										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	0	0%	1	0.01%	0	0%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Total										
0–12 Years	0	0%	0	0%	0	0%	0	0%	0	0%
13–17 Years	1	0.01%	1	0.01%	1	0%	0	0%	0	0%

Table A-5. 2020 PMV Results: MCOs – Audited Identification of Alcohol and Other Drug Services (IAD) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%

Table A-6 provides the MCOs' PMV results for the MPT measure. Because the results for this measure are typically small compared to the number of enrollees for each MCO, trending is not included.

Table A-6. 2020 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
Any Services: Male										
0–12 Years	873	5.85%	1197	8.09%	2,112	9.78%	489	9.63%	207	8.13%
13–17 Years	553	5.85%	663	6.81%	1,335	9.53%	281	10.69%	148	8.56%
18–24 Years	59	3.59%	69	4.14%	134	5.59%	37	8.52%	6	2.04%
Any Services: Female										
0–12 Years	583	3.96%	783	5.46%	1,483	7.03%	290	6.30%	116	4.75%
13–17 Years	752	8.11%	879	9.26%	1,717	12.70%	368	15.40%	148	9.54%
18–24 Years	116	6.90%	120	7.24%	232	9.86%	41	10.03%	20	6.92%
Any Services: Total										
0–12 Years	1,456	4.91%	1,980	6.80%	3,595	8.42%	779	8.04%	323	6.47%
13–17 Years	1,305	6.97%	1,542	8.02%	3,052	11.09%	649	12.93%	296	9.02%
18–24 Years	175	5.26%	189	5.69%	366	7.71%	78	9.25%	26	4.46%

Table A-6. 2020 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Inpatient: Male										
0–12 Years	15	0.10%	10	0.07%	52	0.24%	11	0.22%	8	0.31%
13–17 Years	45	0.48%	35	0.36%	142	1.01%	30	1.14%	20	1.16%
18–24 Years	4	0.24%	7	0.42%	21	0.88%	1	0.23%	0	0%
Inpatient: Female										
0–12 Years	21	0.14%	21	0.15%	70	0.33%	11	0.24%	5	0.20%
13–17 Years	72	0.78%	58	0.61%	215	1.59%	40	1.67%	24	1.55%
18–24 Years	5	0.30%	11	0.66%	25	1.06%	4	0.98%	2	0.69%
Inpatient: Total										
0–12 Years	36	0.12%	31	0.11%	122	0.29%	22	0.23%	13	0.26%
13–17 Years	117	0.62%	93	0.48%	357	1.30%	70	1.39%	44	1.34%
18–24 Years	9	0.27%	18	0.54%	46	0.97%	5	0.59%	2	0.34%
Intensive Outpatient/Partial Hospitalization: Male										
0–12 Years	7	0.05%	4	0.03%	2	0.01%	0	0%	1	0.04%
13–17 Years	15	0.16%	14	0.14%	4	0.03%	0	0%	2	0.12%
18–24 Years	1	0.06%	0	0%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Female										
0–12 Years	5	0.03%	5	0.03%	1	0%	0	0%	0	0%
13–17 Years	17	0.18%	19	0.20%	12	0.09%	1	0.04%	2	0.13%

Table A-6. 2020 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	**Aetna**		**Simply Healthcare**		**Staywell**		**Sunshine**		**UnitedHealthcare**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
18–24 Years	1	0.06%	5	0.30%	0	0%	0	0%	0	0%
Intensive Outpatient/Partial Hospitalization: Total										
0–12 Years	12	0.04%	9	0.03%	3	0.01%	0	0%	1	0.02%
13–17 Years	32	0.17%	33	0.17%	16	0.06%	1	0.02%	4	0.12%
18–24 Years	2	0.06%	5	0.15%	0	0%	0	0%	0	0%
Outpatient: Male										
0–12 Years	866	5.81%	1192	8.06%	2,101	9.73%	485	9.55%	205	8.06%
13–17 Years	534	5.65%	648	6.66%	1,297	9.26%	267	10.16%	142	8.21%
18–24 Years	59	3.59%	66	3.96%	125	5.22%	36	8.29%	6	2.04%
Outpatient: Female										
0–12 Years	575	3.90%	774	5.40%	1,476	6.99%	288	6.25%	115	4.70%
13–17 Years	726	7.83%	852	8.98%	1,665	12.32%	354	14.81%	144	9.28%
18–24 Years	112	6.66%	117	7.06%	226	9.61%	40	9.78%	20	6.92%
Outpatient: Total										
0–12 Years	1,441	4.86%	1,966	6.75%	3,577	8.38%	773	7.98%	320	6.41%
13–17 Years	1,260	6.73%	1,500	7.80%	2,962	10.76%	621	12.37%	286	8.72%
18–24 Years	171	5.14%	183	5.51%	351	7.39%	76	9.02%	26	4.46%
Emergency Department: Male										
0–12 Years	1	0.01%	1	0.01%	2	0.01%	0	0%	0	0%
13–17 Years	2	0.02%	0	0%	3	0.02%	1	0.04%	1	0.06%

Table A-6. 2020 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
18–24 Years	0	0%	1	0.06%	0	0%	0	0%	0	0%
Emergency Department: Female										
0–12 Years	1	0.01%	1	0.01%	2	0.01%	0	0%	0	0%
13–17 Years	1	0.01%	5	0.05%	9	0.07%	6	0.25%	0	0%
18–24 Years	0	0%	0	0%	0	0%	0	0%	1	0.35%
Emergency Department: Total										
0–12 Years	2	0.01%	2	0.01%	4	0.01%	0	0%	0	0%
13–17 Years	3	0.02%	5	0.03%	12	0.04%	7	0.14%	1	0.03%
18–24 Years	0	0%	1	0.03%	0	0%	0	0%	1	0.17%
Telehealth: Male										
0–12 Years	1	0.01%	1	0.01%	3	0.01%	0	0%	3	0.12%
13–17 Years	0	0%	1	0.01%	2	0.01%	0	0%	1	0.06%
18–24 Years	0	0%	0	0%	1	0.04%	0	0%	0	0%
Telehealth: Female										
0–12 Years	3	0.02%	0	0%	1	0%	0	0%	0	0%
13–17 Years	2	0.02%	0	0%	3	0.02%	1	0.04%	3	0.19%
18–24 Years	0	0%	0	0%	0	0%	0	0%	0	0%
Telehealth: Total										
0–12 Years	4	0.01%	1	0%	4	0.01%	0	0%	3	0.06%
13–17 Years	2	0.01%	1	0.01%	5	0.02%	1	0.02%	4	0.12%

Table A-6. 2020 PMV Results: MCOs – Audited Mental Health Utilization (MPT) Performance Measure										
Measure	Aetna		Simply Healthcare		Staywell		Sunshine		UnitedHealthcare	
	No.	%	No.	%	No.	%	No.	%	No.	%
18–24 Years	0	0%	0	0%	1	0.02%	0	0%	0	0%

DBM-specific PMV results appear in **Table A-7**. The green and red arrows indicate an increase (⬆) or decrease (⬇) from the previous year's rate. Table cells with a blue background indicate rates that did not change from 2019 to 2020 for that measure. While trending was more limited in the *2019 EQRO Annual Technical Report*, due to the All Enrollees category and the Any Dental or Oral Health Service measure not being included in the 2018 report and the ADV measure age category change from 2018 to 2019, comparisons for this year's report may be made with greater confidence.

Table A-7. 2020 PMV Results: DBMs									
Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Annual Dental Visit									
All Enrollees	55.40%⬇	26,279	14,558	63.66%⬆	55,779	35,510	60.59%⬆	51,193	31,020
Enrollees Age 5 to 6†	53.50%⬇	2,301	1,231	65.60%⬆	3,375	2,214	59.98%⬆	2,936	1,761
Enrollees Age 7 to 10	61.75%⬇	9,391	5,799	69.05%⬇	15,899	10,979	66.35%⬆	13,854	9,192
Enrollees Age 11 to 14	55.62%⬇	8,170	4,544	65.23%⬆	18,843	12,291	62.07%⬆	17,390	10,794
Enrollees Age 15 to 18	46.50%⬇	6,417	2,984	56.77%⬆	17,662	10,026	54.51%⬆	17,013	9,273
Any Dental Service									
Enrolled at Least 1 Month: All Enrollees	40.77%⬇	59,912	24,425	48.09%⬆	116,744	56,148	45.06%⬆	105,754	47,649
Enrolled at Least 1 Month: Age 5**	17.11%⬇	1,327	227	28.47%⬆	3,744	1,066	30.30%⬆	4,832	1,464
Enrolled at Least 1 Month: Age 6–9	42.49%⬇	20,850	8,860	50.91%⬆	32,550	16,570	48.04%⬆	27,979	13,442

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 1 Month: Age 10–14	43.30%↓	23,487	10,169	50.63%↑	46,354	23,467	47.41%↑	41,397	19,627
Enrolled at Least 1 Month: Age 15–18	36.28%↓	14,248	5,169	44.13%↑	34,096	15,045	41.58%↑	31,546	13,116
Enrolled at Least 3 Months Continuously: All Enrollees	45.82%↓	51,145	23,433	53.83%↑	100,260	53,966	50.79%↑	90,403	45,917
Enrolled at Least 3 Months Continuously: Age 5	21.74%↑	805	175	37.87%↓	2,321	879	40.02%↑	3,276	1,311
Enrolled at Least 3 Months Continuously: Age 6–9	47.74%↓	17,726	8,463	57.40%↑	27,567	15,824	54.54%↑	23,595	12,869
Enrolled at Least 3 Months Continuously: Age 10–14	48.39%↓	20,240	9,795	56.31%↑	40,181	22,624	53.22%↑	35,709	19,005
Enrolled at Least 3 Months Continuously: Age 15–18	40.41%↓	12,374	5,000	48.49%↑	30,191	14,639	45.76%↑	27,823	12,732
Enrolled at Least 6 Months Continuously: All Enrollees	50.80%↓	39,855	20,247	59.01%↑	80,152	47,300	55.80%↑	72,462	40,434
Enrolled at Least 6 Months Continuously: Age 5	18.18%↓	11	2	46.26%↓	910	421	47.34%↑	1,747	827
Enrolled at Least 6 Months Continuously: Age 6–9	52.96%↓	13,766	7,291	63.11%↓	21,713	13,702	60.24%↑	18,626	11,221
Enrolled at Least 6 Months Continuously: Age 10–14	53.08%↓	16,114	8,554	61.40%↑	32,644	20,045	58.04%↑	29,174	16,934

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: Age 15–18	44.16%↓	9,964	4,400	52.77%↑	24,885	13,132	49.98%↑	22,915	11,452
Enrolled at Least 11 Months Continuously: All Enrollees	56.19%↓	24,698	13,878	63.57%↓	52,854	33,597	60.23%↑	47,680	28,718
Enrolled at Least 11 Months Continuously: Age 5	50.0%↑	2	1	††			47.91%↓	215	103
Enrolled at Least 11 Months Continuously: Age 6–9	60.05%↓	7,954	4,776	67.99%↓	13,444	9,141	64.84%↓	11,709	7,592
Enrolled at Least 11 Months Continuously: Age 10–14	58.25%↓	10,303	6,002	65.98%↓	22,204	14,650	62.61%↑	19,784	12,386
Enrolled at Least 11 Months Continuously: Age 15–18	48.13%↓	6,439	3,099	56.99%↓	17,206	9,806	54.08%↑	15,972	8,637
Preventive Dental Services									
Enrolled at Least 1 Month: All Enrollees	37.71%↑	59,912	22,592	45.22%↑	116,744	52,788	42.34%↑	105,754	44,772
Enrolled at Least 1 Month: Age 5**	15.22%↑	1,327	202	25.88%↑	3,744	969	28.60%↑	4,832	1,382
Enrolled at Least 1 Month: Age 6–9	40.09%↑	20,850	8,358	48.71%↑	32,550	15,855	46.17%↑	27,979	12,919
Enrolled at Least 1 Month: Age 10–14	40.50%↑	23,487	9,512	47.95%↑	46,354	22,228	45.13%↑	41,397	18,681
Enrolled at Least 1 Month: Age 15–18	31.72%↓	14,248	4,520	40.29%↑	34,096	13,736	37.37%↑	31,546	11,790

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: All Enrollees	42.55%↓	51,145	21,762	50.88%↑	100,260	51,008	47.95%↑	90,403	43,347
Enrolled at Least 3 Months Continuously: Age 5	19.50%↓	805	157	35.46%↓	2,321	823	37.94%↑	3,276	1,243
Enrolled at Least 3 Months Continuously: Age 6–9	45.25%↓	17,726	8,021	55.22%↓	27,567	15,223	52.67%↑	23,595	12,427
Enrolled at Least 3 Months Continuously: Age 10–14	45.41%↓	20,240	9,191	53.61%↑	40,181	21,542	50.87%↑	35,709	18,165
Enrolled at Least 3 Months Continuously: Age 15–18	35.50%↓	12,374	4,393	44.45%↑	30,191	13,420	41.38%↑	27,823	11,512
Enrolled at Least 6 Months Continuously: All Enrollees	47.77%↓	39,855	19,038	56.31%↑	80,152	45,130	53.05%↑	72,462	38,438
Enrolled at Least 6 Months Continuously: Age 5	9.09%↓	11	1	44.40%↓	910	404	45.62%↑	1,747	797
Enrolled at Least 6 Months Continuously: Age 6–9	50.87%↓	13,766	7,003	61.25%↓	21,713	13,299	58.50%¥↑	18,626	10,897
Enrolled at Least 6 Months Continuously: Age 10–14	50.40%↓	16,114	8,121	58.98%↑	32,644	19,254	55.83%↑	29,174	16,288
Enrolled at Least 6 Months Continuously: Age 15–18	39.27%↓	9,964	3,913	48.92%↑	24,885	12,173	45.63%↑	22,915	10,456
Enrolled at Least 11 Months Continuously: All Enrollees	53.23%↓	24,698	13,146	61.0%↓	52,854	32,242	57.60%↑	47,680	27,463

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 5	50.0%↑	2	1	††			45.12%↓	215	97
Enrolled at Least 11 Months Continuously: Age 6–9	58.03%↓	7,954	4,616	66.24%↓	13,444	8,905	63.34%↓	11,709	7,417
Enrolled at Least 11 Months Continuously: Age 10–14	55.73%↓	10,303	5,742	63.73%↓	22,204	14,151	60.41%↓	19,784	11,952
Enrolled at Least 11 Months Continuously: Age 15–18	43.28%↓	6,439	2,787	53.39%↑	17,206	9,186	50.07%↑	15,972	7,997
Dental Treatment Services									
Enrolled at Least 1 Month: All Enrollees	16.08%↓	59,912	9,632	18.55%↑	116,744	21,651	16.33%↑	105,754	17,273
Enrolled at Least 1 Month: Age 5**	4.67%↓	1,327	62	7.32%↑	3,744	274	8.32%↑	4,832	402
Enrolled at Least 1 Month: Age 6–9	16.94%↓	20,850	3,531	20.78%↑	32,550	6,765	18.96%↑	27,979	5,305
Enrolled at Least 1 Month: Age 10–14	16.23%↓	23,487	3,813	18.23%↑	46,354	8,452	15.78%↑	41,397	6,533
Enrolled at Least 1 Month: Age 15–18	15.62%↓	14,248	2,226	18.07%↑	34,096	6,160	15.95%↑	31,546	5,033
Enrolled at Least 3 Months Continuously: All Enrollees	18.23%↓	51,145	9,325	20.90%↑	100,260	20,950	18.54%↑	90,403	16,762
Enrolled at Least 3 Months Continuously: Age 5	6.09%↓	805	49	9.69%↑	2,321	225	11.26%↑	3,276	369

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 6–9	19.19%↓	17,726	3,401	23.70%↑	27,567	6,533	21.77%↑	23,595	5,136
Enrolled at Least 3 Months Continuously: Age 10–14	18.29%↓	20,240	3,702	20.35%↑	40,181	8,176	17.80%↑	35,709	6,357
Enrolled at Least 3 Months Continuously: Age 15–18	17.56%↓	12,374	2,173	19.93%↑	30,191	6,016	17.61%↑	27,823	4,900
Enrolled at Least 6 Months Continuously: All Enrollees	20.34%↓	39,855	8,108	23.19%↑	80,152	18,589	20.69%↑	72,462	14,989
Enrolled at Least 6 Months Continuously: Age 5	0%↓	11	0	13.19%↑	910	120	13.97%↓	1,747	244
Enrolled at Least 6 Months Continuously: Age 6–9	21.48%↓	13,766	2,957	26.46%↑	21,713	5,746	24.56%↑	18,626	4,574
Enrolled at Least 6 Months Continuously: Age 10–14	20.06%↓	16,114	3,232	22.44%↑	32,644	7,324	19.63%↑	29,174	5,726
Enrolled at Least 6 Months Continuously: Age 15–18	19.26%↓	9,964	1,919	21.70%↑	24,885	5,399	19.40%↑	22,915	4,445
Enrolled at Least 11 Months Continuously: All Enrollees	22.80%↓	24,698	5,632	25.16%↑	52,854	13,298	22.38%↑	47,680	10,671
Enrolled at Least 11 Months Continuously: Age 5	0%	2	0	††			14.42%↓	215	31
Enrolled at Least 11 Months Continuously: Age 6–9	24.84%↓	7,954	1,976	28.88%↑	13,444	3,882	26.28%↑	11,709	3,077

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 10–14	22.36%↓	10,303	2,304	24.28%↑	22,204	5,391	21.35%↑	19,784	4,224
Enrolled at Least 11 Months Continuously: Age 15–18	21.0%↓	6,439	1,352	23.39%↑	17,206	4,025	20.91%↑	15,972	3,339
Dental Sealants (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	11.32%↑	44,337	5,019	8.97%↓	116,744	10,469	12.41%↑	69,376	8,610
Enrolled at Least 1 Month: Age 6–9	11.94%↑	20,850	2,490	14.25%↑	32,550	4,640	13.54%↑	27,979	3,787
Enrolled at Least 1 Month: Age 10–14	10.77%↑	23,487	2,529	12.57%↑	46,354	5,829	11.65%↑	41,397	4,823
Enrolled at Least 3 Months Continuously: All Enrollees	12.85%↓	37,966	4,879	10.14%↓	100,260	10,163	14.10%↑	59,304	8,361
Enrolled at Least 3 Months Continuously: Age 6–9	13.66%↓	17,726	2,421	16.29%↓	27,567	4,490	15.51%↑	23,595	3,660
Enrolled at Least 3 Months Continuously: Age 10–14	12.14%↓	20,240	2,458	14.12%↑	40,181	5,673	13.16%↑	35,709	4,701
Enrolled at Least 6 Months Continuously: All Enrollees	14.46%↓	29,880	4,320	11.34%↓	80,152	9,086	15.70%↑	47,800	7,503
Enrolled at Least 6 Months Continuously: Age 6–9	15.50%↓	13,766	2,134	18.39%↓	21,713	3,992	17.49%↑	18,626	3257
Enrolled at Least 6 Months Continuously: Age 10–14	13.57%↓	16,114	2,186	15.60%↑	32,644	5,094	14.55%↑	29,174	4246

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: All Enrollees	16.46%↓	18,257	3,005	12.36%↓	52,854	6,533	16.64%↑	31,493	5,239
Enrolled at Least 11 Months Continuously: Age 6–9	18.77%↓	7,954	1,493	20.70%↓	13,444	2,783	18.56%↓	11,709	2,173
Enrolled at Least 11 Months Continuously: Age 10–14	14.68%↓	10,303	1,512	16.89%↑	22,204	3,750	15.50%↑	19,784	3,066
Dental Sealants – With Exclusions (The age 5 and age 15–18 stratifications do not apply to this measure.)									
Enrolled at Least 1 Month: All Enrollees	11.57%↓	42,575	4,924	88.0%↑	78,906	69,437	12.92%↑	59,098	7,635
Enrolled at Least 1 Month: Age 6–9	12.43%↓	19,505	2,425	80.54%↑	32,549	26,214	14.48%↑	25,317	3,667
Enrolled at Least 1 Month: Age 10–14	10.83%↓	23,070	2,499	93.24%↑	46,357	43,223	11.75%↑	33,781	3,968
Enrolled at Least 3 Months Continuously: All Enrollees	13.17%↓	36,324	4,784	86.57%↑	67,750	58,653	14.88%↑	49,689	7,395
Enrolled at Least 3 Months Continuously: Age 6–9	14.31%↓	16,463	2,356	78.0%↑	27,566	21,502	16.77%↑	21,120	3,541
Enrolled at Least 3 Months Continuously: Age 10–14	12.22%↓	19,861	2,428	92.45%↑	40,184	37,151	13.49%↑	28,569	3,854
Enrolled at Least 6 Months Continuously: All Enrollees	14.88%↓	28,447	4,232	85.10%↑	54,359	46,258	16.79%↑	39,281	6,596
Enrolled at Least 6 Months Continuously: Age 6–9	16.37%↓	12,673	2,074	75.25%↑	21,713	16,340	19.15%↑	16,408	3142

