**The Florida Healthy Kids Managed Care Quality Strategy Plan**

**Fiscal Year 2018-2019**

**Effective July 1, 2018**

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# Background

Florida KidCare is the umbrella program for Florida's Medicaid for children and Children's Health Insurance Program (CHIP). Florida KidCare consists of four program components (Florida Healthy Kids, MediKids, the Children's Medical Services Managed Care Plan and Medicaid), which provide children statewide with health insurance coverage. All four Florida KidCare programs provide the medical, dental and vision services that children need at each stage of their growth and development.

The Florida Healthy Kids component of Florida KidCare is provided by the Florida Healthy Kids Corporation (FHKC). Florida Healthy Kids provides subsidized services for children ages 5 through 18 whose families exceed the income eligibility threshold for Medicaid but whose income does not exceed 200 percent of the federal poverty level. For as little as $15 or $20 per month, the subsidized plan provides comprehensive child-centered health and dental benefits including age appropriate screening and preventive services for all qualifying children in the household.

FHKC currently contracts with four subsidized health plans: Aetna Better Health of Florida, Amerigroup Community Care, Staywell Kids and UnitedHealth care Community Plan (Health Plans); and three dental plans: Argus Dental and Vision, DentaQuest and Managed Care of North America (MCNA) (Dental Plans). When referring to Health Plans and Dental Plans collectively, "the Plans" is used in this document. FHKC provides families with at least two Health Plan options in every county. Families can also choose from any of the statewide Dental Plans.

FHKC also provides an unsubsidized health plan with a dental coverage add-on option for Florida children ages 5 through 18 whose families exceed 200 percent of the federal poverty level. This "full-pay" plan is not part of Florida's CHIP and therefore not included in the above definition of a "Plan" for this document.

# Mission and Goals

FHKC operates under the umbrella of a 2015-2018 strategic plan. The plan sets a high-level course for FHKC to reach six goals and articulates the future role of FHKC amid the evolving health care landscape.

**Vision**

All Florida's children have comprehensive, quality health care services.

**Mission**

Ensure the availability of child-centered health plans that provide comprehensive, quality health care services.

**Goals**

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

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

Together, these goals provide a structure for continuous quality improvement for all enrollees regardless of health status or demographics.

The Florida Healthy Kids Managed Care Quality Strategy Plan (Quality Strategy Plan) documents FHKC's strategy for assessing and improving the quality of services provided by the Plans in support of these goals. The Quality Strategy Plan is reviewed at least annually and updated as needed, but at least every three years. FHKC also evaluates the effectiveness of the Quality Strategy Plan at least every three years.

FHKC consults with Florida's federally recognized tribes in accordance with Florida's Tribal Consultation policy and makes the Quality Strategy Plan available for public comment when making significant changes to the document. In this document, "significant change" means a material change in the goals or strategies described in this Quality Strategy Plan, including one or more of the following:

- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level,
- Changes to the quality assurance and access standards developed under section 409.820, Florida Statutes, and
- Major and material changes to reporting or contract requirements made to address pervasive quality deficiencies identified through analysis of the Plans' reports, FHKC's contract monitoring activities, and enrollee and provider complaints.

FHKC routinely reviews and assesses the quality of the Florida Healthy Kids program. Minor to moderate changes impacting the day-to-day execution of this Quality Strategy Plan are expected and do not constitute a significant change. Examples include quality assurance indicators such as trends in grievances and appeals, plan experience, network access, and enrollee and provider complaints.

The Quality Strategy Plan is composed of two main parts: Access to Quality Care and Quality Assurance.

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# Access to Quality Care

Providing enrollees with access to appropriate, high-quality care is a vital aspect of providing comprehensive, quality health care services. FHKC monitors the Plans and reported data for emerging trends, potential areas of concern, areas of opportunity and compliance with contractual requirements related to the provider network and availability of services.

## The Provider Network

### Network Adequacy

Ensuring enrollees have adequate access to health care providers is foundational to providing quality care, but can be a challenge.

- According to the U.S. Census Bureau, although Florida is now the third most populous state in the country, many areas of the state remain rural. Often, there are too few physicians practicing in these rural areas to meet the needs of those living there, as shown by Health Resources and Services Administration's health professional shortage area and medically underserved areas and populations designations.
- Physicians may not be willing to contract with publicly funded insurance programs or may accept fewer children with publicly funded insurance coverage than children with private insurance coverage. Generally, this is because of the tendency, or reputation, of publicly funded insurance plans to pay providers less than private insurance plans.
- As reported in the American Academy of Pediatrics August 2013 Pediatrician Workforce Policy Statement, the number of pediatric subspecialists, including pediatric surgeons, currently in the workforce is insufficient.

To mitigate the impact of these challenges on enrollees, FHKC requires the Plans meet certain network adequacy standards. These standards require that enrollees have access to the specified provider type within the listed driving time and driving distance from their home addresses.