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 6 Months Continuously: Age 10–14	13.68%↓	15,774	2,158	91.64%↑	32,646	29,918	15.10%↑	22,873	3454
Enrolled at Least 11 Months Continuously: All Enrollees	17.14%↓	17,115	2,934	82.47%↑	35,650	29,399	18.13%↑	24,730	4,483
Enrolled at Least 11 Months Continuously: Age 6–9	20.40%↓	7,080	1,444	69.67%↑	13,444	9,366	20.87%↓	9,966	2,080
Enrolled at Least 11 Months Continuously: Age 10–14	14.85%↓	10,035	1,490	90.21%↑	22,206	20,033	16.28%↑	14,764	2,403
Diagnostic Dental Services									
Enrolled at Least 1 Month: All Enrollees	38.64%↓	59,912	23,152	47.06%↑	116,744	54,934	42.47%↑	105,754	44,915
Enrolled at Least 1 Month: Age 5**	16.20%↓	1,327	215	27.51%↑	3,744	1,030	29.16%↑	4,832	1,409
Enrolled at Least 1 Month: Age 6–9	41.02%↓	20,850	8,553	50.17%↑	32,550	16,331	46.57%↑	27,979	13,029
Enrolled at Least 1 Month: Age 10–14	41.13%↓	23,487	9,660	49.56%↑	46,354	22,973	44.78%↑	41,397	18,539
Enrolled at Least 1 Month: Age 15–18	33.16%↓	14,248	4,724	42.82%↑	34,096	14,600	37.84%↑	31,546	11,938
Enrolled at Least 3 Months Continuously: All Enrollees	43.52%↓	51,145	22,256	52.82%↑	100,260	52,959	48.03%↑	90,403	43,422
Enrolled at Least 3 Months Continuously: Age 5	20.75%↓	805	167	37.05%↓	2,321	860	38.86%↑	3,276	1,273

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 6–9	46.23%↓	17,726	8,195	56.73%↓	27,567	15,640	53.06%↑	23,595	12,520
Enrolled at Least 3 Months Continuously: Age 10–14	46.04%↓	20,240	9,318	55.31%↑	40,181	22,225	50.38%↑	35,709	17,990
Enrolled at Least 3 Months Continuously: Age 15–18	36.98%↓	12,374	4,576	47.15%↑	30,191	14,234	41.83%↑	27,823	11,639
Enrolled at Least 6 Months Continuously: All Enrollees	48.59%↓	39,855	19,366	58.17%↑	80,152	46,621	53.03%↑	72,462	38,426
Enrolled at Least 6 Months Continuously: Age 5	18.18%↓	11	2	45.49%↓	910	414	46.42%↑	1,747	811
Enrolled at Least 6 Months Continuously: Age 6–9	51.66%↓	13,766	7,111	62.53%↓	21,713	13,577	58.89%↑	18,626	10,969
Enrolled at Least 6 Months Continuously: Age 10–14	50.84%↓	16,114	8,192	60.61%↑	32,644	19,786	55.20%↓	29,174	16,105
Enrolled at Least 6 Months Continuously: Age 15–18	40.76%↓	9,964	4,061	51.61%↑	24,885	12,844	46.0%↑	22,915	10,541
Enrolled at Least 11 Months Continuously: All Enrollees	53.90%↓	24,698	13,312	62.78%↓	52,854	33,182	57.38%↑	47,680	27,361
Enrolled at Least 11 Months Continuously: Age 5	50.0%↑	2	1	††			47.44%↓	215	102
Enrolled at Least 11 Months Continuously: Age 6–9	58.81%↓	7,954	4,678	67.43%↓	13,444	9,065	63.54%↓	11,709	7,440

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 10–14	55.92%↓	10,303	5,761	65.28%↑	22,204	14,495	59.78%↑	19,784	11,827
Enrolled at Least 11 Months Continuously: Age 15–18	44.60%↓	6,439	2,872	55.92%↓	17,206	9,622	50.04%↑	15,972	7,992
Any Dental or Oral Health Service									
Enrolled at Least 1 Month: All Enrollees	40.77%↑	59,912	24,425	48.09%↑	116,744	56,148	45.06%↑	105,754	47,649
Enrolled at Least 1 Month: Age 5**	17.11%↑	1,327	227	28.47%↑	3,744	1,066	30.30%↑	4,832	1,464
Enrolled at Least 1 Month: Age 6–9	42.49%↑	20,850	8,860	50.91%↑	32,550	16,570	48.04%↑	27,979	13,442
Enrolled at Least 1 Month: Age 10–14	43.30%↑	23,487	10,169	50.63%↑	46,354	23,467	47.41%↑	41,397	19,627
Enrolled at Least 1 Month: Age 15–18	36.28%↑	14,248	5,169	44.13%↑	34,096	15,045	41.58%↑	31,546	13,116
Enrolled at Least 3 Months Continuously: All Enrollees	45.82%↑	51,145	23,433	53.83%↑	100,260	53,966	50.79%↑	90,403	45,917
Enrolled at Least 3 Months Continuously: Age 5	21.74%↑	805	175	37.87%↓	2,321	879	40.02%↑	3,276	1,311
Enrolled at Least 3 Months Continuously: Age 6–9	47.74%↑	17,726	8,463	57.40%↑	27,567	15,824	54.54%↑	23,595	12,869
Enrolled at Least 3 Months Continuously: Age 10–14	48.39%↑	20,240	9,795	56.31%↑	40,181	22,624	53.22%↑	35,709	19,005

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 3 Months Continuously: Age 15–18	40.41%↑	12,374	5,000	48.49%↑	30,191	14,639	45.76%↑	27,823	12,732
Enrolled at Least 6 Months Continuously: All Enrollees	50.80%↑	39,855	20,247	59.01%↑	80,152	47,300	55.80%↑	72,462	40,434
Enrolled at Least 6 Months Continuously: Age 5	18.18%↑	11	2	46.26%↓	910	421	47.34%↑	1,747	827
Enrolled at Least 6 Months Continuously: Age 6–9	52.96%↑	13,766	7,291	63.11%↓	21,713	13,702	60.24%↑	18,626	11,221
Enrolled at Least 6 Months Continuously: Age 10–14	53.08%↑	16,114	8,554	61.40%↑	32,644	20,045	58.04%↑	29,174	16,934
Enrolled at Least 6 Months Continuously: Age 15–18	44.16%↑	9,964	4,400	52.77%↑	24,885	13,132	49.98%↑	22,915	11,452
Enrolled at Least 11 Months Continuously: All Enrollees	56.19%↑	24,698	13,878	63.57%↓	52,854	33,597	60.23%↑	47,680	28,718
Enrolled at Least 11 Months Continuously: Age 5	50.0%↑	2	1	††			47.91%↓	215	103
Enrolled at Least 11 Months Continuously: Age 6–9	60.05%↑	7,954	4,776	67.99%↓	13,444	9,141	64.84%↓	11,709	7,592
Enrolled at Least 11 Months Continuously: Age 10–14	58.25%↑	10,303	6,002	65.98%↓	22,204	14,650	62.61%↑	19,784	12,386

Table A-7. 2020 PMV Results: DBMs

Measure	Argus			DentaQuest			MCNA		
	Rate (%)	Den.*	Num.*	Rate (%)	Den.	Num.	Rate (%)	Den.	Num.
Enrolled at Least 11 Months Continuously: Age 15–18	48.13%↑	6,439	3,099	56.99%↓	17,206	9,806	54.08%↑	15,972	8,637

** Den.=Denominator; Num.=Numerator*
† The age range for this stratification is 4–6 years; as age 4 years does not apply to the Florida Healthy Kids population, the stratification has been renamed Age 5–6 for this report.
*** The age range for this stratification is 3–5 years; as ages 3 and 4 years do not apply to the Florida Healthy Kids population, the stratification has been renamed Age 5 for this report.*
†† The denominator was zero; thus, no measure rate was calculated.
¥ Table cells with a blue background indicate rates that did not change from 2019 to 2020 for that measure.

ACA

ACA Standards

Table A-8 displays each MCO's and DBM's compliance with federal statutes, its relative contract, and additional compliance standards established by FHKC. Individual results are presented for each ACA standard reviewed in the 2018, 2019, and 2020 ACA.

Table A-8. ACA Standard Results 2018–2020: MCOs and DBMs

Standard	MCOs		DBMs		
	Aetna	Simply Healthcare	Argus	DentaQuest	MCNA
Enrollee Information	88.9%	81.4%	89.3%	79.4%	97.1%
Enrollee Rights and Protections & Confidentiality	85.3%	84.3%	73.4%	65.0%	66.7%
Credentialing (Provider Selection)	92.9%	71.2%	64.9%	59.5%	88.1%
2020 Overall Compliance Standard Score	**89.3%**	**78.6%**	**76.7%**	**68.8%**	**86.5%**
Coverage and Authorization of Services	98.2%	93.0%	98.1%	81.1%	90.6%
Coordination and Continuity of Care	100%	75.0%	0%	0%	50.0%
Subcontractual Relationships and Delegation	100%	73.7%	*	*	*
2019 Overall Compliance Standard Score	**99.0%**	**85.0%**	**91.2%**	**75.4%**	**87.7%**
Access and Availability of Services & Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%
Grievance System	96.4%	84.3%	100%	51.8%	96.4%
Quality Assessment and Performance Improvement & Practice Guidelines & Health Information System	100%	100%	95.3%	85.0%	100%
Program Integrity	94.4%	100%	94.4%	88.7%	100%
2018 Overall Compliance Standard Score	**97.5%**	**93.5%**	**97.8%**	**74.0%**	**98.5%**

** The Subcontractual Relationships and Delegation standard does not apply to the DBMs.*

File Review

The results in **Table A-9** present each MCO's and DBM's compliance with each file review for the 2020, 2019, and 2018 ACA.

Table A-9. ACA File Review Results 2018–2020: MCOs and DBMs

File Review	MCOs		DBMs		
	Aetna	Simply Healthcare	Argus	DentaQuest	MCNA
2020					
Credentialing	41.4%	86.8%	94.1%	100%	88.2%
Recredentialing	46.0%	86.6%	92.2%	94.4%	83.3%
2019					
UM Denials	100%	100%	100%	80.0%	98.0%
2018					
Grievances	100%	100%	80.0%	96.4%	100%
Appeals	100%	100%	84.6%	100%	100%

ANA

The following evaluation activities were performed for all three MCOs and all three DBMs:

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

The network adequacy information in **tables A-10** through **A-13** was obtained from analyses performed on provider and enrollee data. The standards used to assess provider networks for the MCOs and DBMs appear in Appendix B. The contract minimum standard for the MCOs is to provide 90.0% of their FHKC enrollees access to one provider for each of the required provider types within required timeframes. Results for areas not meeting this minimum standard are emphasized with **bold red** text. **Table A-10** includes the time analysis results by MCO, and Table A-11 includes the distance analysis results by MCO.

Table A-10. 2020 Network Adequacy Results: Time Analysis by MCO and Provider/Specialty Type

Provider/Specialty Type	Aetna		Community Care		Simply Healthcare	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Provider (PCP) – Family Medicine	99.72%	95.85%	99.28%	95.90%	99.63%	97.38%
PCP – Pediatrics	99.73%	91.15%	100%	99.80%	99.72%	96.92%
Allergy & Immunology	94.45%	**78.28%**	97.02%	95.70%	98.50%	92.32%
Dermatology	98.40%	97.88%	99.85%	**47.34%**	99.54%	97.87%
Obstetrics & Gynecology	99.97%	**89.18%**	99.12%	**36.48%**	99.98%	88.26%
Optometry	99.37%	99.98%	99.27%	97.54%	99.86%	99.47%
Otolaryngology	93.16%	95.90%	97.56%	**45.49%**	97.38%	94.41%
Behavioral Health – Pediatric	99.49%	100%	99.27%	100%	99.94%	100%
Behavioral Health – Other	99.95%	100%	99.90%	100%	100%	100%

Table A-10. 2020 Network Adequacy Results: Time Analysis by MCO and Provider/Specialty Type						
Provider/Specialty Type	**Aetna**		**Community Care**		**Simply Healthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural
Specialist – Pediatric	98.45%	98.58%	96.33%	**66.80%**	96.77%	**74.31%**
Specialist – Other	99.69%	91.44%	99.93%	**87.30%**	99.93%	93.08%
Hospital	97.42%	**87.83%**	99.96%	**54.71%**	99.82%	91.71%
Pharmacy	99.72%	95.85%	99.73%	93.85%	99.85%	94.72%

Table A-11. 2020 Network Adequacy Results: Distance Analysis by MCO and Provider/Specialty Type						
Provider/Specialty Type	**Aetna**		**Community Care**		**Simply Healthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Provider (PCP) – Family Medicine	99.88%	97.18%	100%	95.90%	99.79%	98.25%
PCP – Pediatrics	99.82%	93.85%	100%	100%	99.89%	98.67%
Allergy & Immunology	96.80%	**67.87%**	98.24%	**89.14%**	99.30%	**86.55%**
Dermatology	99.19%	95.32%	99.95%	**46.31%**	99.84%	95.52%
Obstetrics & Gynecology	99.99%	92.50%	99.27%	**39.96%**	100%	91.37%
Optometry	99.87%	99.45%	99.27%	90.37%	99.97%	97.95%
Otolaryngology	95.35%	93.40%	99.24%	**43.85%**	98.16%	**89.81%**
Behavioral Health – Pediatric	99.77%	100%	99.27%	91.80%	99.98%	100%
Behavioral Health – Other	99.97%	100%	100%	100%	100%	100%
Specialist – Pediatric	99.07%	96.22%	98.45%	**65.98%**	97.53%	**63.85%**
Specialist – Other	99.81%	93.81%	99.99%	90.57%	99.97%	95.10%

Table A-11. 2020 Network Adequacy Results: Distance Analysis by MCO and Provider/Specialty Type						
Provider/Specialty Type	**Aetna**		**Community Care**		**Simply Healthcare**	
	Urban	Rural	Urban	Rural	Urban	Rural
Hospital	95.55%	92.07%	99.87%	**58.20%**	99.17%	93.96%
Pharmacy	99.88%	97.18%	99.71%	91.39%	99.57%	**86.13%**

Table A-12 includes results from the time analysis by DBM, and **Table A-13** includes results from the distance analysis by DBM. The minimum access threshold is not defined in the DBMs' contracts as a percentage of FHKC enrollees with access; thus, no areas are identified as not meeting a standard in these two tables.

Table A-12. 2020 Network Adequacy: Travel Time Analysis by DBM and Provider/Specialty Type						
Provider/Specialty Type	**Argus**		**DentaQuest**		**MCNA**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Dentists	99.46%	99.42%	99.54%	95.65%	99.40%	98.52%
Orthodontists	92.23%	80.57%	99.60%	85.64%	99.45%	87.64%
Dental Specialists	94.11%	55.37%	95.09%	52.45%	95.10%	56.61%

Table A-13. 2020 Network Adequacy: Distance Analysis by DBM and Provider/Specialty Type						
Provider/Specialty Type	**Argus**		**DentaQuest**		**MCNA**	
	Urban	Rural	Urban	Rural	Urban	Rural
Primary Care Dentists	99.73%	99.69%	99.66%	96.93%	99.73%	99.44%
Orthodontists	90.28%	73.39%	98.50%	75.97%	97.91%	79.99%
Dental Specialists	94.87%	40.91%	96.55%	42.93%	96.80%	42.46%

EDV

The results in **tables A-14** through **A-36** were obtained through analysis of MCO claim and encounter data and DBM claim data for service dates in 2020Q1 and 2020Q2. Discussion of these results is included in the EDV section of the report.

Table A-14. Total Claim Lines and Encounter Lines Submitted by MCOs

MCO	2020Q1 Dates of Service		2020Q2 Dates of Service	
	Claim Lines	Encounter Lines	Claim Lines	Encounter Lines
Aetna	460,381	18,259	261,889	17,501
Community Care	64,088	475	37,486	1,906
Simply Healthcare	552,868	28,910	254,173	13,313

Table A-15. Total Claim Lines Submitted by DBMs

DBM	2020Q1 Dates of Service	2020Q2 Dates of Service
Argus	68,271	7,223
DentaQuest	150,460	16,388
MCNA	123,264	12,124

Table A-16. Percentage of MCO Enrollees with at Least One Claim/Encounter

MCO	2020Q1 Dates of Service			2020Q2 Dates of Service		
	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter
Aetna	52.63%	5.00%	54.36%	35.90%	6.98%	39.43%*
Community Care	49.74%	0.56%	49.88%*	33.93%	1.91%	34.85%*

Table A-16. Percentage of MCO Enrollees with at Least One Claim/Encounter						
MCO	2020Q1 Dates of Service			2020Q2 Dates of Service		
	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter	Percentage with Distinct Claim	Percentage with Distinct Encounter	Percentage with Distinct Claim and/or Encounter
Simply Healthcare	56.0%	6.74%	58.31%	41.14%	2.25%	41.96%*

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

Table A-17. Percentage of DBM Enrollees with at Least One Claim		
DBM	2020Q1 Dates of Service	2020Q2 Dates of Service
Argus	22.22%	13.29%
DentaQuest	27.16%	16.32%
MCNA	25.37%	14.13%

Table A-18. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM				
MCO/DBM	2020Q1 Dates of Service		2020Q2 Dates of Service	
	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters
Aetna	47.50%	43.45%	43.05%	42.45%
Community Care	6.78%	5.99%	6.96%	6.58%
Simply Healthcare	45.72%	50.56%	45.54%	50.97%
MCO Total	**100%**	**100%**	**100%**	**100%**
Argus	21.91%	19.11%	22.09%	20.21%
DentaQuest	41.98%	45.16%	41.75%	45.86%

Table A-18. Percentage of Enrollment Versus Claims and Encounter Data by MCO/DBM				
MCO/DBM	2020Q1 Dates of Service		2020Q2 Dates of Service	
	% Enrollment	% Claims & Encounters	% Enrollment	% Claims & Encounters
MCNA	36.11%	35.73%	36.16%	33.93%
DBM Total	100%	100%	100%	100%

Table A-19. Distribution by Medical Service Type for MCOs—Claim Lines							
MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
2020Q1 Dates of Service							
Aetna	1,401 (0.30%)	106,864 (23.19%)	88,576 (19.24%)	45,027 (9.78%)	133,067 (28.90%)	20,441 (4.44%)	65,306 (14.19%)
Community Care	120 (0.19%)	13,359 (20.84%)	12,925 (20.17%)	6,620 (10.33%)	13,397 (20.90%)	2,412 (3.76%)	15,255 (23.80%)
Simply Healthcare	2,251 (0.41%)	131,634 (23.81%)	130,386 (23.58%)	46,578 (8.42%)	110,758 (20.03%)	21,996 (3.98%)	109,265 (19.76%)
2020Q2 Dates of Service							
Aetna	1,037 (0.40%)	58,274 (22.25%)	68,572 (26.18%)	31,052 (11.86%)	58,675 (22.40%)	9,099 (3.47%)	35,180 (13.43%)
Community Care	98 (0.26%)	8,404 (22.42%)	7,958 (21.23%)	4,765 (12.71%)	7,475 (19.94%)	1,343 (3.58%)	7,443 (19.86%)
Simply Healthcare	1,308 (0.51%)	62,821 (24.72%)	73,900 (29.07%)	31,794 (12.51%)	43,034 (16.93%)	9,494 (3.74%)	31,822 (12.52%)

Table A-20. Distribution by Medical Service Type for MCOs—Encounter Lines

MCO	Medical Service Type						
	Anesthesia	Evaluation and Management	Medicine	Other	Pathology and Laboratory	Radiology	Surgery
2020Q1 Dates of Service							
Aetna	-	4,583 (25.10%)	12,503 (68.48%)	203 (1.11%)	118 (0.65%)	43 (0.24%)	809 (4.43%)
Community Care	-	-	365 (76.84%)	107 (22.53%)	-	-	3 (0.63%)
Simply Healthcare	-	1,663 (5.75%)	15,111 (52.27%)	11,472 (39.68%)	86 (0.30%)	35 (0.12%)	543 (1.88%)
2020Q2 Dates of Service							
Aetna	-	2,613 (14.93%)	11,460 (65.48%)	3,086 (17.63%)	6 (0.03%)	36 (0.21%)	300 (1.71%)
Community Care	-	1 (0.05%)	1,353 (70.99%)	434 (22.77%)	-	-	118 (6.19%)
Simply Healthcare	-	1,081 (8.12%)	7,822 (58.75%)	4,052 (30.44%)	63 (0.47%)	11 (0.08%)	284 (2.13%)

Table A-21. Distribution by Dental Service Type for DBMs—Claim Lines

Dental Service Type	Argus		DentaQuest		MCNA	
	2020Q1	2020Q2	2020Q1	2020Q2	2020Q1	2020Q2
Dental Preventative Services	28,369 (41.55%)	16,778 (42.04%)	64,251 (42.70%)	34,969 (43.20%)	50,631 (41.08%)	25,373 (41.89%)
Dental Radiographs/Diagnostic Imaging	20,085 (29.42%)	11,409 (28.59%)	41,829 (27.80%)	22,168 (27.39%)	36,829 (29.88%)	18,106 (29.89%)

Table A-21. Distribution by Dental Service Type for DBMs—Claim Lines

Dental Service Type	Argus		DentaQuest		MCNA	
	2020Q1	2020Q2	2020Q1	2020Q2	2020Q1	2020Q2
Dental Clinical Oral Evaluations	8,319 (12.19%)	5,039 (12.63%)	19,197 (12.76%)	11,020 (13.62%)	15,591 (12.65%)	8,086 (13.35%)
Dental Restorative	4,993 (7.31%)	2,615 (6.55%)	10,808 (7.18%)	4,997 (6.17%)	8,804 (7.14%)	3,514 (5.80%)
Dental Adjunctive General Service	2,649 (3.88%)	1,708 (4.28%)	4,889 (3.25%)	2,953 (3.65%)	4,038 (3.28%)	1,998 (3.30%)
Dental Oral & Maxillofacial Surgery	1,687 (2.47%)	1,153 (2.89%)	3,983 (2.65%)	2,224 (2.75%)	3,683 (2.99%)	1,964 (3.24%)
Dental Endodontics	846 (1.24%)	586 (1.47%)	2,416 (1.61%)	1,299 (1.60%)	1,114 (0.90%)	564 (0.93%)
Dental Orthodontics	692 (1.01%)	341 (0.85%)	1,375 (0.91%)	669 (0.83%)	1,061 (0.86%)	547 (0.90%)
Dental Oral Pathology Laboratory	299 (0.44%)	145 (0.36%)	990 (0.66%)	413 (0.51%)	1,002 (0.81%)	289 (0.48%)
Dental Periodontics	133 (0.19%)	95 (0.24%)	393 (0.26%)	130 (0.16%)	306 (0.25%)	90 (0.15%)
Dental Pre-Diagnostic Services	158 (0.23%)	23 (0.06%)	246 (0.16%)	28 (0.03%)	173 (0.14%)	24 (0.04%)
Dental Tests And Examinations	36 (0.05%)	16 (0.04%)	54 (0.04%)	49 (0.06%)	30 (0.02%)	15 (0.02%)
Dental Fixed Prosthodontics	4 (0.01%)	2 (0.01%)	23 (0.02%)	3 (0%)*	1 (0%)*	1 (0%)*
Dental Removable Prosthodontics	1 (0%)*	0 (0%)	1 (0%)*	0 (0%)	1 (0%)*	2 (0%)*
Dental Image Capture Only	0	0 (0%)	3 (0%)*	0 (0%)	0 (0%)	0 (0%)
Undefined	0	1 (0%)*	2 (0%)*	16 (0.02%)	0 (0%)	0 (0%)
Total	**68,271**	**39,911**	**150,460**	**80,938**	**123,264**	**60,573**

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

Table A-22. Distinct Claims by Provider Type for MCOs

Provider Type	Aetna # Distinct Claims		Community Care # Distinct Claims		Simply Healthcare # Distinct Claims	
	2020Q1	2020Q2	2020Q1	2020Q2	2020Q1	2020Q2
Physician	94,529 (73.63%)	51,432 (73.81%)	13,685 (70.79%)	8,225 (69.53%)	107,914 (71.77%)	57,533 (63.92%)
Independent Laboratory	11,912 (9.28%)	7,748 (11.12%)	1,406 (7.27%)	1,009 (8.53%)	6,146 (4.09%)	4,167 (4.63%)
General Hospital	11,641 (9.07%)	4,613 (6.62%)	1,948 (10.08%)	629 (5.32%)	15,728 (10.46%)	6,496 (7.22%)
Nurse Practitioner (ARNP)	4,528 (3.53%)	2,191 (3.14%)	389 (2.01%)	196 (1.66%)	4,414 (2.94%)	2,550 (2.83%)
Durable Medical Equipment/Medical Supplies	1,392 (1.08%)	1,270 (1.82%)	87 (0.45%)	62 (0.52%)	1,242 (0.83%)	1,073 (1.19%)
Physician Assistant	1,252 (0.98%)	741 (1.06%)	191 (0.99%)	160 (1.35%)	1,188 (0.79%)	652 (0.72%)
Other	3,133 (2.43%)	1,691 (2.43%)	1,626 (8.42%)	1,551 (13.11%)	13,732 (9.14%)	17,547 (19.49%)
Total	**128,387***	**69,686***	**19,332**	**11,832***	**150,364***	**90,018***

** Total number of claims may be greater than the total in Table 22 due to some claims having more than one provider type.*

Table A-23. Distinct Encounters by Provider Type for MCOs

Provider Type	Aetna # Distinct Encounters		Community Care # Distinct Encounters		Simply Healthcare # Distinct Encounters	
	2020Q1	2020Q2	2020Q1	2020Q2	2020Q1	2020Q2
Physician	3,372 (26.16%)	4,675 (39.94%)	-	-	1,372 (9.85%)	1,148 (15.09%)

Table A-23. Distinct Encounters by Provider Type for MCOs						
Provider Type	**Aetna** # Distinct Encounters		**Community Care** # Distinct Encounters		**Simply Healthcare** # Distinct Encounters	
	2020Q1	2020Q2	2020Q1	2020Q2	2020Q1	2020Q2
Therapist (PT, OT, ST, RT)	620 (4.81%)	863 (7.37%)	98 (76.56%)	539 (70.09%)	5,340 (38.35%)	5,180 (68.10%)
Other	8,900 (69.03%)	6,168 (52.69%)	30 (23.44%)	230 (29.91%)	7,214 (51.80%)	1,279 (16.81)
Total	**12,892**	**11,706***	**128**	**769**	**13,926**	**7,607**

** Total number of claims may be greater than the total in Table 22 due to some claims having more than one provider type.*

Table A-24. Average Number of Days from Last Service Date to Distinct Claim Paid Date for MCOs				
MCO	**Professional** Avg. Days from Last Service Date to Distinct Claim Paid Date		**Institutional** Avg. Days from Last Service Date to Distinct Claim Paid Date	
	2020Q1	2020Q2	2020Q1	2020Q2
Aetna	25.75	23.71	22.24	24.0
Community Care	26.02	22.16	39.86	22.45
Simply Healthcare	31.59	24.61	23.32	22.91

Table A-25. Average Number of Days from Billing Date to Distinct Claim Paid Date for MCOs				
MCO	**Professional** Avg. Days from Billing Date to Distinct Claim Paid Date		**Institutional** Avg. Days from Billing Date to Distinct Claim Paid Date	
	2020Q1	2020Q2	2020Q1	2020Q2
Aetna	8.48	6.86	7.25	8.45

Table A-25. Average Number of Days from Billing Date to Distinct Claim Paid Date for MCOs				
MCO	**Professional**		**Institutional**	
	Avg. Days from Billing Date to Distinct Claim Paid Date		Avg. Days from Billing Date to Distinct Claim Paid Date	
	2020Q1	2020Q2	2020Q1	2020Q2
Community Care	0.01	3.64	3.42	4.47
Simply Healthcare	4,778.50*	8,091.94*	10.62	9.99

** Accurate systematic calculation of these values was impacted by a high number of blank Billing Date fields.*

Table A-26. Average Number of Days from Last Service Date and from Billing Date to Distinct Claim Paid Date for DBMs				
DBM	Avg. Days from Last Service Date to Distinct Claim Paid Date		Avg. Days from Billing Date to Distinct Claim Paid Date	
	2020Q1	2020Q2	2020Q1	2020Q2
Argus	-2.13	-83.41	-10.67	-91.21
DentaQuest	13.30	11.89	6.00	5.53
MCNA	19.63	15.89	9.18	7.63

** Accurate systematic calculation of these values was impacted by a number of detail lines with a claim paid date of 1/1/1900, creating negative average values.*

Table A-27 includes completeness and validity rates of claim data for the MCOs. Scores between 90.0% and 99.99% are identified in **green**; scores below 90.0% are identified in **red**.

Table A-27. Completeness and Validity Rates—Claim Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=460,381)		**Aetna (N=261,889)**	
Member Identification (ID)	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Admit Date	8.82%	100%	43.39%	100%
Diagnosis Code	100%	100%	100%	99.80%
Procedure Code	96.85%	99.77%	97.03%	98.75%
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%†
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	99.74%	100%	99.83%	100%
Treating Provider National Provider Identifier (NPI)	100%	100%	100%	100%
Treating Provider Medicaid ID	99.74%	100%	99.83%	100%
Treating Provider Specialty Code	99.74%	100%	99.83%	100%
Billing Provider Type	98.29%	100%	99.0%	100%

Table A-27. Completeness and Validity Rates—Claim Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider NPI	99.54%	100%	100%	100%
Billing Provider Medicaid ID	99.74%	100%	99.0%	100%
Billing Provider Specialty Code	98.29%	100%	99.0%	100%
Facility Provider Type	99.94%	100%	99.94%	100%
Facility Provider NPI	100%	100%	100%	100%
Facility Provider Medicaid ID	99.94%	100%	99.94%	100%
Place of Service	99.93%	99.66%	99.89%	97.37%
	Community Care (N=64,088)		**Community Care (N=37,486)**	
Member ID	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%
Diagnosis Code	100%	100%	100%	99.79%
Procedure Code	95.90%	99.98%	97.06%	99.39%
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%

Table A-27. Completeness and Validity Rates—Claim Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Type	99.68%	100%	99.40%	100%
Treating Provider NPI	99.88%	100%	99.94%	100%
Treating Provider Medicaid ID	99.10%	99.94%	97.71%	99.99%
Treating Provider Specialty Code	100%	99.70%	100%	99.72%
Billing Provider Type	99.99%	100%	99.98%	100%
Billing Provider NPI	100%	100%	100%	100%
Billing Provider Medicaid ID	99.20%	99.97%	98.04%	100%
Billing Provider Specialty Code	100%	99.82%	100%	99.98%
Facility Provider Type	100%	100%	100%	100%
Facility Provider NPI	100%	100%	100%	100%
Facility Provider Medicaid ID	100%	100%	100%	100%
Place of Service	100%	98.78%	100%	92.23%
	Simply Healthcare (N=552,868)		**Simply Healthcare (N=254,173)**	
Member ID	100%†	92.58%	100%†	92.69%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	95.50%	100%	91.24%	100%
Claim Paid Date	100%	100%	100%	100%
Admit Date	100%	100%	100%	100%
Diagnosis Code	99.89%	100%†	100%†	99.77%
Procedure Code	97.83%	99.17%	97.97%	97.07%

Table A-27. Completeness and Validity Rates—Claim Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	99.99%	99.97%	99.92%	99.95%
Treating Provider NPI	100%†	100%	99.93%	100%†
Treating Provider Medicaid ID	99.97%	99.97%	99.71%	99.95%
Treating Provider Specialty Code	99.97%	99.97%	99.78%	99.95%
Billing Provider Type	99.97%	99.97%	99.79%	99.97%
Billing Provider NPI	100%	99.99%	99.93%	99.99%
Billing Provider Medicaid ID	99.87%	99.97%	99.08%	99.97%
Billing Provider Specialty Code	99.92%	99.97%	99.65%	99.97%
Facility Provider Type	99.96%	100%	99.92%	100%
Facility Provider NPI	99.96%	100%	99.92%	100%
Facility Provider Medicaid ID	99.95%	100%	99.86%	100%
Place of Service	100%	99.18%	100%	88.47%

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

Table A-28 includes completeness and validity rates of encounter data for the MCOs. Scores between 90.0% and 99.99% are identified in **green**; scores below 90.0% are identified in **red**.

Table A-28. Completeness and Validity Rates—Encounter Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=18,259)		**Aetna (N=17,501)**	
Member Identification (ID)	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Diagnosis Code	100%	99.92%	100%	99.96%
Procedure Code	99.06%	100%	98.54%	100%
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	96.53%	100%	98.74%	100%
Treating Provider National Provider Identifier (NPI)	100%	100%	100%	100%
Treating Provider Medicaid ID	96.53%	100%	98.74%	100%
Treating Provider Specialty Code	96.53%	100%	98.74%	100%
Billing Provider Type	96.26%	100%	97.90%	100%
Billing Provider NPI	100%	100%	100%	100%

Table A-28. Completeness and Validity Rates—Encounter Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider Medicaid ID	96.26%	100%	97.90%	100%
Billing Provider Specialty Code	96.26%	100%	97.90%	100%
Place of Service	99.99%	99.87%	99.06%	99.48%
	Community Care (N=475)		**Community Care (N=1,906)**	
Member ID	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Diagnosis Code	100%	100%	100%	100%
Procedure Code	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%
Treating Provider NPI	100%	100%	100%	100%
Treating Provider Medicaid ID	100%	100%	100%	100%
Treating Provider Specialty Code	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%

Table A-28. Completeness and Validity Rates—Encounter Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider NPI	100%	100%	100%	100%
Billing Provider Medicaid ID	100%	100%	100%	100%
Billing Provider Specialty Code	100%	100%	100%	100%
Place of Service	100%	94.53%	95.86%	76.52%
	Simply Healthcare (N=28,910)		**Simply Healthcare (N=13,313)**	
Member ID	99.99%	93.83%	100%	94.69%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Diagnosis Code	100%	100%	100%	100%
Procedure Code	100%	99.92%	100%	99.97%
First Date of Service	100%	100%	100%	100%
Last Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Total Days	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%
Treating Provider NPI	100%	100%	100%	100%
Treating Provider Medicaid ID	99.34%	100%	99.32%	100%
Treating Provider Specialty Code	100%	100%	100%	100%

Table A-28. Completeness and Validity Rates—Encounter Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Billing Provider Type	100%	100%	100%	100%
Billing Provider NPI	100%	100%†	100%	100%
Billing Provider Medicaid ID	92.64%	100%	98.84%	100%
Billing Provider Specialty Code	100%	100%	100%	100%
Place of Service	100%	98.83%	100%	69.76%

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

Table A-29 includes completeness and validity rates of pharmacy data for the MCOs. Scores between 90.0% and 99.99% are identified in **green**; scores below 90.0% are identified in **red**.

Table A-29. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Aetna (N=210,172)		**Aetna (N=153,665)**	
Member Identification (ID)	100%	100%	100%	100%†
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%

Table A-29. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Type	94.44%	100%	94.56%	100%
Treating Provider National Provider Identifier (NPI)	99.93%	100%†	100%	100%
Treating Provider Medicaid ID	94.44%	100%	94.56%	100%
Treating Provider Specialty Code	94.44%	100%	94.56%	100%
Billing Provider Type	99.59%	100%	99.50%	100%
Billing Provider NPI	100%	100%	100%	100%
Billing Provider Medicaid ID	99.59%	100%	99.50%	100%
Billing Provider Specialty Code	99.59%	100%	99.50%	100%
National Drug Code (NDC)	100%	99.99%	100%	100%†
Class	99.75%	0%	99.79%	3.27%
Primary Pharmacy ID	100%	100%	100%	96.74%
Days' Supply	100%	100%	100%	100%
	Community Care (N=13)		**Community Care (N=6,374)**	
Member ID	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%

Table A-29. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Type	100%	100%	85.03%	100%
Treating Provider NPI	100%	100%	100%	100%
Treating Provider Medicaid ID	100%	100%	85.03%	100%
Treating Provider Specialty Code	100%	100%	85.03%	100%
Billing Provider Type	100%	100%	99.34%	100%
Billing Provider NPI	100%	100%	100%	100%
Billing Provider Medicaid ID	100%	100%	99.37%	100%
Billing Provider Specialty Code	100%	100%	99.34%	100%
NDC	100%	100%	100%	100%
Class	100%	100%	100%	99.97%
Primary Pharmacy ID	100%	100%	100%	100%
Days' Supply	100%	100%	100%	100%
	Simply Healthcare (N=244,737)		**Simply Healthcare (N=171,155)**	
Member ID	99.73%	93.21%	100%	93.82%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
First Date of Service	100%	100%	100%	100%
Units of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%

Table A-29. Completeness and Validity Rates—Pharmacy Lines Submitted by MCOs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Treating Provider Type	99.78%	100%	99.82%	100%
Treating Provider NPI	100%	100%	100%	100%
Treating Provider Medicaid ID	99.78%	100%†	99.82%	100%†
Treating Provider Specialty Code	99.78%	100%	99.82%	100%
Billing Provider Type	100%	100%	100%	100%
Billing Provider NPI	100%	100%	100%	100%
Billing Provider Medicaid ID	99.71%	100%	99.68%	100%
Billing Provider Specialty Code	100%	100%	100%	100%
NDC	89.93%	100%	84.86%	100%
Class	89.93%	100%	84.86%	100%
Primary Pharmacy ID	90.11%	100%	85.02%	100%
Days' Supply	90.11%	100%	85.02%	100%

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

Table A-30 includes completeness and validity rates of claim data for the DBMs. Scores between 90.0% and 99.99% are identified in **green**; scores below 90.0% are identified in **red**.

Table A-30. Completeness and Validity Rates—Claim Lines Submitted by DBMs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	Argus (N=68,271)		**Argus (N=39,911)**	
Member Identification (ID)	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	99.89%	100%	99.39%
Primary Procedure Code	100%	99.84%	100%	99.75%
First Date of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%
Treating Provider NPI	84.66%	99.95%	91.49%	99.98%
Treating Provider Medicaid ID	100%	100%	100%	100%
Treating Provider Specialty Code	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%
Billing Provider National Provider Identifier (NPI)	99.35%	100%	99.12%	100%
Billing Provider Medicaid ID	99.35%	100%	99.12%	100%
Billing Provider Specialty Code	100%	100%	100%	100%
Place of Service	99.26%	99.99%	99.52%	99.77%

Table A-30. Completeness and Validity Rates—Claim Lines Submitted by DBMs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
	DentaQuest (N=150,460)		**DentaQuest (N=80,938)**	
Member ID	100%	100%	100%	100%
Plan ID	100%	100%	100%	100%
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Primary Procedure Code	100%	99.87%	100%	99.69%
First Date of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%
Treating Provider NPI	99.19%	100%	99.55%	100%
Treating Provider Medicaid ID	99.45%	40.76%	99.56%	45.54%
Treating Provider Specialty Code	99.45%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%
Billing Provider NPI	99.19%	100%	99.55%	100%
Billing Provider Medicaid ID	100%	0%	99.99%	0%
Billing Provider Specialty Code	98.87%	100%	100%	100%
Place of Service	100%	100%	100%	99.08%
	MCNA (N=123,264)		**MCNA (N=60,573)**	
Member ID	100%	76.93%	100%	77.57%
Plan ID	100%	100%	100%	100%

Table A-30. Completeness and Validity Rates—Claim Lines Submitted by DBMs				
Field	**2020Q1 Dates of Service**		**2020Q2 Dates of Service**	
	Completeness Rate	Validity Rate*	Completeness Rate	Validity Rate*
Claim Reference Number	100%	100%	100%	100%
Billing Date	100%	100%	100%	100%
Claim Paid Date	100%	100%	100%	100%
Primary Procedure Code	100%	99.90%	100%	99.81%
First Date of Service	100%	100%	100%	100%
Financial Report Service Category	100%	100%	100%	100%
Treating Provider Type	100%	100%	100%	100%
Treating Provider NPI	100%	99.82%	100%	99.91%
Treating Provider Medicaid ID	99.82%	95.02%	99.91%	93.80%
Treating Provider Specialty Code	100%	100%	100%	100%
Billing Provider Type	100%	100%	100%	100%
Billing Provider NPI	100%	99.82%	100%	99.91%
Billing Provider Medicaid ID	99.82%	95.02%	99.91%	93.80%
Billing Provider Specialty Code	100%	100%	100%	100%
Place of Service	100%	99.96%	100%	99.67%

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

Tables A-31 through **A-34** include claim, encounter, and pharmacy claim data adjudicated/paid in 2020 Q1, Q2, and Q3.

Table A-31. 2020Q1 Claims and Encounters Adjudicated/Paid by MCOs and DBMs

MCO/DBM	Total Claims and Encounter Records (N=370,803)				N=368,804
MCO	Claims N (% of MCO Total)		Encounters	Total Claims and Encounters	Pharmacy Claims
	Institutional	Professional	Professional		
Aetna	12,486 (10.07%)	111,540 (89.93%)	7,765	131,791	179,583
Service Date Range	9/13/18 – 3/21/20	6/17/18 – 3/25/20	2/26/16 – 3/30/20	2/26/16 – 3/30/20	4/23/19 – 4/1/20
Community Care Plan	1,493 (9.78%)	13,777 (90.22%)	0	15,270	0
Service Date Range	1/1/20 – 3/24/20	1/1/20 – 3/31/20	-	1/1/20 – 3/31/20	-
Simply Healthcare	14,523 (12.61%)	100,686 (87.38%)	0	115,209	189,221
Service Date Range	4/18/17 – 3/15/20	10/21/15 -3/20/20	-	4/18/17 – 3/15/20	2/26/18 – 3/25/20
Staywell	5,340 (16.48%)	27,058 (83.52%)	0	32,398	*
Service Date Range	4/5/17 – 12/31/19	2/19/10 – 12/31/19	-	2/19/10 – 12/31/19	*
Sunshine	0 (0%)	100 (100%)	0	100	*
Service Date Range	-	11/29/18 – 12/31/19	-	11/29/18 – 12/31/19	*
UnitedHealthcare	39 (8.46%)	422 (91.54%)	0	461	*
Service Date Range	1/6/20 – 3/17/20	1/1/20 – 3/27/20	-	1/1/20 – 3/27/20	*
Total MCOs	**33,881**	**253,583**	**7,765**	**295,229**	**368,804**
DBM	**Claims**			**Total**	
Argus	14,408		†	14,408	**
Service Date Range	10/18/17 – 3/20/20			10/18/17 – 3/20/20	

Table A-31. 2020Q1 Claims and Encounters Adjudicated/Paid by MCOs and DBMs				
MCO/DBM	**Total Claims and Encounter Records (N=370,803)**			**N=368,804**
DentaQuest	34,161	†	34,161	**
Service Date Range	1/27/10 – 3/27/20		1/27/10 – 3/27/20	
MCNA	27,005	†	27,005	**
Service Date Range	1/1/00 – 3/20/20		1/1/00 – 3/20/20	
Total DBMs			**75,574**	**

** MCOs with contracts ending 12/31/19 submitted 2020 data in a prior data layout; thus, pharmacy claims counts are not available for these MCOs.*
† The DBMs are fee-for-service only and do not utilize capitation; therefore, no encounters are reported.
*** The DBMs do not process pharmacy claims; thus, no pharmacy data are included.*

Table A-32. 2020Q2 Claims and Encounters Adjudicated/Paid by MCOs and DBMs					
MCO/DBM	**Total Claims and Encounter Records (N=252,731)**				**N=281,200**
MCO	**Claims** N (% of MCO Total)		**Encounters**	**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	**Professional**	**Professional**		
Aetna	4,977 (6.83%)	67,886 (93.17%)	13,013)	85,876 (100%)	131,923
Service Date Range	1/29/19 – 6/22/20	1/1/19 – 6/24/20	8/14/17 – 6/19/20	8/4/17 – 6/24/20	10/31/18 – 7/1/20
Community Care Plan	1,068 (7.89%)	12,469 (92.11%)	698	14,235 (100%)	6,222
Service Date Range	1/1/20 – 6/22/20	1/1/19 -6/24/20	1/2/20 – 6/27/20	1/2/20 – 6/27/20	1/15/20 – 6/29/20
Simply Healthcare	7,370 (7.07%)	96,801 (92.93%)	8,115	112,286 (100%)	142,055
Service Date Range	2/24/17 – 6/16/20	11/12/16 – 6/25/20	11/29/18 – 6/26/20	11/12/16 – 6/26/20	5/18/19 – 6/18/20

Table A-32. 2020Q2 Claims and Encounters Adjudicated/Paid by MCOs and DBMs					
MCO/DBM	**Total Claims and Encounter Records (N=252,731)**				**N=281,200**
Staywell	1,178 (18.88%)	5,063 (81.12%)	0	6,241	*
Service Date Range	7/19/10 – 12/31/19	1/11/11 – 12/31/19	-	7/19/10 – 12/31/19	
Sunshine	0 (0%)	22 (100%)	0	22	*
Service Date Range	-	01/02/19 – 12/31/19	-	1/2/19 – 12/31/19	
UnitedHealthcare	87 (18.13%)	393 (81.88%)	0	480	*
Service Date Range	10/2/19 – 12/30/19	10/1/19 – 12/31/19	-	10/1/19 – 12/31/19	
Total MCOs	**14,680 (7.44%)**	**182,634 (92.56%)**	**21,826**	**219,140**	**281,200**
DBM	**Claims**			**Total**	
Argus	5,922 (100%)		†	5,922	**
Service Date Range	2/7/19 – 6/16/20			2/7/19 – 6/16/20	
DentaQuest	16,195 (100%)		†	16,195	**
Service Date Range	7/16/14 – 6/29/20			7/16/14 – 6/29/20	
MCNA	11,474 (100%)		†	11,474	**
Service Date Range	8/12/07 – 6/23/20			8/12/07 – 6/23/20	
Total DBMs				**33,591**	**

** MCOs with contracts ending 12/31/19 submitted 2020 data in a prior data layout; thus, pharmacy claims counts are not available for these MCOs.*
† The DBMs are fee-for-service only and do not utilize capitation; therefore, no encounters are reported.
*** The DBMs do not process pharmacy claims; thus, no pharmacy data are included.*

Table A-33. 2020Q3 Claims and Encounters Adjudicated/Paid by MCOs and DBMs						
MCO/DBM	**Total Claims and Encounter Records (N=341,071)**					**N=278,455**
MCO	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	Professional	Institutional	Professional		
Aetna	5,759 (6.20%)	87,091 (93.80%)	0 (0%)	30,769 (100%)	123,619	133,890
Service Date Range	1/24/19 – 9/19/20	3/19/18 – 9/23/20	-	6/8/18 – 9/28/20	3/19/18 – 9/28/20	9/21/19 – 10/1/20
Community Care	1,043 (9.24%)	10,243 (90.76%)	178 (13.57%)	1,134 (86.43%)	12,598	8,527
Service Date Range	1/2/20 – 9/22/20	1/1/20 – 9/26/20	6/1/20 – 8/31/20	1/6/20 – 9/25/20	1/1/20 – 9/26/20	4/27/20 – 9/30/20
Simply Healthcare	9,365 (7.08%)	122,860 (92.92%)	0 (0%)	9,101 (100%)	141,326	136,038
Service Date Range	5/26/17 – 9/16/20	3/6/17 – 9/24/20	-	8/1/19 – 9/25/20	3/6/17 – 9/25/20	5/28/19 – 9/18/20
Total MCOs	**16,167 (6.84%)**	**220,194 (93.16%)**	**41,182**		**277,543**	**278,455**
DBM	**Claims**				**Total**	
Argus	13,191 (100%)		*		13,191	†
Service Date Range	3/24/16 – 9/24/20				3/24/16 – 9/24/20	
DentaQuest	26,638 (100%)		*		26,638	†
Service Date Range	8/10/10 – 9/26/20				8/10/10 – 9/26/20	
MCNA	23,699 (100%)		*		23,699	†
Service Date Range	6/5/12 – 9/25/20				6/5/12 – 9/25/20	

Table A-33. 2020Q3 Claims and Encounters Adjudicated/Paid by MCOs and DBMs						
MCO/DBM	**Total Claims and Encounter Records (N=341,071)**					**N=278,455**
MCO	**Claims** N (% of MCO Total)		**Encounters** N (% of MCO Total)		**Total Claims and Encounters**	**Pharmacy Claims**
	Institutional	Professional	Institutional	Professional		
Total DBMs					**63,528**	†

Table A-34. 2020Q1 Claim Adjustments Submitted by MCOs and DBMs				
MCO/DBM	**Total Claim Records (N=37,823)**			**N=21,582**
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Aetna	1,653 (28.75%)	4,097 (71.25%)	5,750	13,020
Service Date Range	10/6/15 – 3/10/20	9/11/09 – 3/13/20	9/11/09 – 3/13/20	4/23/19 – 4/1/20
Community Care Plan	0 (0%)	0 (0%)	0	0
Service Date Range	-	-	-	-
Simply Healthcare	1,176 (6.80%)	16,126 (93.20%)	17,302	8,562
Service Date Range	6/26/17 – 2/28/20	1/4/16 – 3/11/20	1/4/16 – 3/11/20	2/26/18 – 3/25/20
Staywell	3,089 (66.44%)	1,560 (33.56%)	4,649	*
Service Date Range	3/16/15 – 12/27/19	3/16/11 – 12/30/19	3/16/11 – 12/30/19	*
Sunshine	1,040 (12.41%)	7,338 (87.59%)	8,378	*
Service Date Range	11/7/15 – 12/31/19	4/1/16 – 12/31/19	11/7/15 – 12/31/19	*
UnitedHealthcare	0	0	0	*
Service Date Range	-	-	-	*
Total MCOs	**6,958 (19.29%)**	**29,121 (80.71%)**	**36,079**	**21,582**

Table A-34. 2020Q1 Claim Adjustments Submitted by MCOs and DBMs			
MCO/DBM	**Total Claim Records (N=37,823)**		**N=21,582**
DBM	**Claim Adjustments**	**Total**	
Argus	350	350	†
Service Date Range	7/6/18 – 3/13/20	7/6/18 – 3/13/20	
DentaQuest	294	294	†
Service Date Range	10/8/18 – 3/13/20	10/8/18 – 3/13/20	
MCNA	1,100	1,100	†
Service Date Range	9/27/16 – 2/26/20	9/27/16 – 2/26/20	
Total DBMs		**1,744**	†

** MCOs with contracts ending 12/31/19 submitted 2020 data in a prior data layout; thus, pharmacy claims counts are not available for these MCOs.*
† The DBMs do not process pharmacy claims; thus, no pharmacy data are included.

Table A-35. 2020Q2 Claim Adjustments Submitted by MCOs and DBMs				
MCO/DBM	**Total Claim Records (N=58,055)**			**N=18,694**
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Aetna	2,119 (11.55%)	16,232 (88.45%)	18,351	11,720
Service Date Range	2/18/17 – 6/3/20	1/19/17 – 6/8/20	1/19/17 – 6/8/20	10/31/18 – 6/30/20
Community Care Plan	0 (0%)	0 (0%)	0	0
Service Date Range	–	–	–	–
Simply Healthcare	1,317 (4.03%)	31,349 (95.97%)	32,666	6,974
Service Date Range	11/3/10 – 6/5/20	7/2/14 – 6/3/20	11/3/10 – 6/5/20	1/2/20 – 6/5/20
Staywell	1,108 (54.10%)	940 (45.90%)	2,048	*

Table A-35. 2020Q2 Claim Adjustments Submitted by MCOs and DBMs				
MCO/DBM	**Total Claim Records (N=58,055)**			**N=18,694**
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	Professional		
Service Date Range	4/18/11 – 12/31/19	1/20/11 – 12/31/19	1/20/11 – 12/31/19	
Sunshine	521 (15.59%)	2,820 (84.41%)	3,341	*
Service Date Range	10/5/15 – 12/31/19	10/5/15 – 12/31/19	10/5/15 – 12/31/19	
UnitedHealthcare	0 (0%)	2 (100%)	2	*
Service Date Range	–	12/2/19 – 12/2/19	12/2/19 – 12/2/19	
Total MCOs	**5,065 (8.98%)**	**51,343 (91.02%)**	**56,408**	**18,694**
DBM	**Claim Adjustments**		**Total**	
Argus	347 (100%)		347	†
Service Date Range	2/7/19 – 5/20/20		2/7/19 – 5/20/20	
DentaQuest	486 (100%)		486	†
Service Date Range	2/12/19 – 6/17/20		2/12/19 – 6/17/20	
MCNA	814 (100%)		814	†
Service Date Range	8/21/17 – 20/3/90		8/21/17 – 20/3/90	
Total DBMs			**1,647**	†

** MCOs with contracts ending 12/31/19 submitted 2020 data in a prior data layout; thus, pharmacy claims counts are not available for these MCOs.*
† The DBMs do not process pharmacy claims; thus, no pharmacy data are included.

Table A-36. 2020Q3 Claim Adjustments Submitted by MCOs and DBMs				
MCO/DBM	**Total Claim Records (N=56,924)**			**N=19,204**
MCO	**Claim Adjustments**		**Total Claim Adjustments**	**Pharmacy Claim Adjustments**
	Institutional	**Professional**		
Aetna	2,047 (9.36%)	19,832 (90.64%)	21,879	10,724
Service Date Range	3/14/17 – 8/24/20	2/27/17 – 9/14/20	2/27/17 – 9/14/20	9/21/19 – 9/30/20
Community Care	25 (0.65%)	3,810 (99.35%)	3,835	1,980
Service Date Range	1/8/20 – 8/14/20	1/2/20 – 9/4/20	1/2/20 – 9/4/20	5/15/20 – 9/30/20
Simply Healthcare	1,740 (14.49%)	10,266 (85.51%)	12,006	6,500
Service Date Range	8/15/15 – 8/31/20	10/19/13 – 9/3/20	10/19/13 – 9/3/20	4/29/20 – 9/5/20
Total MCOs	**3,812 (10.11%)**	**33,908 (89.89%)**	**37,720**	**19,204**
DBM	**Claim Adjustments**		**Total**	
Argus	401 (100%)		401	*
Service Date Range	11/11/19 – 9/15/20		11/11/19 – 9/15/20	
DentaQuest	905 (100%)		905	*
Service Date Range	9/19/18 – 9/3/20		9/19/18 – 9/3/20	
MCNA	378 (100%)		378	*
Service Date Range	3/17/15 – 9/3/20		3/17/15 – 9/3/20	
Total DBMs			**1,684**	*

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

APPENDIX B | 2020 Sample Assessment Tools

The assessment tools presented in this appendix represent a comprehensive sample of the tools used to evaluate performance for the **PIP**, PDSA, and ACA EQR activities. The ANA and EDV activities do not use tools in their evaluation; however, the standards used to evaluate MCO and DBM provider networks are included in the ANA section of this appendix, and the encounter data fields validated are included in the EDV section of this appendix. The complete, individual MCO and DBM tools used for these listed reviews are contained within the individual MCO and DBM reports previously submitted to FHKC. Qsource's subcontractor, Quest Analytics, helped to conduct certain EQR activities.

PIP Validation

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

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity I: Choose the Selected Study Topic(s)					
Topics selected for the study should reflect the Florida Healthy Kids enrolled population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of disease. Topics could also address the need for a specific service. The goal of the project should be to improve processes and outcomes of healthcare or services. The topic may be specified by Florida Healthy Kids Corporation (FHKC).					
Element #	**C***	**Study topic(s):**	**Met**	**Not Met**	**NA****
1	☐	Reflects high-volume or high-risk conditions	☐	☐	☐
2	☐	Is selected following collection and analysis of data	☐	☐	☐
3	☐	Addresses a broad spectrum of care and services	☐	☐	☐
4	☐	Includes all eligible populations that meet the study criteria	☐	☐	☐
5	☐	Addresses any exclusion of enrollees with special healthcare needs	☐	☐	☐
6	☑	Has the potential to affect enrollee health, functional status, or satisfaction	☐	☐	☐

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity I Results:		**Total**	**Met**	**Not Met**	**NA**
All Elements		6			
Critical Elements		1			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity II: Define the Study Question(s)					
Stating the study question(s) helps to maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.					
Element #	**C***	**Study question(s):**	**Met**	**Not Met**	**NA****
1	☑	States the problem to be studied in simple terms	☐	☐	☐
2	☑	Is answerable	☐	☐	☐
Activity II Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			2			
Critical Elements			2			
Comment:		<Type comment here>.				
Strength:		<Type strength here>.				
AON:		<Type AON here>.				
Suggestion:		<Type suggestion here>.				

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity III: Use a Representative and Generalizable Study Population					
The selected topic should represent the entire eligible population of Florida Healthy Kids enrollees with system-wide measurement and improvement efforts to which the study indicator(s) applies.					
Element #	**C***	**The representative and generalizable study population:**	**Met**	**Not Met**	**NA****
1	☑	Is accurately and completely defined	☐	☐	☐
2	☐	Includes requirements for the length of an enrollee's enrollment in the MCO/DBM	☐	☐	☐
3	☑	Captures all enrollees to whom the study question applies	☐	☐	☐
Activity III Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			3			
Critical Elements			2			
Comment:		<Type comment here>.			
Strength:		<Type strength here>.			
AON:		<Type AON here>.			
Suggestion:		<Type suggestion here>.			

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity IV: Select the Study Indicators					
A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., a child has received a recommended vaccination) or a status (e.g., a child diagnosed with asthma is not prescribed a controller medication) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.					
Element #	**C***	**Study indicators:**	**Met**	**Not Met**	**NA****
1	☑	Are well defined, objective, and measurable	☐	☐	☐
2	☐	Are based on current, evidence-based practice guidelines; pertinent peer-reviewed literature; or consensus of expert panels	☐	☐	☐
3	☑	Allow for the study questions to be answered	☐	☐	☐
4	☐	Measure changes (outcomes) in health or functional status, enrollee satisfaction, or valid process alternatives	☐	☐	☐
5	☑	Have available data that can be collected on each indicator	☐	☐	☐
6	☐	Are nationally recognized measures, such as HEDIS Technical Specifications, when appropriate	☐	☐	☐
7	☐	Include the basis on which the indicators were adopted, if internally developed	☐	☐	☐
Activity IV Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			7			
Critical Elements			3			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity V: Use Sound Sampling Methods					
If sampling is used to select enrollees in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied. This activity is only scored if sampling is used. **If sampling was not used, e.g. the entire eligible population was assessed, this activity is not scored.**					
Element #	**C***	**Sampling methods:**	**Met**	**Not Met**	**NA****
1	☐	Consider and specify the calculated administrative rate or estimated rate	☐	☐	☐
2	☐	Identify the sample size	☐	☐	☐
3	☐	Specify the confidence level to be used	☐	☐	☐
4	☐	Specify the acceptable margin of error	☐	☐	☐
5	☑	Ensure a representative sample of the eligible population	☐	☐	☐
6	☐	Are in accordance with generally accepted principles of research design and statistical analysis	☐	☐	☐
Activity V Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			6			
Critical Elements			1			
Comment:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity VI: Use Valid and Reliable Data Collection Procedures					
Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.					
Element #	**C***	**Data collection procedures:**	**Met**	**Not Met**	**NA****
1	☐	Identify data elements to be collected	☐	☐	☐
2	☐	Identify specified sources of data	☐	☐	☐
3	☐	Describe a defined and systematic process for collecting baseline and remeasurement data	☐	☐	☐
4	☐	Include data collection and analysis cycles	☐	☐	☐
5	☐	Describe qualified staff and personnel to abstract manual data	☐	☐	☐
6	☐	Describe the data collection tool that supports inter-rater reliability (IRR) and the IRR process	☐	☐	☐
7	☑	Include a manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications	☐	☐	☐
8	☐	Include clear and concise written instructions for completing the manual data collection tool	☐	☐	☐
9	☐	Include an overview of the study in written instructions	☐	☐	☐
10	☐	Include administrative data collection algorithms/flowcharts or narrative that shows activities in the production of indicators	☐	☐	☐
11	☐	Include an estimated degree of administrative data completeness	☐	☐	☐
Activity VI Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			11			
Critical Elements			1			
Comment:		<Type comment here>.				

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>	
Strength:	<Type strength here>.
AON:	<Type AON here>.
Suggestion:	<Type suggestion here>.

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity VII: Analyze Data and Interpret Study Results					
Review the data analysis process for the selected clinical or non-clinical study indicators. Review appropriateness of and adherence to the statistical analysis techniques used, and interpret the findings.					
Element #	**C***	**Study results:**	**Met**	**Not Met**	**NA****
1	☑	Are conducted according to the data analysis plan in the study design	☐	☐	☐
2	☑	Allow for the generalization of results to the study population if a sample was selected	☐	☐	☐
3	☐	Identify factors that threaten internal or external validity of findings	☐	☐	☐
4	☐	Include an interpretation of findings	☐	☐	☐
5	☐	Are presented in a way that provides accurate, clear, and easily understood information	☐	☐	☐
6	☐	Identify the initial measurement and remeasurement of study indicators	☐	☐	☐
7	☐	Identify statistical differences between the initial measurement and the remeasurement(s)	☐	☐	☐
8	☐	Identify factors that affect the ability to compare the initial measurement with the remeasurement	☐	☐	☐
9	☐	Include an interpretation of the extent to which the study was successful	☐	☐	☐
Activity VII Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			9			
Critical Elements			2			
Comment:	<Type comment here>.					
Strength:	<Type strength here>.					
AON:	<Type AON here>.					
Suggestion:	<Type suggestion here>.					

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity VIII: Include Improvement Strategies					
Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, as well as developing and implementing system-wide improvements in care. Interventions are designed to change behavior at an institutional, practitioner, or enrollee level.					
Element #	**C***	**Improvement strategies are:**	**Met**	**Not Met**	**NA****
1	☑	Related to causes/barriers identified through data analysis and quality improvement processes	☐	☐	☐
2	☐	System changes that are likely to induce permanent change	☐	☐	☐
3	☐	Revised if the original interventions were not successful	☐	☐	☐
4	☐	Standardized and monitored if interventions were successful	☐	☐	☐
Activity VIII Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			4			
Critical Elements			1			
Comment:	<Type comment here>.				
Strength:	<Type strength here>.				
AON:	<Type AON here>.				
Suggestion:	<Type suggestion here>.				

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity IX: Assess for Real Improvement					
Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be assessed/analyzed. Also address any random, year-to-year variations; population changes; or sampling errors that may have occurred during the measurement process. This activity is not assessed until a baseline measurement and a minimum of one annual remeasurement has been completed.					
Element #	**C***	**Assessments for real improvement indicate that:**	**Met**	**Not Met**	**NA****
1	☐	The remeasurement methodology is the same as the baseline methodology	☐	☐	☐
2	☐	Documented improvements in processes or outcomes of care are assessed	☐	☐	☐
3	☐	Improvements appear to be the result of planned intervention(s)	☐	☐	☐
4	☐	Statistical evidence that observed improvement is true improvement is addressed	☐	☐	☐
Activity IX Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			4			
Critical Elements			0			
Comment:		<Type comment here>.				
Strength:		<Type strength here>.				
AON:		<Type AON here>.				
Suggestion:		<Type suggestion here>.				

** C = Critical element*
*** NA = Not assessed*

2020 PIP Validation Tool—<MCO/DBM Name> <PIP Topic>					
Activity X: Assess for Sustained Improvement					
Describe any improvement demonstrated through repeated measurements over comparable time periods. Assess for any random, year-to-year variations; population changes; sampling errors; or statistically significant declines that may have occurred during the remeasurement process. This activity is not assessed until a baseline measurement and a minimum of two annual remeasurements have been completed.					
Element #	**C***	**Sustained improvement strategies indicate that:**	**Met**	**Not Met**	**NA****
1	☐	Repeated measurements over comparable time periods are assessed for sustained improvement.	☐	☐	☐
Activity X Results:			**Total**	**Met**	**Not Met**	**NA**
All Elements			1			
Critical Elements			0			
Comment:		<Type comment here>.				
Strength:		<Type strength here>.				
AON:		<Type AON here>.				
Suggestion:		<Type suggestion here>.				

** C = Critical element*
*** NA = Not assessed*

PDSA

The FHKC 2020 PDSA Plan-Do Review Tool and the FHKC 2020 PDSA Study-Act Review Tool were used to assess MCO and DBM PDSAs.

Plan-Do

2020 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity I: Plan				
Element #		**Met**	**Opportunity**	**NA***
1	Set aim of the project	☐	☐	☐
2	Define measure	☐	☐	☐
3	State measure baseline	☐	☐	☐
4	Develop driver diagram	☐	☐	☐
5	Select specific change ideas and rationale for selection	☐	☐	☐
6	Describe planned data collection process	☐	☐	☐
7	Develop initial sustainability plan	☐	☐	☐
Activity I Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	7			
Comment:				
Strength:				
Suggestion:				

** Not applicable*

2020 PDSA—<MCO/DBM Name>
<Clinical/Nonclinical> – <PIP Study Title>

Activity II: Do

Element #	The study question(s):	Met	Opportunity	NA
1	Describe the change implemented and the scale of the test	☐	☐	☐
2	Describe the results of the test	☐	☐	☐

Activity II Results:	Total	Met	Opportunity	NA
All Elements	2			

Comment:

Strength:

Suggestion:

Study-Act

2020 PDSA—<MCO/DBM Name> <Clinical/Nonclinical> – <PIP Study Title>				
Activity III: Study				
Element #		**Met**	**Opportunity**	**NA**
1	Analyze and compare results	☐	☐	☐
2	Describe what was learned from test of change	☐	☐	☐
Activity III Results:	**Total**	**Met**	**Opportunity**	**NA**
All Elements	2			
Comment:				
Strength:				
Suggestion:				

2020 PDSA—<MCO/DBM Name>
<Clinical/Nonclinical> – <PIP Study Title>

Activity IV: Act

Element #		Met	Opportunity	NA
1	Describe action to be taken	☐	☐	☐
2	Complete sustainability plan	☐	☐	☐
3	Describe plan for next PDSA cycle	☐	☐	☐

Activity IV Results:	Total	Met	Opportunity	NA
All Elements	3			

Comment:

Strength:

Suggestion:

ACA

The following assessment tools were used for the ACA evaluation:

- 2020 CA Standards Survey Tools (MCO and DBM)
- Credentialing File Review Tool (MCO and DBM)
- Recredentialing File Review Tool (MCO and DBM)

MCO CA Standards Tool

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
1. Information Format 42 *Code of Federal Regulations* (CFR) 438.10(c)(1), Medical Services Contract (MSC) 3-19-2	The managed care organization (MCO) must provide all required information to enrollees and potential enrollees in a language that is clear and non-technical and in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees in accordance with 42 CFR 438.10.	☐ Easily understood ☐ Readily accessible	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Culturally Competent Communication MSC 3-19-2-A	The MCO must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
3. Electronic Information 42 CFR 438.10(c)(6)(i)-(v)	The MCO must ensure all of the following conditions are met for information provided electronically to enrollees: a. the format is readily accessible; b. the information is placed in a location on the MCO's website that is prominent and readily accessible; c. the information is provided in an electronic form that can be electronically retained and printed; d. the information is consistent with content and language requirements for enrollee information; and e. the MCO informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.	☐ a. Accessible format ☐ b. Prominently placed and readily accessible on MCO website ☐ c. Can be electronically retained and printed ☐ d. Meets content and language requirements ☐ e. Enrollee informed that information is available in paper form without charge upon request, to be received within five business days	**0.200** **0.200** **0.200** **0.200** **0.200**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
4. Enrollee Assistance 42 CFR 438.10(c)(7), MSC 3-5, MSC 3-11	The MCO must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan. The MCO also must comply with the guidance issued by the Office for Civil Rights (OCR) of the United States Department of Health and Human Services regarding the availability of information and assistance for persons with limited English proficiency.	☐ Mechanisms in place to help enrollees and potential enrollees ☐ Compliance with OCR guidance	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
5. Language and Format 42 CFR 438.10(d)(2)-(4), MSC 3-19-2	The MCO must: a. ensure enrollee information is in an easily understood language and format, including a font size no smaller than 12 point; b. make interpretation services available free of charge to each enrollee, including oral interpretation and the use of auxiliary aids such as teletypewriter / Telecommunications Device for the Deaf (TTY/TDY) and American Sign Language (oral interpretation requirements apply to all non-English languages, not just those that Florida Healthy Kids Corporation [FHKC] identifies as prevalent); c. ensure that all written materials for enrollees include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size, explaining the availability of written translations and oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a); d. make all its written materials available in English, Spanish, and all appropriate foreign languages; e. make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area; f. make its written materials available in alternative formats upon request of the potential enrollee or enrollee—taking into consideration enrollees' special needs, including those who are visually impaired or have limited reading proficiency—at no cost; and	☐ a. Easily understood language and format, with no smaller than 12-point font size ☐ b. Interpretation services available free of charge ☐ c. Written materials include taglines in prevalent non-English languages in print no less than 18-point font size and explain availability of translation services ☐ d. All written materials available in English, Spanish, and all other appropriate foreign languages ☐ e. Written materials available in prevalent non-English languages in service area ☐ f. Written materials available in alternative formats upon request at no cost ☐ g. Notification to enrollees of availability of information in alternative formats and how to access those formats	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
	g. notify all enrollees that information is available at no cost upon request in alternative formats, including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area, and how to access those formats.				
Findings **Strength** **AON** **Suggestion**					
6. Minimum Requirements for Enrollee Notification MSC 3-19-2-C	At a minimum, the MCO must ensure that all enrollees are made aware of: a. the rights and responsibilities of both the enrollee and MCO; b. the role of the primary care provider (PCP); c. what to do in an emergency or urgent medical situation; d. how to request a grievance or appeal, or contact the Independent Review Organization (IRO); e. how to report fraud and abuse; f. procedures for referrals and prior authorizations, including prescription coverage; g. how to acquire behavioral health and substance abuse services; h. any additional telephone numbers or contact information for reaching the MCO; and i. eligibility compliance requirements under the program, specifically for payment of premiums and renewal.	☐ a. Rights and responsibilities of both enrollee and MCO ☐ b. Role of PCP ☐ c. What to do in emergency or urgent medical situation ☐ d. How to request grievance or appeal, or contact IRO ☐ e. How to report fraud and abuse ☐ f. Procedures for referrals and prior authorizations, including prescription coverage ☐ g. How to acquire behavioral health and substance abuse services ☐ h. Any additional telephone numbers or contact information for reaching MCO	**0.111** **0.111** **0.111** **0.111** **0.111** **0.111** **0.111** **0.111**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
		☐ i. Eligibility compliance requirements under program, specifically for payment of premiums and renewal	**0.111**		
Findings **Strength** **AON** **Suggestion**					
7. Provider Termination Notice 42 CFR 438.10(f)(1), MSC 3-19-2	The MCO must make a good faith effort to provide written notice to enrollees who received primary or regular care from a terminating network provider within 15 calendar days of receipt or issuance of the provider termination notice.	☐ Written notice to enrollee ☐ Notice provided within 15 calendar days	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
8. Advance Directives MSC 3-19-2	The MCO must provide adult enrollees with written information on advance directive policies, including a description of applicable Florida law, within five business days of the enrollee's 18th birthday or enrollment, if enrollee enrolled as an adult. Such information must be updated to reflect changes in state law within 90 calendar days of the effective date of such change.	☐ Adult enrollees provided with written information on advance directive policies, including applicable Florida law, within five business days of enrollee's 18th birthday or enrollment, if enrollee enrolled as adult ☐ Information updated to reflect changes in state law within 90 calendar days	**0.500** **0.500**	**1**	**0.000**
Findings					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
Strength					
AON					
Suggestion					
9. Certificates of Creditable Coverage MSC 3-19-2	The MCO is responsible for issuing certificates of creditable coverage to enrollees, upon enrollee request.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
10. Physician Incentive Plan 42 CFR 438.10(f)(3), MSC 3-4	The MCO must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
11. Enrollee Handbook 42 CFR 438.10(g)(1), MSC 3-11-B, MSC 3-19-2	Within five business days of receipt of an enrollment file, the MCO must provide each enrollee a model enrollee handbook provided by FHKC that complies with any federal or state requirements, uses FHKC-developed definitions for managed care terminology, and serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	☐ Model enrollee handbook provided by FHKC provided to enrollees within five business days of receipt of enrollment file ☐ Complies with any federal and state requirements ☐ Uses FHKC-developed managed care terminology definitions ☐ Serves similar function as summary of benefits and coverage described in 45 CFR 147.200(a)	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
12. Enrollee Handbook Content – 1 42 CFR 438.10(g)(2)(i)-(iv)	The MCO's enrollee handbook must include, at a minimum: a. benefits provided by the MCO; b. how and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided; c. the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled; and d. procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's PCP.	☐ a. Benefits provided by the MCO ☐ b. How and where to access benefits and transportation ☐ c. Amount, duration, and scope of available benefits ☐ d. Procedures for obtaining benefits	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
13. Enrollee Handbook Content – 2 42 CFR 438.10(g)(2)(v)-(viii)	The MCO's enrollee handbook must include, at a minimum: a. the extent to which, and how, after-hours and emergency coverage are provided, including: 1. what constitutes an emergency medical condition and emergency services, 2. the fact that prior authorization is not required for emergency services, and 3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care; b. any restrictions on the enrollee's freedom of choice among network providers; c. the extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers, with an explanation that the MCO cannot require an enrollee to obtain a referral before choosing a family planning provider; and d. cost sharing, if any is imposed under the FHKC plan.	☐ a. Extent to which, and how, after-hours and emergency coverage are provided ☐ b. Restrictions on enrollee's choice among network providers ☐ c. Extent to which, and how, enrollees may obtain benefits, including explanation about not needing referral for family planning provider ☐ d. Cost sharing, if applicable	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
14. Enrollee Handbook Content – 3 42 CFR 438.10(g)(2)(ix)-(xii)	The MCO's enrollee handbook must include, at a minimum: a. enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100; b. the process of selecting and changing the enrollee's PCP; c. grievance, appeal, and independent review procedures and timeframes in an FHKC-developed or -approved description, to include: 1. the right to file grievances and appeals, 2. the requirements and timeframes for filing a grievance or appeal, 3. the availability of assistance in the filing process, 4. the right to request use of an IRO or the federal review process after the MCO has made a determination on an enrollee's appeal that is adverse to the enrollee, and 5. the fact that, when requested by the enrollee, benefits that the MCO seeks to reduce or terminate will continue if the enrollee files an appeal or a request to use an IRO or the federal review process within the timeframes specified for filing, and that the enrollee may, consistent with FHKC policy, be required to pay the cost of services furnished while the appeal or IRO/federal review process is pending if the final decision is adverse to the enrollee; and d. how to exercise an advance directive, as set forth in 42 CFR 438.3(j).	☐ a. Enrollee rights and responsibilities ☐ b. Process of selecting and changing enrollee's PCP ☐ c. FHKC-developed or -approved grievance, appeal, and independent review procedures and timeframes ☐ d. How to exercise advance directive	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings **Strength** **AON**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
Suggestion					
15. Enrollee Handbook Content – 4 42 CFR 438.10(g)(2)(xiii)-(xvi)	The MCO's enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or languages; b. the toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. other content required by FHKC in its Plan Model Enrollee Handbook.	☐ a. How to access auxiliary aids and services ☐ b. Toll-free numbers ☐ c. How to report suspected fraud or abuse ☐ d. Other FHKC-required content in Plan Model Enrollee Handbook	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
16. Information Delivery Methods 42 CFR 438.10(g)(3)(i)-(iv)	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the MCO: - mails a printed copy of the information to the enrollee's mailing address; - provides the information by email after obtaining the enrollee's agreement to receive the information by email; - posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or - provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
17. Notice of Changes 42 CFR 438.10(g)(4), MSC 3-19-2	The MCO must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 days before the intended effective date of the change.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

18. Provider Directory Content
 	
42 CFR 438.10(h)(1)-(2), MSC 3-11-C, MSC 3-19-2
	The MCO must make available in paper form upon request, and electronic form, the following information about each PCP, specialist (including behavioral health providers), hospital, and pharmacy in its network:
	a. the provider's name as well as any group affiliation;
	b. street address(es);
	c. telephone number(s);
	d. website URL, if any;
	e. specialty, as appropriate;
	f. office hours;
	g. age limitations, if any;
	h. whether the provider is accepting new patients;
	i. the provider's cultural and linguistic capabilities, including Non-English languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office;
	j. whether the provider has completed cultural competency training; and
		☐ a. Provider's name and group affiliation
		☐ b. Street address(es)
		☐ c. Telephone number(s)
		☐ d. Website URL, if any
		☐ e. Specialty, as appropriate
		☐ f. Office hours
		☐ g. Age limitations, if any
		☐ h. Accepting new patients or not
		☐ i. Cultural and linguistic capabilities
		☐ j. Whether provider has completed cultural competency training
		☐ k. Accommodations for people with physical disabilities
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
				1	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
	k. whether the provider's office/institutional has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.				
Findings **Strength** **AON** **Suggestion**					
19. Provider Directory Updates 42 CFR 438.10(h)(3), MSC 3-19-2	Information included in a paper provider directory or a printable electronic provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the MCO receives updated provider information.	☐ Paper directory updated monthly ☐ Electronic directory updated no later than 30 calendar days after receipt of updated provider information	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
20. Provider Directory Availability 42 CFR 438.10(h)(4), MSC 3-19-2	As specified by the Secretary of Health and Human Services, provider directories must be made available on the MCO's website in a machine-readable file and format as well as in paper form.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
AON					
Suggestion					
21. Pharmacy Information 42 CFR 438.10(i)(1)-(2), MSC 3-19-2	The MCO must make available in electronic or print format the following information: a. which medications are covered, both generic and name brand; and b. what tier each medication is on.	☐ a. Covered medications ☐ b. Medication tier	**0.500** **0.500**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
22. Pharmacy Drug Lists 42 CFR 438.10(i)(3), MSC 3-19-2	As specified by the Secretary of Health and Human Services and in accordance with state and federal regulations, the MCO must make its drug lists available on its website in a machine-readable file and format.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
Enrollee Information			**XX.X%**	**22**	**X.XXX**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
1. Enrollee Rights 42 CFR 438.100(b)(1)-(3), MSC 3-18	An enrollee of the MCO has the right to: a. receive information in accordance with 42 CFR 438.10; b. be treated with respect and with due consideration for their dignity and privacy; c. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; d. participate in decisions regarding their healthcare, including the right to refuse treatment; e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion; f. request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies; and g. be furnished healthcare services in accordance with 42 CFR 438.206 through 438.210.	☐ a. Information in accordance with 42 CFR 438.10 ☐ b. Treated with respect and consideration for dignity and privacy ☐ c. Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand ☐ d. Participation in healthcare-related decisions, including refusal of treatment ☐ e. Free from any form of restraint or seclusion ☐ f. Copy of medical records and right to request amendments or corrections ☐ g. Healthcare services in accordance with 42 CFR 438.206 through 438.210	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
2. Freedom to Exercise Rights 42 CFR 438.100(c)	An enrollee of the MCO has the freedom to exercise their rights without being adversely treated by the MCO.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
3. Compliance with Federal and State Laws 42 CFR 438.100(d), MSC 4-12	The MCO must comply with any other applicable federal and state laws, including Title VI of the *Civil Rights Act of 1964* as implemented by regulations at 45 CFR part 80; the *Age Discrimination Act of 1975* as implemented by regulations at 45 CFR part 91; the *Rehabilitation Act of 1973*; Title IX of the Education Amendments of 1972 (regarding education programs and activities); titles II and III of the *Americans with Disabilities Act*; section 1557 of the *Patient Protection and Affordable Care Act*; Section 654 of the *Omnibus Budget Reconciliation Act of 1981*; Title XXI of the federal *Social Security Act*; and all applicable state and federal laws and regulations governing FHKC.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
4. Staff Education and Training MSC 3-1	The MCO must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to enrollee rights and advance directive policies and procedures.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
5. Provider–Enrollee Communication 42 CFR 438.102(a)(1)(i)-(iv), MSC 3-4	The MCO must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient, for: a. the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b. any information the enrollee needs to decide among all relevant treatment options; c. the risks, benefits, and consequences of treatment or non-treatment; and d. the enrollee's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.	☐ a. Enrollee's health status, medical care, or treatment options ☐ b. Information needed to decide on treatment option ☐ c. Risks, benefits, and consequences of treatment and non-treatment ☐ d. Participation in healthcare-related decisions, including refusal of treatment	**0.250** **0.250** **0.250** **0.250**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
6. MCO Non-Refusal to Cover Benefits or Services MSC 3-5	The MCO must not object or otherwise refuse to provide a benefit or service covered under its contract with FHKC on moral or religious grounds.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Marketing Material Requirements 42 CFR 438.104(b)(1)(i)-(v), MSC 3-19-1, MSC 3-19-2-E	The MCO must: a. distribute the materials to its entire service area as indicated in its contract with FHKC; b. comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the beneficiary receives, from FHKC, the accurate oral and written information the enrollee needs to make an informed decision on whether to enroll; c. avoid seeking to influence enrollment in conjunction with the sale or offering of any private insurance; d. avoid engaging directly or indirectly in door-to-door, telephone, email, texting, or other cold-call marketing activities; e. avoid using absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the marketing activities review process; f. avoid using superlatives in its logos or product tag lines; and	☐ a. Materials to entire service area ☐ b. Ensure potential enrollee receives oral and written information to make decision about enrolling ☐ c. No offering of private insurance ☐ d. No engaging in marketing activities ☐ e. No use of absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC ☐ f. No use of superlatives in MCO's logos or product tag lines ☐ g. No comparison of MCO to other MCOs	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
	g. avoid comparing itself to another MCO unless: 1. such comparison is contained in an independent study, a copy of which has been provided for prior review to FHKC, and 2. the MCO has received written concurrence from all other MCOs being compared. The MCO must provide this documentation to FHKC for prior review.				
Findings **Strength** **AON** **Suggestion**					
8. Marketing Material Assurances 42 CFR 438.104(b)(2)(i)-(ii), MSC 3-19-2	The MCO must ensure FHKC that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud enrollees or FHKC. Inaccurate, false, or misleading information includes, but is not limited to, suggesting that enrollees must enroll in the MCO to obtain or retain benefits or that the MCO is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, FHKC, or a similar entity.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
9. Liability for Payment 42 CFR 438.106(a)-(c), MSC 3-10	The MCO must provide that its Florida Healthy Kids enrollees are not held liable for any of the following: a. the MCO's debts, in the event of the MCO's insolvency; b. covered services provided to the enrollee, for which: 1. FHKC does not pay the MCO, or 2. FHKC or the MCO does not pay the individual or healthcare provider that furnished the services under a contractual, referral, or other arrangement; and c. payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO covered the services directly.	☐ a. MCO's debts ☐ b. Covered services provided to enrollee ☐ c. Payments for covered services	**0.333** **0.333** **0.333**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
10. Protections from Collection MSC 3-10	The MCO and any representative of the MCO must not collect or attempt to collect from an enrollee any money for services covered by the Florida Healthy Kids program or any monies owed by FHKC to the MCO: a. If the enrollee receives a covered service from a provider under the MCO's contract with FHKC in accordance with the Covered Benefits under Attachment D, but the provider is not paid by the MCO, the enrollee must not be held liable for monies owed to the provider by the MCO. b. If the provider is paid less than billed charges, neither the provider nor the MCO may hold the enrollee liable for the rest of the fee except for any co-payment as specified in Attachment D of the MCO's contract with FHKC. c. The MCO must include such a prohibition in all provider contracts serving FHKC enrollees.	☐ a. If enrollee receives covered service from provider but provider is not paid by MCO, enrollee not held liable for monies owed to provider by MCO ☐ b. If provider is paid less than billed charges, neither provider nor MCO may hold enrollee liable for remaining fee except any applicable co-payment ☐ c. Prohibition included in all provider contracts serving FHKC enrollees	**0.333** **0.333** **0.333**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
11. Emergency and Post-Stabilization Services 42 CFR 438.114(c)(1)(i)	The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
12. Emergency and Post-Stabilization Services – Denial of Payment 42 CFR 438.114(c)(1)(ii)(A)-(B)	The MCO may not deny payment for treatment obtained under either of the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; resulted in serious impairment to bodily functions; or caused serious dysfunction of any bodily organ or part. b. A representative of the MCO instructs the enrollee to seek emergency services.	☐ a. Emergency medical condition ☐ b. Enrollee instructed to seek emergency services	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
13. Emergency Service Limitations 42 CFR 438.114(d)(1)(i)-(ii)	The MCO must not: a. limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; or b. refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, the MCO, or FHKC of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.	☐ a. No limitation of what constitutes emergency medical condition on basis of lists of diagnoses or symptoms ☐ b. No refusal to cover emergency services based on emergency room provider's lack of notification	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
14. Emergency Medical Condition Screening and Treatment 42 CFR 438.114(d)(2)	The MCO must not hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
15. Responsibility for Emergency Coverage and Payment 42 CFR 438.114(d)(3)	The MCO must be bound as responsible for coverage and payment of the determination of when the enrollee is sufficiently stabilized for transfer or discharge, whether the determination is made by the attending emergency physician or the provider actually treating the enrollee.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
16. Post-Stabilization Care Services Coverage and Payment 42 CFR 438.114(e)	The MCO must provide coverage and payment for post-stabilization care services in accordance with provisions set forth in 42 CFR 422.113(c).	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
17. Enrollee Confidentiality 42 CFR 438.224, MSC 4-7-1	The MCO must: a. use and disclose medical records and any other health and enrollment information that identifies a particular enrollee in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable; b. treat all information obtained through its performance under its contract with FHKC as confidential to the extent such information is protected under Florida and federal law; c. not use any information except as necessary for the proper discharge of its obligations under its contract with FHKC; d. not use or disclose any protected health information (PHI), personally identifiable information (PII), or other identified information obtained through its performance under its contract with FHKC, except as allowed under the contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119; and e. not disclose such information without the written consent of FHKC, the applicant, or the enrollee, except as otherwise required under Florida or federal law.	☐ a. Use and disclose medical records and any other health and enrollment information that identifies particular enrollee in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E ☐ b. Treat all information obtained through performance under contract with FHKC as confidential to extent such information is protected under Florida and federal law ☐ c. No use of any information except as necessary for proper discharge of obligations under contract with FHKC ☐ d. No use or disclosure of any PHI, PII, or other identified information obtained through performance under contract with FHKC, except as allowed under contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119 ☐ e. No disclosure of such information without written consent of FHKC, applicant, or enrollee, except as otherwise required under Florida or federal law	**0.200** **0.200** **0.200** **0.200** **0.200**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	Criteria	Criteria Met	Criteria Value	Element	
				Value	Score
Enrollee Rights and Protections					
Findings					
Strength					
AON					
Suggestion					
Enrollee Rights and Protections			**XX.X%**	**17**	**X.XXX**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
1. Delivery Network – Provider Credentialing 42 CFR 438.206(b)(6), MSC 3-2-2-A, Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)	The MCO must demonstrate that its network providers are credentialed as required by 42 CFR 438.214. The MCO's PCP network must include only: a. board-certified pediatricians; b. board-certified family practice physicians; c. physician extenders working under the direct supervision of a board-certified practitioner; d. providers who have recently completed a National Board for Certification of Training Administrators of Graduate Medical Education Programs approved residency program in pediatrics or family practice and are eligible for board certification but have not yet achieved board certification. Such providers must become board certified within three years of joining the network to remain eligible to act as a PCP for the Florida Healthy Kids population; and/or e. providers who have been granted a waiver to the board-certification requirement in accordance with FHKC's policies and procedures.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
2. Institutional Standards MSC 3-2-2-B, UCRP	Facilities used for enrollees must meet applicable accreditation and licensure requirements and meet institutional regulations specified by the Agency for Health Care Administration (AHCA).	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
Strength					
AON					
Suggestion					
3. Mental Healthcare and Substance Abuse Providers MSC 3-2-2, UCRP	The MCO must ensure that all direct behavioral health services provided to children and adolescents under the MCO's contract with FHKC are delivered by individuals or entities who meet the minimal licensure and credentialing standards set forth in statutes and rules of the Department of Children and Families, the Department of Health, and the Division of Health Quality Assurance of AHCA, pertinent to the treatment and prevention of mental health and substance abuse disorders in children and adolescents.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
4. License 42 CFR 438.214(b)(2), MSC 3-2-2, UCRP	The MCO must maintain written policies and procedures (P&Ps) for credentialing and recredentialing of network providers. At a minimum, the MCO's credentialing and recredentialing P&Ps must verify provider licenses, including licenses issued in states other than Florida. Verification must confirm that: a. the license is not expired; and b. there are no current limitations on the provider's license.	☐ a. Confirmation that provider license is not expired ☐ b. Confirmation that there are no current limitations on provider's license	**0.500** **0.500**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
Findings					
Strength					
AON					
Suggestion					
5. At-Risk Providers – 1 UCRP	The MCO's credentialing and recredentialing P&Ps must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste, and abuse: a. Criminal background checks, including fingerprints, must be conducted for providers, and any person with at least five percent direct or indirect ownership interest in the provider, when such person meets the criteria for a "high" risk. b. Risk levels must be adjusted from "limited" or "moderate" to "high" when any of the following occurs: 1. a provider has a payment suspension imposed based on a credible allegation of fraud, waste, or abuse; 2. the provider has an existing Medicaid or Children's Health Insurance Program (CHIP) overpayment; 3. the provider has been excluded by the Department of Health and Human Services (HHS) or a state Medicaid or CHIP program within the previous 10 years; or 4. a temporary moratorium has been lifted in the previous six months for a particular provider type or provider.	☐ a. Criminal background checks, including fingerprints, conducted for providers and any person with at least five percent direct or indirect ownership interest in provider, when such person meets criteria for "high" risk ☐ b. Risk levels adjusted from "limited" or "moderate" to "high" when warranted	**0.500** **0.500**	**1**	**0.000**
Findings					
Strength					
AON					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
Suggestion					
6. At-Risk Providers – 2 UCRP	The MCO's credentialing and recredentialing P&Ps must include pre- and post-enrollment site visits to verify the accuracy of information submitted by providers who are designated as moderate or high categorical risks to the Florida Healthy Kids program and to determine compliance with state and federal enrollment requirements: a. The MCO must require providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations. b. Providers must be denied enrollment in the network or terminated from the network if the provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing.	☐ a. MCO requires providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations ☐ b. Providers denied enrollment in network or terminated from network if provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of provider is not in program's best interests and documents such determinations in writing	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
7. Exclusions UCRP	The MCO's credentialing and recredentialing P&Ps must confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the following federal databases upon enrollment and recredentialing: - Social Security Agency's death master file - National Plan and Provider Enumeration System (NPPES)	☐ Confirm identity of provider or any person with ownership or control interest or who is agent or managing employee of provider ☐ Determine exclusion status of provider or any person with ownership or control interest or who is agent or managing employee of provider	**0.500** **0.500**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	- List of Excluded Individuals/Entities (LEIE) - Excluded Parties List System (EPLS)				
Findings **Strength** **AON** **Suggestion**					
8. Exclusions – Ongoing Monitoring UCRP	The MCO's credentialing and recredentialing P&Ps must confirm the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the LEIE and EPLS databases on a monthly basis.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
9. Provider Contract Compliance UCRP	The MCO's credentialing and recredentialing P&Ps must monitor providers for compliance with the provider contract, including: a. appointment timeliness standards; b. maintenance of accurate directory information, including: 1. office hours, 2. street address, 3. phone number, and 4. acceptance of new patients; and c. taking appropriate corrective action with providers.	☐ a. Monitor provider compliance with appointment timeliness standards ☐ b. Monitor provider maintenance of accurate directory information ☐ c. Take appropriate corrective action with providers	**0.333** **0.333** **0.333**	**1**	**0.000**
Findings **Strength**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
AON					
Suggestion					
10. Quality Monitoring UCRP	The MCO's credentialing and recredentialing P&Ps must develop a process to identify quality deficiencies, including: a. monitoring and evaluating claims and encounter data for patterns of care by individual providers; b. conducting ongoing reviews of providers; and c. taking appropriate corrective action with providers.	☐ a. Monitoring and evaluating claims and encounter data for patterns of care by individual providers ☐ b. Conducting ongoing reviews of providers ☐ c. Taking appropriate corrective action with providers	**0.333** **0.333** **0.333**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
11. Appropriate Actions UCRP	The MCO's credentialing and recredentialing P&Ps must impose appropriate sanctions, suspension, restriction, and termination of providers, including terminating or denying enrollment because of inability to verify the identity of the provider applicant or upon determination that the provider has falsified any information provided on the application.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
12. Board Certification Exemption UCRP	The MCO's credentialing and recredentialing P&Ps must ensure PCPs without board certification are removed from the network or receive an exemption timely.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
13. Recredentialing UCRP	The MCO's credentialing and recredentialing P&Ps must: a. recredential providers at least every three years; b. repeat criminal background checks at least every five years; and c. recredential providers, including screening activities, prior to allowing providers who were removed from the network to re-enroll in the network.	☐ a. Recredential providers at least every three years ☐ b. Repeat criminal background checks at least every five years ☐ c. Recredential providers, including screening activities, prior to allowing providers who were removed from network to re-enroll in network	**0.333** **0.333** **0.333**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
14. Verifications UCRP	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must: a. have a current state license (medical, occupational, or institutional) or authority to do business in the state in which they practice; b. have no revocation, moratorium, or suspension of their license imposed in Florida or any other state; c. have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under the sanction have been met; d. provide evidence of professional liability claims history; e. not be on the state or federal exclusions lists; f. not have had Medicaid prescribing rights suspended by AHCA; and g. not had enrollment terminated under Title XVIII of the Act or under the Medicaid program or CHIP of any other state. This provision applies only to providers terminated on or after January 1, 2011, from such programs.	☐ a. Have current state license or authority to do business in state in which they practice ☐ b. Have no revocation, moratorium, or suspension of license imposed in Florida or any other state ☐ c. Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under sanction have been met ☐ d. Provide evidence of professional liability claims history ☐ e. Not on state or federal exclusions lists ☐ f. Not have had Medicaid prescribing rights suspended by AHCA ☐ g. Not had enrollment terminated under Title XVIII of the Act or under Medicaid program or CHIP of any other state	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
15. Disclosures UCRP	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must provide disclosures related to ownership and management, business transactions, and conviction of crimes to the MCO. a. Ownership and management disclosures include the information required by 42 CFR 455.104(b): 1. Providers must provide this information upon submission of an application, execution of a provider agreement, upon FHKC's request, during recredentialing, and within 35 days after any change in ownership. 2. MCOs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, does not submit timely and accurate information, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 3. MCOs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, fails to cooperate with any required screening methods, including failing to submit sets of fingerprints in the form and manner required within 30 days of request, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 4. MCOs must deny providers enrollment in the network or terminate them from the network when any person	☐ a. Ownership and management disclosures include information required by 42 CFR 455.104(b) ☐ b. Business transaction disclosures include information about ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during 12-month period and any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor during previous five-year period ☐ c. Disclosures related to conviction of crimes include identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in provider, or is agent or managing employee of provider, and has been convicted of criminal offense related to person's involvement in any program under Medicare, Medicaid, or Title XX services program since inception of those programs	**0.333** **0.333** **0.333**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. b. Business transaction disclosures include information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the previous five-year period: 1. The provider must provide such disclosures within 35 days of the date of request by CMS, AHCA, or FHKC. 2. MCOs must include a provision to provide this information within the required timeframe in the provider agreement. c. Disclosures related to the conviction of crimes include the identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. Providers must provide this information upon entering into a new provider agreement, renewing an existing provider agreement, or upon request by FHKC.				
Findings					
Strength					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
AON					
Suggestion					
16. Criminal Background Checks UCRP	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must consent to criminal background checks, including fingerprinting. Providers and any person with a five percent or more direct or indirect ownership interest in the provider are required to submit a set of fingerprints in the requested form and manner within 30 days upon request.	☐ Consent to criminal background checks, including fingerprinting ☐ Providers and any person with five percent or more direct or indirect ownership interest in provider required to submit set of fingerprints in requested form and manner within 30 days upon request	**0.500** **0.500**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					
17. Verifications and Attestations UCRP	To be eligible to participate in the MCO's Florida Healthy Kids network, providers must meet the following requirements when the provider is a physician: a. good standing of privileges at the hospital designated at the primary admitting institutional by the physician or if the physician does not have admitting privileges, good standing of privileges at the hospital by another provider with whom the physician has entered into an arrangement for hospital coverage; b. valid Drug Enforcement Administration (DEA) certificates, when applicable; c. attestation that the total active patient load for all populations, including Medicaid Fee-for-Service (FFS), Children's Medical Services Network, Medicaid Managed Care Plans, Medicare, Florida KidCare, and	☐ a. Good standing of privileges at hospital designated at primary admitting institutional by physician or if physician does not have admitting privileges, good standing of privileges at hospital by another provider with whom physician has entered into arrangement for hospital coverage ☐ b. Valid DEA certificates, when applicable ☐ c. Attestation that total active patient load for all populations is no more than 3,000 patients per provider	**0.200** **0.200** **0.200**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	commercial patients, is no more than 3,000 patients per provider. An active patient is a patient who is seen by the provider at least three times per year; d. facilities that meet the MCO's standards, including that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; evidence that the provider's office meets criteria for access for persons with disabilities; and acceptable medical recordkeeping practices; and e. provide a statement regarding any physical or behavioral health problems that may affect the provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become a Medicaid or CHIP provider.	☐ d. Facilities that meet MCO's standards, evidence that provider's office meets criteria for access for persons with disabilities, and acceptable medical recordkeeping practices ☐ e. Statement regarding any physical or behavioral health problems that may affect provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become Medicaid or CHIP provider	**0.200** **0.200**		
Findings **Strength** **AON** **Suggestion**					
18. Education and Training UCRP	The MCO must have a system for the verification and examination of each provider's credentials. This system must maintain documentation (including copies of provider licenses) of all provider requirements listed in the UCRP, as well as each provider's: - education; - experience; - prior training; - ongoing service training; and - National Provider Identifier (NPI) and taxonomy.	☐ System for verification and examination of each provider's credentials ☐ Documentation of all provider requirements listed in UCRP ☐ Documentation of each provider's education, experience, prior training, ongoing service training, and NPI and taxonomy	**0.333** **0.333** **0.333**	**1**	**0.000**

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
Findings					
Strength					
AON					
Suggestion					
19. Immunization Registry Enrollment MSC 3-2-2-A	In order to participate as a PCP in the Florida Healthy Kids program, PCPs in the MCO's network must provide all covered immunizations to enrollees and be enrolled with the Florida State Health Online Tracking System (SHOTS), Florida's statewide online immunization registry. The MCO must ensure that all primary care network providers are registered with the SHOTS program. The MCO must assure that its primary care network providers continue to keep the enrollee's immunization record updated in the SHOTS database. Immunizations must be administered at each provider's office.	☐ All primary care network providers registered with SHOTS program ☐ Immunizations administered at each provider's office	**0.500** **0.500**	**1**	**0.000**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <MCO>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
20. Provider Nondiscrimination 42 CFR 438.214(c), MSC 3-2	The MCO's network provider selection policies and procedures, consistent with 42 CFR 438.12, must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification, including providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCO must provide affected providers with written notice of the reason for its decision to decline to include individual providers or groups of providers in its provider network.	☐ No discrimination against providers acting within scope of license or certification solely on basis of that license or certification, including providers serving high-risk populations or specializing in conditions that require costly treatment ☐ Written notice of MCO's decision to decline to include providers or groups of providers in MCO's network	**0.500** **0.500**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
21. Excluded Providers 42 CFR 438.214(d)	The MCO must not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the *Social Security Act*.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**0.000**
Findings **Strength** **AON** **Suggestion**					
Credentialing			**XX.X%**	**21**	**X.XXX**

DBM CA Standards Tool

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
1. Information Format *42 Code of Federal Regulations* (CFR) 438.10(c)(1), Dental Services Contract (DSC) 3-19-2	The dental benefit manager (DBM) must provide all required information to enrollees and potential enrollees in a language that is clear and non-technical and in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees in accordance with 42 CFR 438.10.	☐ Easily understood ☐ Readily accessible	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Culturally Competent Communication DSC 3-19-2-A	The DBM must provide services, including oral and written communication to enrollees, in a culturally competent manner appropriate for the population.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
3. Electronic Information 42 CFR 438.10(c)(6)(i)-(v)	The DBM must ensure all of the following conditions are met for information provided electronically to enrollees: a. the format is readily accessible; b. the information is placed in a location on the DBM's website that is prominent and readily accessible; c. the information is provided in an electronic form that can be electronically retained and printed; d. the information is consistent with content and language requirements for enrollee information; and e. the DBM informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within five business days.	☐ a. Accessible format ☐ b. Prominently placed and readily accessible on DBM website ☐ c. Can be electronically retained and printed ☐ d. Meets content and language requirements ☐ e. Enrollee informed that information is available in paper form without charge upon request, to be received within five business days	**0.200** **0.200** **0.200** **0.200** **0.200**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. Enrollee Assistance 42 CFR 438.10(c)(7), DSC 3-5, DSC 3-11	The DBM must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan. The DBM also must comply with the guidance issued by the Office for Civil Rights (OCR) of the United States Department of Health and Human Services regarding the availability of information and assistance for persons with limited English proficiency.	☐ Mechanisms in place to help enrollees and potential enrollees ☐ Compliance with OCR guidance	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
5. Language and Format 42 CFR 438.10(d)(2)-(4), DSC 3-19-2	The DBM must: a. ensure enrollee information is in an easily understood language and format, including a font size no smaller than 12 point; b. make interpretation services available free of charge to each enrollee, including oral interpretation and the use of auxiliary aids such as teletypewriter / Telecommunications Device for the Deaf (TTY/TDY) and American Sign Language (oral interpretation requirements apply to all non-English languages, not just those that Florida Healthy Kids Corporation [FHKC] identifies as prevalent); c. ensure that all written materials for enrollees include taglines in the prevalent non-English languages in the service area, as well as large print of no less than 18-point font size, explaining the availability of written translations and oral interpretation to understand information provided and the toll-free and TTY/TDY telephone number of the entity providing choice counseling services as required by 42 CFR 438.71(a); d. make all its written materials available in English, Spanish, and all appropriate foreign languages; e. make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area; f. make its written materials available in alternative formats upon request of the potential enrollee or enrollee—taking into consideration enrollees' special needs, including those who are visually impaired or have limited reading proficiency—at no cost; and	☐ a. Easily understood language and format, with no smaller than 12-point font size ☐ b. Interpretation services available free of charge ☐ c. Written materials include taglines in prevalent non-English languages in print no less than 18-point font size and explain availability of translation services ☐ d. All written materials available in English, Spanish, and all other appropriate foreign languages ☐ e. Written materials available in prevalent non-English languages in service area ☐ f. Written materials available in alternative formats upon request at no cost ☐ g. Notification to enrollees of availability of information in alternative formats and how to access those formats	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
	g. notify all enrollees that information is available at no cost upon request in alternative formats, including auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the service area, and how to access those formats.				
Findings **Strength** **AON** **Suggestion**					
6. Minimum Requirements for Enrollee Notification DSC 3-19-2-C	At a minimum, the DBM must ensure that all enrollees are made aware of: a. the rights and responsibilities of both the enrollee and the DBM; b. the role of the primary care dentist; c. what to do in an emergency or urgent medical situation; d. how to request a grievance or appeal, or request an independent review; e. how to report fraud and abuse; f. procedures for referrals and prior authorizations; g. any additional telephone numbers or contact information for reaching the DBM; h. eligibility compliance requirements under the program, specifically for payment of premiums and renewal; and i. how to access other program services not covered by the DBM, such as other healthcare services, to at least include information about contacting the Florida KidCare enrollee call center.	☐ a. Rights and responsibilities of both enrollee and DBM ☐ b. Role of primary care dentist ☐ c. What to do in emergency or urgent medical situation ☐ d. How to request grievance or appeal, or request independent review ☐ e. How to report fraud and abuse ☐ f. Procedures for referrals and prior authorizations ☐ g. Any additional telephone numbers or contact information for reaching DBM ☐ h. Eligibility compliance requirements under program, specifically for payment of premiums and renewal	**0.111** **0.111** **0.111** **0.111** **0.111** **0.111** **0.111** **0.111**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
		☐ i. How to access other program services not covered by DBM	**0.111**		
Findings **Strength** **AON** **Suggestion**					
7. Provider Termination Notice 42 CFR 438.10(f)(1), DSC 3-19-2	The DBM must make a good faith effort to provide written notice to enrollees who received primary or regular care from a terminating network provider within 15 calendar days of receipt or issuance of the provider termination notice.	☐ Written notice to enrollee ☐ Notice provided within 15 calendar days	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
8. Certificates of Creditable Coverage DSC 3-19-2	The DBM is responsible for issuing certificates of creditable coverage to enrollees, upon enrollee request.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
9. Provider Incentive Plan 42 CFR 438.10(f)(3), DSC 3-4	The DBM must make available, upon request, any provider incentive plans in place as set forth in 42 CFR 438.3(i).	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Enrollment with a Primary Dental Care Provider DSC 3-2-1	The DBM must provide each enrollee the following minimum information within five business days of notification of enrollment: a. notification of enrollee's primary dental care assignment, including contact information for the provider if the DBM has chosen to auto assign. If the DBM does not auto assign, the DBM must provide all relevant information to the enrollee such that the enrollee may choose a primary dental care provider; b. the enrollee's ability to select another provider from the DBM's network; c. a provider directory; and d. the procedures for changing providers.	☐ a. Notification of enrollee's primary dental care assignment, including contact information if auto assigned; relevant information so enrollee may choose provider if not auto assigned ☐ b. Enrollee's ability to select another provider from DBM's network ☐ c. Provider directory ☐ d. Procedures for changing providers	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
11. Enrollee Handbook 42 CFR 438.10(g)(1), DSC 3-11-B, DSC 3-19-2	Within five business days of receipt of an enrollment file, the DBM must provide each enrollee a model enrollee handbook provided by FHKC that complies with any federal or state requirements, uses FHKC-developed definitions for managed care terminology, and serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	☐ Model enrollee handbook provided by FHKC provided to enrollees within five business days of receipt of enrollment file ☐ Complies with any federal and state requirements ☐ Uses FHKC-developed managed care terminology definitions ☐ Serves similar function as summary of benefits and coverage described in 45 CFR 147.200(a)	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Enrollee Handbook Content – 1 42 CFR 438.10(g)(2)(i)-(iv)	The DBM's enrollee handbook must include, at a minimum: a. benefits provided by the DBM; b. how and where to access any benefits provided by FHKC, including any cost sharing, and how transportation is provided; c. the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled; and d. procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary dental care provider.	☐ a. Benefits provided by DBM ☐ b. How and where to access benefits and transportation ☐ c. Amount, duration, and scope of available benefits ☐ d. Procedures for obtaining benefits	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
Strength					
AON					
Suggestion					
13. Enrollee Handbook Content – 2 42 CFR 438.10(g)(2)(v)-(viii)	The DBM's enrollee handbook must include, at a minimum: a. the extent to which, and how, after-hours and emergency coverage are provided, including: 1. what constitutes an emergency medical condition and emergency services, 2. the fact that prior authorization is not required for emergency services, and 3. the fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care; b. any restrictions on the enrollee's freedom of choice among network providers; c. the extent to which, and how, enrollees may obtain benefits; and d. cost sharing, if any is imposed under the FHKC plan.	☐ a. Extent to which, and how, after-hours and emergency coverage are provided ☐ b. Restrictions on enrollee's choice among network providers ☐ c. Extent to which, and how, enrollees may obtain benefits ☐ d. Cost sharing, if applicable	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
14. Enrollee Handbook Content – 3 42 CFR 438.10(g)(2)(ix)-(xii)	The DBM's enrollee handbook must include, at a minimum: a. enrollee rights and responsibilities, including the elements specified in 42 CFR 438.100; b. the process of selecting and changing the enrollee's primary dental care provider; and c. grievance, appeal, and independent review procedures and timeframes in an FHKC-developed or -approved description, to include: 1. the right to file grievances and appeals, 2. the requirements and timeframes for filing a grievance or appeal, 3. the availability of assistance in the filing process, 4. the right to request use of an IRO or the federal review process after the DBM has made a determination on an enrollee's appeal that is adverse to the enrollee, and 5. the fact that, when requested by the enrollee, benefits that the DBM seeks to reduce or terminate will continue if the enrollee files an appeal or a request to use an IRO or the federal review process within the timeframes specified for filing, and that the enrollee may, consistent with FHKC policy, be required to pay the cost of services furnished while the appeal or IRO/federal review process is pending if the final decision is adverse to the enrollee.	☐ a. Enrollee rights and responsibilities ☐ b. Process of selecting and changing enrollee's primary dental care provider ☐ c. FHKC-developed or -approved grievance, appeal, and independent review procedures and timeframes	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
15. Enrollee Handbook Content – 4 42 CFR 438.10(g)(2)(xiii)-(xvi)	The DBM's enrollee handbook must include, at a minimum: a. how to access auxiliary aids and services, including additional information in alternative formats or languages; b. the toll-free telephone number for enrollee services, medical management, and any other unit providing services directly to enrollees; c. information on how to report suspected fraud or abuse; and d. other content required by FHKC in its Plan Model Enrollee Handbook.	☐ a. How to access auxiliary aids and services ☐ b. Toll-free numbers ☐ c. How to report suspected fraud or abuse ☐ d. Other FHKC-required content in Plan Model Enrollee Handbook	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Information Delivery Methods 42 CFR 438.10(g)(3)(i)-(iv)	The information required to be provided to the enrollee in an enrollee handbook will be considered to be provided if the DBM: - mails a printed copy of the information to the enrollee's mailing address; - provides the information by email after obtaining the enrollee's agreement to receive the information by email; - posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or	☐ Yes ☐ No	**1.000** **0.000**	**X.XXX**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
	- provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.				
Findings **Strength** **AON** **Suggestion**					
17. Notice of Changes 42 CFR 438.10(g)(4), DSC 3-19-2	The DBM must give each enrollee notice of any change that FHKC defines as significant in the information in the enrollee handbook, at least 30 days before the intended effective date of the change.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

18. Provider Directory Content
 	
42 CFR 438.10(h)(1)-(2), DSC 3-11-C, DSC 3-19-2
	The DBM must make available in paper form upon request, and electronic form, the following information for each primary dental care provider and specialist in its network:
	a. the provider's name as well as any group affiliation;
	b. street address(es);
	c. telephone number(s);
	d. website URL, if any;
	e. specialty, as appropriate;
	f. office hours;
	g. age limitations, if any;
	h. whether the provider is accepting new patients;
		☐ a. Provider's name and group affiliation
		☐ b. Street address(es)
		☐ c. Telephone number(s)
		☐ d. Website URL, if any
		☐ e. Specialty, as appropriate
		☐ f. Office hours
		☐ g. Age limitations, if any
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
			0.090
				1	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
	i. the provider's cultural and linguistic capabilities, including Non-English languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office; j. whether the provider has completed cultural competency training; and k. whether the provider's office/institutional has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.	☐ h. Accepting new patients or not ☐ i. Cultural and linguistic capabilities ☐ j. Whether provider has completed cultural competency training ☐ k. Accommodations for people with physical disabilities	**0.090** **0.090** **0.090** **0.090**		
Findings **Strength** **AON** **Suggestion**					
19. Provider Directory Updates 42 CFR 438.10(h)(3), DSC 3-19-2	Information included in a paper provider directory or a printable electronic provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the DBM receives updated provider information.	☐ Paper directory updated monthly ☐ Electronic directory updated no later than 30 calendar days after receipt of updated provider information	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Information					
20. Provider Directory Availability 42 CFR 438.10(h)(4), DSC 3-19-2	As specified by the Secretary of Health and Human Services, provider directories must be made available on the DBM's website in a machine-readable file and format as well as in paper form.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
		Enrollee Information	**XX.X%**	**20**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
1. Enrollee Rights 42 CFR 438.100(b)(1)-(3), DSC 3-18	An enrollee of the DBM has the right to: a. receive information in accordance with 42 CFR 438.10; b. be treated with respect and with due consideration for their dignity and privacy; c. receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; d. participate in decisions regarding their healthcare, including the right to refuse treatment; e. be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion; f. request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies; and g. be furnished healthcare services in accordance with 42 CFR 438.206 through 438.210.	☐ a. Information in accordance with 42 CFR 438.10 ☐ b. Treated with respect and consideration for dignity and privacy ☐ c. Information on available treatment options and alternatives in manner appropriate to enrollee's condition and ability to understand ☐ d. Participation in healthcare-related decisions, including refusal of treatment ☐ e. Free from any form of restraint or seclusion ☐ f. Copy of medical records and right to request amendments or corrections ☐ g. Healthcare services in accordance with 42 CFR 438.206 through 438.210	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
2. Freedom to Exercise Rights 42 CFR 438.100(c)	An enrollee of the DBM has the freedom to exercise their rights without being adversely treated by the DBM.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
3. Compliance with Federal and State Laws 42 CFR 438.100(d), DSC 4-12	The DBM must comply with any other applicable federal and state laws, including Title VI of the *Civil Rights Act of 1964* as implemented by regulations at 45 CFR part 80; the *Age Discrimination Act of 1975* as implemented by regulations at 45 CFR part 91; the *Rehabilitation Act of 1973*; Title IX of the Education Amendments of 1972 (regarding education programs and activities); titles II and III of the *Americans with Disabilities Act*; section 1557 of the *Patient Protection and Affordable Care Act*; Section 654 of the *Omnibus Budget Reconciliation Act of 1981*; Title XXI of the federal *Social Security Act*; and all applicable state and federal laws and regulations governing FHKC.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
4. Staff Education and Training DSC 3-1	The DBM must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to enrollee rights.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
5. Provider–Enrollee Communication 42 CFR 438.102(a)(1)(i)-(iv), DSC 3-4	The DBM must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient, for: a. the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b. any information the enrollee needs to decide among all relevant treatment options; c. the risks, benefits, and consequences of treatment or non-treatment; and d. the enrollee's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.	☐ a. Enrollee's health status, medical care, or treatment options ☐ b. Information needed to decide on treatment option ☐ c. Risks, benefits, and consequences of treatment and non-treatment ☐ d. Participation in healthcare-related decisions, including refusal of treatment	**0.250** **0.250** **0.250** **0.250**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
6. DBM Non-Refusal to Cover Benefits or Services DSC 3-5	The DBM must not object or otherwise refuse to provide a benefit or service covered under its contract with FHKC on moral or religious grounds.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
7. Marketing Material Requirements 42 CFR 438.104(b)(1)(i)-(v), DSC 3-19-1, DSC 3-19-2-E	The DBM must: a. distribute the materials to its entire service area as indicated in its contract with FHKC; b. comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the beneficiary receives, from FHKC, the accurate oral and written information the enrollee needs to make an informed decision on whether to enroll; c. avoid seeking to influence enrollment in conjunction with the sale or offering of any private insurance; d. avoid engaging directly or indirectly in door-to-door, telephone, email, texting, or other cold-call marketing activities; e. avoid using absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the marketing activities review process;	☐ a. Materials to entire service area ☐ b. Ensure potential enrollee receives oral and written information to make decision about enrolling ☐ c. No offering of private insurance ☐ d. No engaging in marketing activities ☐ e. No use of absolute superlatives in marketing materials unless such use is substantiated with supporting data provided to FHKC ☐ f. No use of superlatives in DBM's logos or product tag lines ☐ g. No comparison of DBM to other DBMs	**0.142** **0.142** **0.142** **0.142** **0.142** **0.142** **0.142**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
	f. avoid using superlatives in its logos or product tag lines; and g. avoid comparing itself to another DBM unless: 1. such comparison is contained in an independent study, a copy of which has been provided for prior review to FHKC, and 2. the DBM has received written concurrence from all other DBMs being compared. The DBM must provide this documentation to FHKC for prior review.				
Findings **Strength** **AON** **Suggestion**					
8. Marketing Material Assurances 42 CFR 438.104(b)(2)(i)-(ii), DSC 3-19-2	The DBM must ensure FHKC that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud enrollees or FHKC. Inaccurate, false, or misleading information includes, but is not limited to, suggesting that enrollees must enroll in the DBM to obtain or retain benefits or that the DBM is endorsed by the Centers for Medicare & Medicaid Services (CMS), the federal or state government, FHKC, or a similar entity.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
9. Liability for Payment 42 CFR 438.106(a)-(c), DSC 3-10	The DBM must provide that its Florida Healthy Kids enrollees are not held liable for any of the following: a. the DBM's debts, in the event of the DBM's insolvency; b. covered services provided to the enrollee, for which: 1. FHKC does not pay the DBM, or 2. FHKC or the DBM does not pay the individual or healthcare provider that furnished the services under a contractual, referral, or other arrangement; and c. payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the DBM covered the services directly.	☐ a. DBM's debts ☐ b. Covered services provided to enrollee ☐ c. Payments for covered services	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
10. Protections from Collection DSC 3-10	The DBM and any representative of the DBM must not collect or attempt to collect from an enrollee any money for services covered by the Florida Healthy Kids program or any monies owed by FHKC to the DBM: a. If the enrollee receives a covered service from a provider under the DBM's contract with FHKC in accordance with the Covered Benefits under Attachment D, but the provider is not paid by the DBM, the enrollee must not be held liable for monies owed to the provider by the DBM.	☐ a. If enrollee receives covered service from provider but provider is not paid by DBM, enrollee not held liable for monies owed to provider by DBM ☐ b. If provider is paid less than billed charges, neither provider nor DBM may hold enrollee liable for remaining fee except any applicable co-payment	**0.333** **0.333**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
	b. If the provider is paid less than billed charges, neither the provider nor the DBM may hold the enrollee liable for the rest of the fee except for any co-payment as specified in Attachment D of the DBM's contract with FHKC. c. The DBM must include such a prohibition in all provider contracts serving FHKC enrollees.	☐ c. Prohibition included in all provider contracts serving FHKC enrollees	**0.333**		
Findings **Strength** **AON** **Suggestion**					
11. Emergency and Post-Stabilization Services 42 CFR 438.114(c)(1)(i)	The DBM must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the DBM.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
12. Enrollee Confidentiality 42 CFR 438.224, DSC 4-7-1	The DBM must: a. use and disclose medical records and any other health and enrollment information that identifies a particular enrollee in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable;	☐ a. Use and disclose medical records and any other health and enrollment information that identifies particular enrollee in accordance with privacy requirements in 45 CFR parts 160 and 164, subparts A and E	**0.200**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Enrollee Rights and Protections					
	b. treat all information obtained through its performance under its contract with FHKC as confidential to the extent such information is protected under Florida and federal law; c. not use any information except as necessary for the proper discharge of its obligations under its contract with FHKC; d. not use or disclose any protected health information (PHI), personally identifiable information (PII), or other identified information obtained through its performance under its contract with FHKC, except as allowed under the contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119; and e. not disclose such information without the written consent of FHKC, the applicant, or the enrollee, except as otherwise required under Florida or federal law.	☐ b. Treat all information obtained through performance under contract with FHKC as confidential to extent such information is protected under Florida and federal law ☐ c. No use of any information except as necessary for proper discharge of obligations under contract with FHKC ☐ d. No use or disclosure of any PHI, PII, or other identified information obtained through performance under contract with FHKC, except as allowed under contract and Florida and federal laws, including HIPAA, Florida Statutes sections 624.91 and 409.821, and Florida Statutes Chapter 119 ☐ e. No disclosure of such information without written consent of FHKC, applicant, or enrollee, except as otherwise required under Florida or federal law	**0.200** **0.200** **0.200** **0.200**		
Findings					
Strength					
AON					
Suggestion					
Enrollee Rights and Protections			**XX.X%**	**12**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
1. Delivery Network – Provider Credentialing 42 CFR 438.206(b)(6), DSC 3-2-2-A	The DBM must demonstrate that its network providers are credentialed as required by 42 CFR 438.214. The DBM's primary dental care provider network must include only those licensed dentists and specialists practicing within the scope of their professional license to serve as providers under the DBM's contract with FHKC.	☐ Credentialed as required by 42 CFR 438.214 ☐ Licensed dentists and specialists practicing within scope of their professional license	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
2. Institutional Standards DSC 3-2-2-B, Florida Healthy Kids Uniform Credentialing and Recredentialing Policy (UCRP)	Facilities used for enrollees must meet applicable accreditation and licensure requirements and meet institutional regulations specified by the Agency for Health Care Administration (AHCA).	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
3. License 42 CFR 438.214(b)(2), DSC 3-2-2, UCRP	The DBM must maintain written policies and procedures (P&Ps) for credentialing and recredentialing of network providers. At a minimum, the DBM's credentialing and recredentialing P&Ps must verify provider licenses, including licenses issued in states other than Florida. Verification must confirm that: a. the license is not expired; and b. there are no current limitations on the provider's license.	☐ a. Confirmation that provider license is not expired ☐ b. Confirmation that there are no current limitations on provider's license	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
4. At-Risk Providers – 1 UCRP	The DBM's credentialing and recredentialing P&Ps must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste, and abuse: a. Criminal background checks, including fingerprints, must be conducted for providers, and any person with at least five percent direct or indirect ownership interest in the provider, when such person meets the criteria for a "high" risk. b. Risk levels must be adjusted from "limited" or "moderate" to "high" when any of the following occurs: 1. a provider has a payment suspension imposed based on a credible allegation of fraud, waste, or abuse; 2. the provider has an existing Medicaid or Children's Health Insurance Program (CHIP) overpayment; 3. the provider has been excluded by the Department of Health and Human Services (HHS) or a state	☐ a. Criminal background checks, including fingerprints, conducted for providers and any person with at least five percent direct or indirect ownership interest in provider, when such person meets criteria for "high" risk ☐ b. Risk levels adjusted from "limited" or "moderate" to "high" when warranted	**0.500** **0.500**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	Medicaid or CHIP program within the previous 10 years; or 4. a temporary moratorium has been lifted in the previous six months for a particular provider type or provider.				
Findings **Strength** **AON** **Suggestion**					
5. At-Risk Providers – 2 UCRP	The DBM's credentialing and recredentialing P&Ps must include pre- and post-enrollment site visits to verify the accuracy of information submitted by providers who are designated as moderate or high categorical risks to the Florida Healthy Kids program and to determine compliance with state and federal enrollment requirements: a. The DBM must require providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations. b. Providers must be denied enrollment in the network or terminated from the network if the provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing.	☐ a. DBM requires providers to allow CMS, FHKC, their agents, and their designated contractors to conduct unannounced onsite inspections of any and all provider locations ☐ b. Providers denied enrollment in network or terminated from network if provider fails to permit access to provider locations for any site visits, unless FHKC determines that denial or termination of provider is not in program's best interests and documents such determinations in writing	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
6. Exclusions UCRP	The DBM's credentialing and recredentialing P&Ps must confirm the identify and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the following federal databases upon enrollment and recredentialing: - Social Security Agency's death master file - National Plan and Provider Enumeration System (NPPES) - List of Excluded Individuals/Entities (LEIE) - Excluded Parties List System (EPLS)	☐ Confirm identity of provider or any person with ownership or control interest or who is agent of managing employee of provider ☐ Determine exclusion status of provider or any person with ownership or control interest or who is agent of managing employee of provider	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
7. Exclusions – Ongoing Monitoring UCRP	The DBM's credentialing and recredentialing P&Ps must confirm the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of the LEIE and EPLS databases on a monthly basis.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
8. Provider Contract Compliance UCRP	The DBM's credentialing and recredentialing P&Ps must monitor providers for compliance with the provider contract, including: a. appointment timeliness standards; b. maintenance of accurate directory information, including: 1. office hours, 2. street address, 3. phone number, and 4. acceptance of new patients; and c. taking appropriate corrective action with providers.	☐ a. Monitor provider compliance with appointment timeliness standards ☐ b. Monitor provider maintenance of accurate directory information ☐ c. Take appropriate corrective action with providers	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
9. Quality Monitoring UCRP	The DBM's credentialing and recredentialing P&Ps must develop a process to identify quality deficiencies, including: a. monitoring and evaluating claims and encounter data for patterns of care by individual providers; b. conducting ongoing reviews of providers; and c. taking appropriate corrective action with providers.	☐ a. Monitoring and evaluating claims and encounter data for patterns of care by individual providers ☐ b. Conducting ongoing reviews of providers ☐ c. Taking appropriate corrective action with providers	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
10. Appropriate Actions UCRP	The DBM's credentialing and recredentialing P&Ps must impose appropriate sanctions, suspension, restriction, and termination of providers, including terminating or denying enrollment because of inability to verify the identity of the provider applicant or upon determination that the provider has falsified any information provided on the application.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
11. Board Certification Exemption UCRP	The DBM's credentialing and recredentialing P&Ps must ensure primary dental care providers without board certification are removed from the network or receive an exemption timely.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
12. Recredentialing UCRP	The DBM's credentialing and recredentialing P&Ps must: a. recredential providers at least every three years; b. repeat criminal background checks at least every five years; and c. recredential providers, including screening activities, prior to allowing providers who were removed from the network to re-enroll in the network.	☐ a. Recredential providers at least every three years ☐ b. Repeat criminal background checks at least every five years ☐ c. Recredential providers, including screening activities, prior to allowing providers who were removed from network to re-enroll in network	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
13. Verifications UCRP	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must: a. have a current state dental license or authority to do business in the state in which they practice; b. have no revocation, moratorium, or suspension of their license imposed in Florida or any other state; c. have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under the sanction have been met; d. provide evidence of professional liability claims history; e. not be on the state or federal exclusions lists; f. not have had Medicaid prescribing rights suspended by AHCA; and	☐ a. Have current state license or authority to do business in state in which they practice ☐ b. Have no revocation, moratorium, or suspension of license imposed in Florida or any other state ☐ c. Have no sanctions imposed by Medicare or Medicaid unless there is proof of reinstatement or other documentation showing that all obligations under sanction have been met ☐ d. Provide evidence of professional liability claims history	**0.142** **0.142** **0.142** **0.142**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	g. not had enrollment terminated under Title XVIII of the Act or under the Medicaid program or CHIP of any other state. This provision applies only to providers terminated on or after January 1, 2011, from such programs.	☐ e. Not on state or federal exclusions lists ☐ f. Not have had Medicaid prescribing rights suspended by AHCA ☐ g. Not had enrollment terminated under Title XVIII of the Act or under Medicaid program or CHIP of any other state	**0.142** **0.142** **0.142**		
Findings **Strength** **AON** **Suggestion**					
14. Disclosures UCRP	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must provide disclosures related to ownership and management, business transactions, and conviction of crimes to the DBM. a. Ownership and management disclosures include the information required by 42 CFR 455.104(b): 1. Providers must provide this information upon submission of an application, execution of a provider agreement, upon FHKC's request, during recredentialing, and within 35 days after any change in ownership. 2. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider,	☐ a. Ownership and management disclosures include information required by 42 CFR 455.104(b) ☐ b. Business transaction disclosures include information about ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during 12-month period and any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor during previous five-year period	**0.333** **0.333**	**1**	**X.XXX**

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	does not submit timely and accurate information, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 3. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider, or who is an agent or managing employee of the provider, fails to cooperate with any required screening methods, including failing to submit sets of fingerprints in the form and manner required within 30 days of request, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. 4. DBMs must deny providers enrollment in the network or terminate them from the network when any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years, unless FHKC determines that denial or termination of the provider is not in the best interests of the program and documents such determinations in writing. b. Business transaction disclosures include information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period and any significant business transactions between the provider and any wholly owned supplier, or between the	☐ c. Disclosures related to conviction of crimes include identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in provider, or is agent or managing employee of provider, and has been convicted of criminal offense related to person's involvement in any program under Medicare, Medicaid, or Title XX services program since inception of those programs	**0.333**		

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
	provider and any subcontractor during the previous five-year period: 1. The provider must provide such disclosures within 35 days of the date of request by CMS, AHCA, or FHKC. 2. DBMs must include a provision to provide this information within the required timeframe in the provider agreement. c. Disclosures related to the conviction of crimes include the identity of any person who has ownership or control interest, as defined in 42 CFR 455.101 and 42 CFR 455.102, in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. Providers must provide this information upon entering into a new provider agreement, renewing an existing provider agreement, or upon request by FHKC.				
Findings					
Strength					
AON					
Suggestion					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
15. Criminal Background Checks UCRP	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must consent to criminal background checks, including fingerprinting. Providers and any person with a five percent or more direct or indirect ownership interest in the provider are required to submit a set of fingerprints in the requested form and manner within 30 days upon request.	☐ Consent to criminal background checks, including fingerprinting ☐ Providers and any person with five percent or more direct or indirect ownership interest in provider required to submit set of fingerprints in requested form and manner within 30 days upon request	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength** **AON** **Suggestion**					
16. Verifications and Attestations UCRP	To be eligible to participate in the DBM's Florida Healthy Kids network, providers must meet the following requirements when the provider is a dentist: a. facilities that meet the DBM's standards, including that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; evidence that the provider's office meets criteria for access for persons with disabilities; and acceptable medical recordkeeping practices; and b. provide a statement regarding any physical or behavioral health problems that may affect the provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become a Medicaid or CHIP provider.	☐ a. Facilities that meet DBM's standards, evidence that provider's office meets criteria for access for persons with disabilities, and acceptable medical recordkeeping practices ☐ b. Statement regarding any physical or behavioral health problems that may affect provider's ability to provide healthcare, any history of chemical dependency/substance use disorder, any history of loss of license and/or felony or misdemeanor convictions, and eligibility to become Medicaid or CHIP provider	**0.500** **0.500**	**1**	**X.XXX**
Findings **Strength**					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
AON					
Suggestion					
17. Education and Training UCRP	The DBM must have a system for the verification and examination of each provider's credentials. This system must maintain documentation (including copies of provider licenses) of all provider requirements listed in the UCRP, as well as each provider's: - education; - experience; - prior training; - ongoing service training; and - National Provider Identifier (NPI) and taxonomy.	☐ System for verification and examination of each provider's credentials ☐ Documentation of all provider requirements listed in UCRP ☐ Documentation of each provider's education, experience, prior training, ongoing service training, and NPI and taxonomy	**0.333** **0.333** **0.333**	**1**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
18. Provider Nondiscrimination 42 CFR 438.214(c), DSC 3-2	The DBM's network provider selection policies and procedures, consistent with 42 CFR 438.12, must not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification, including providers that serve high-risk populations or specialize in conditions that require costly treatment. The DBM must provide affected providers with written notice of the reason for its decision to decline to include individual providers or groups of providers in its provider network.	☐ No discrimination against providers acting within scope of license or certification solely on basis of that license or certification, including providers serving high-risk populations or specializing in conditions that require costly treatment ☐ Written notice of DBM's decision to decline to include providers or groups of providers in DBM's network	**0.500** **0.500**	**1**	**X.XXX**
Findings					
Strength					
AON					

2020 Annual Compliance Assessment: <DBM>					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Credentialing					
Suggestion					
19. Excluded Providers 42 CFR 438.214(d)	The DBM must not employ or contract with providers excluded from participation in federal healthcare programs under either section 1128 or section 1128A of the *Social Security Act*.	☐ Yes ☐ No	**1.000** **0.000**	**1**	**X.XXX**
Findings					
Strength					
AON					
Suggestion					
Credentialing			**XX.X%**	**19**	**X.XXX**

MCO Credentialing File Review Tool

Florida Healthy Kids 2020 MCO Credentialing File Review Tool*																														
MCO: <MCO>																														Date: <D/M/YY>
#	Review Element	File Number																												
		1 - <XX>			2 - <XX>			3 - <XX>			4 - <XX>			5 - <XX>			6 - <XX>			7 - <XX>			8 - <XX>			9 - <XX>			10 - <XX>		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
1	Medicaid ID																													
2	Current license, no limitations, AHCA HQA license for facilities (must be in file)																													
3	PCP board certification (certified, eligible, waived)																													
4	Valid DEA																													
5	Education and training (education, experience, prior training, NPI, taxonomy)																													
6	Professional Liability Claims History																													
7	Exclusion status [SSA death master file, NPPES, OIG (LEIE), SAM (EPLS)]																													
8	Sanctions (Medicare, Medicaid)																													
9	Title XVIII, Medicaid, CHIP enrollment not terminated																													
10	Medicaid prescribing rights not suspended by AHCA																													
11	Hospital privileges or covering provider in good standing																													
12	Immunization Registry (PCP providers registered in SHOTS program)																													
13	Attestation: Physical or behavioral health problems affecting ability to provide healthcare																													

Florida Healthy Kids
2020 MCO Credentialing File Review Tool*

MCO: <MCO> **Date: <D/M/YY>**

#	Review Element	File Number																											
		1 - <XX>			2 - <XX>			3 - <XX>			4 - <XX>			5 - <XX>			6 - <XX>			7 - <XX>			8 - <XX>			9 - <XX>			10 - <XX>		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
14	Attestation: History of chemical dependency or substance use disorder																												
15	Attestation: Loss of licensure																												
16	Attestation: Felony or misdemeanor convictions																												
17	Attestation: Patient load no more than 3,000 active patients																												
18	Disclosures: Ownership and management, business transactions, criminal convictions																												
19	Criminal background check and fingerprints required**																												
20	Risk Level**																												
21	Site visit for moderate or high risk**																												
	Totals																												

** Yellow highlighting indicates criterion is deemed compliant as a result of National Committee for Quality Assurance (NCQA) 100% credentialing accreditation scores.*
*** Conducted by Agency for Health Care Administration (AHCA). Deemed complete by verification of active Medicaid ID.*

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

MCO Recredentialing File Review Tool

Florida Healthy Kids
2020 MCO Recredentialing File Review Tool*

MCO: <MCO> **Date: <M/D/YY>**

#	Review Element	File Number																																							
		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
1	Recredentialed within 3 years																																								
	Last credentialing date																																								
	Current recredentialing date																																								
2	Medicaid ID																																								
3	Current license, no limitations, AHCA HQA license for facilities																																								
4	PCP board certification (certified, eligible, waived)																																								
5	Valid DEA																																								
6	Ongoing training																																								
7	Professional liability claims history																																								
8	Exclusion status [SSA death master file, NPPES, OIG (LEIE), SAM (EPLS)]																																								

Florida Healthy Kids
2020 MCO Recredentialing File Review Tool*

MCO: <MCO> **Date: <M/D/YY>**

#	Review Element	File Number																																			
		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
9	Sanctions (Medicare, Medicaid)																																				
10	Title XVIII, Medicaid, CHIP enrollment not terminated																																				
11	Medicare prescribing rights not suspended by AHCA**																																				
12	Hospital privileges or covering provider in good standing																																				
13	Immunization Registry (PCP providers registered in SHOTS program)																																				
14	Attestation: Physical or behavioral health problems affecting ability to provide healthcare																																				
15	Attestation: History of chemical																																				

Florida Healthy Kids
2020 MCO Recredentialing File Review Tool*

MCO: <MCO> **Date: <M/D/YY>**

#	Review Element	File Number																																					
		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
	dependency or substance use disorder																																								
16	Attestation: Loss of licensure																																								
17	Attestation: Felony or misdemeanor convictions																																								
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19	Disclosures: Ownership and management, business transactions, criminal convictions																																								
20	Criminal background check and fingerprints required**																																								
21	Risk level**																																								
22	Site visit for moderate or high risk**																																								
	Totals																																								

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*** Conducted by Agency for Health Care Administration (AHCA). Deemed complete by verification of active Medicaid ID.*

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

DBM Credentialing File Review Tool

Florida Healthy Kids 2020 DBM Credentialing File Review Tool*																														
DBM: <DBM>																														Date: <M/D/YY>
#	Review Element	File Number																												
		1 - <XX>			2 - <XX>			3 - <XX>			4 - <XX>			5 - <XX>			6 - <XX>			7 - <XX>			8 - <XX>			9 - <XX>			10 - <XX>		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
1	Medicaid ID																													
2	Current license, no limitations, AHCA HQA license for facilities																													
3	Valid DEA																													
4	Education and training (education, experience, prior training, NPI, taxonomy)																													
5	Professional liability claims history																													
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9	Medicare prescribing rights not suspended by ACHA**																													
10	Attestation: Physical or behavioral health problems affecting ability to provide healthcare																													
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12	Attestation: Loss of licensure																													
13	Attestation: Felony or misdemeanor convictions																													
14	Disclosures: Ownership and management, business transactions, criminal convictions																													
15	Criminal background check and fingerprints required**																													

Florida Healthy Kids 2020 DBM Credentialing File Review Tool*																														
DBM: <DBM>																														**Date: <M/D/YY>**
#	**Review Element**	**File Number**																												
		1 - <XX>			**2 - <XX>**			**3 - <XX>**			**4 - <XX>**			**5 - <XX>**			**6 - <XX>**			**7 - <XX>**			**8 - <XX>**			**9 - <XX>**			**10 - <XX>**		
		Y	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**	**Y**	**N**	**NA**
16	Risk level**																													
17	Site visit for moderate or high risk**																													
	Totals																													

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*** Conducted by Agency for Health Care Administration (AHCA). Deemed complete by verification of active Medicaid ID.*

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

DBM Recredentialing File Review Tool

Florida Healthy Kids 2020 DBM Recredentialing File Review Tool*																																											
DBM: <DBM>																																											
#	Review Element	File Number																																										
		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
1	Recredentialed within 3 years																																										
	Last credentialing date																																										
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Florida Healthy Kids 2020 DBM Recredentialing File Review Tool*																																							
DBM: <DBM>																																									
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		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
9	Title XVIII, Medicaid, CHIP enrollment not terminated																																							
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Florida Healthy Kids 2020 DBM Recredentialing File Review Tool*																																							
DBM: <DBM>																																									
Date: <M/D/YY>																																								
#	Review Element	File Number																																							
		1 - <XX>				2 - <XX>				3 - <XX>				4 - <XX>				5 - <XX>				6 - <XX>				7 - <XX>				8 - <XX>				9 - <XX>				10 - <XX>			
			Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA		Y	N	NA
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Raw Score	
Y	
N	
NA	
Compliance Score	
Y/(Y+N)	**%**

ANA

The ANA tool templates for appointment availability were used to assess appointment availability for FHKC's MCOs and DBMs as part of the 2020 ANA.

2020 Appointment Availability Standards Review Tool		
Standard	**Evident in P&Ps**	**Comments**
Emergency care shall be provided immediately.	<Yes or No>	
Urgently needed care shall be provided within 24 hours.	<Yes or No>	
Routine care of enrollees who do not require emergency or urgent care shall be provided within seven calendar days of the enrollee's request for services.	<Yes or No>	
Routine physical examinations shall be provided within four weeks of the enrollee's request.	<Yes or No>	

2020 Appointment Availability Standards Provider and Enrollee Communication Review Tool		
Standard	**Evident in Provider Manual**	**Evident in Enrollee Handbook**
Emergency care shall be provided immediately.	<Yes or No>	<Yes or No>
Urgently needed care shall be provided within 24 hours.	<Yes or No>	<Yes or No>
Routine care of enrollees who do not require emergency or urgent care shall be provided within seven calendar days of the enrollee's request for services.	<Yes or No>	<Yes or No>
Routine physical examinations shall be provided within four weeks of the enrollee's request.	<Yes or No>	<Yes or No>

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

2020 ANA FHKC Travel Time and Distance Requirements for MCOs				
Provider/Specialty Type	Time (in minutes)		Distance (in miles)	
	Urban	Rural	Urban	Rural
Allergy/Immunology	30	60	30	45
Dermatology	30	60	30	45
OB/GYN	30	30	30	30
Optometry	30	60	30	45
Otolaryngology (ENT)	30	60	30	45
PCP – Pediatrician	20	30	20	30
PCP – Family Physician	20	20	20	20
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

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

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

MCO Provider/Specialty Types and Provider Categories	
Specialty Type	**Specialty Code**
Pediatric Oncology	P021
Pediatric Orthopedic Surgery	P025
Pediatric Pulmonology	P030
Pediatric Surgery	P015
Specialist – Other	
Cardiology	008
Chiropractor	010
Endocrinology	012
Gastroenterology	014
General Surgery	015
Infectious Disease	017
Internal Medicine	003
Nephrology	018
Neurology	019
Oncology	021
Ophthalmology	023
Orthopedic Surgery	025
Podiatry	028
Pulmonology	030

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

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

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

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

DBM Provider Specialty Types and Codes	
Specialty Type	Specialty Code
Primary Care Dentists	
Pediatric Dentists	P201
General Dentists	201
Dental Specialists	
Endodontists	204
Oral Surgeons	024
Periodontists	203
Prosthodontists	206
Orthodontists	202

EDV

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

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

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

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