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Health Plans:

| | Time Standards – in minutes | | Distance Standards – in miles | |
|---|---|---|---|---|
| | **Rural** | **Urban** | **Rural** | **Urban** |
| PCP – Pediatricians | 30 | 20 | 30 | 20 |
| PCP – Family physicians | 20 | 20 | 20 | 20 |
| Behavioral health – pediatric | 60 | 30 | 45 | 30 |
| Behavioral health – other | 60 | 30 | 45 | 30 |
| Allergy/immunology | 60 | 30 | 45 | 30 |
| Dermatologist | 60 | 30 | 45 | 30 |
| OB/GYN | 30 | 30 | 30 | 30 |
| Optometrist | 60 | 30 | 45 | 30 |
| Otolaryngologist (ENT) | 60 | 30 | 45 | 30 |
| Specialists – pediatric | 40 | 20 | 30 | 20 |
| Specialists – other | 20 | 20 | 20 | 20 |
| Hospitals | 30 | 30 | 30 | 20 |
| Pharmacies | 15 | 15 | 10 | 10 |
| Urgent Care Center | Report | Report | Report Req. | Report |

The “other” designation for behavioral health providers and specialists means any provider within that provider type that does not have a pediatric subspecialty.

The health plans are required to report access to urgent care centers, but no specific access standard is required at this time.

Dental Plans:

| | Time Standards – in minutes | | Distance Standards – in miles | |
|---|---|---|---|---|
| | **Rural** | **Urban** | **Rural** | **Urban** |
| Dental – primary care | 30 | 20 | 30 | 20 |
| Orthodontist | 70 | 30 | 50 | 20 |
| Specialists | 40 | 20 | 30 | 20 |

Additionally, each Plan is required to demonstrate it has the capacity to serve the population expected to be enrolled in the service area. The Plan must provide documentation demonstrating it maintains a network of providers sufficient in number of providers, provider mix and geographic distribution to serve the population.

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The Plans must provide such assurance:

- At the time the Plan enters into a contract with FHKC;
- On an annual basis; and
- Any time there has been a significant change in the Plan's operations that would affect the adequacy of capacity and services.

The Plans are also required to submit network adequacy attestations on a quarterly basis.

FHKC's contracted External Quality Review Organization (EQRO) validates the provider network annually. Prior to 2018, the EQRO validated access to primary care providers. Beginning in 2018, the EQRO's network validation process will expand to also include certain pediatric specialists, dental specialists, and hospitals.

The Plans may request an exception to the network adequacy requirements for a particular geographic area and provider type. Plans seeking a service area network access waiver must seek formal approval from FHKC and must provide the following information and documentation:

- Identification of the service area
- The reason for the request, which may include:
    - No providers exist in the area.
    - No providers exist in the area are able to pass the Plan's credentialing or recredentialing standards.
    - Limited providers exist in the area and all refuse to contract with the Plan despite the Plan's documented good faith efforts to contract.
- The number of providers in the area
- The distance to the nearest network provider
- Documentation of the Plan's efforts to find providers in the area, as well as proof of existing providers' inability to be credentialed/recredentialed or proof of the Plan's good faith efforts to contract, as appropriate. The Plan must provide the practice address and phone number of any provider refusing to contract.
- Certification attesting that documentation is complete and accurate.
- The Plan's strategy to monitor the area and take action should any change occur.
- Explanation of how the Plan will provide timely services to enrollees in the area.

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Once a waiver has been granted, the Plan must monitor and report on enrollee access to the relevant provider type as well as activity relating to the Plan's monitoring plan on a quarterly basis. Waivers must be re-approved every two years unless revoked.

Waivers may be revoked for the following reasons:

- The situation in the area has changed and the Plan can reasonably be expected to meet access requirements.
- Failure to provide continuing evidence that such a waiver is appropriate.
- Failure to adequately monitor, take action, or report as required by the Plan's documented plan, the Contract and state or federal law.

The Plans are required to provide covered services to enrollees regardless of any gaps in network adequacy. Should an enrollee require a covered service and there is no network provider available to the enrollee, the Plan is required to cover the service with an out-of-network provider at no additional cost to the enrollee.

### Timely Access to Services

The Plans are also required to ensure network providers offer timely treatment to enrollees. FHKC holds the Plans to the following standards:

- Emergency care must be provided immediately.
- Urgently needed care must be provided within 24 hours.
- Routine care must be provided within seven calendar days.
- Routine physical exams must be provided within four weeks.
- Follow-up care must be provided as medically appropriate.

### Accuracy of Provider Information

In addition to a robust provider network, enrollees must have access to an accurate provider directory to effectively utilize their benefits. The Plans maintain electronic provider directory tools and are also required to maintain an electronic version (PDF) of the provider directory on their websites. Enrollees can access the tool or PDF on demand or request the Plan mail a hardcopy of the PDF at no cost to the enrollee.

The Plans report all changes to their provider networks to FHKC monthly. As part of monitoring the provider network, FHKC conducts regular, randomized reviews of the provider directory. Discrepancies between the provider directory and the reported network changes are sent to the plan for review and correction. Major issues, trends or repeated errors may result in directions for additional corrective action to the Plans.

Quarterly, the Dental Plans provide provider network reports to FHKC for InsureKidsNow.gov, a federal tool for outreach and enrollment information, ideas and materials. FHKC then provides the Insure Kids Now validation and geophone reports generated by the quarterly submissions back to the Dental Plans for use in verifying the accuracy of their provider data.

## Provider Quality

To provide quality health care services to Florida's children, FHKC must not only ensure that enrollees have adequate access to providers, but also that enrollees have access to high-quality providers.

### Uniform Credentialing Policy

Providers are required to hold a Florida Medicaid ID, although they are not required to accept Medicaid. This aligns the basic requirements for Florida Healthy Kids credentialing with Florida Medicaid standards.

The Plans are required to be accredited and are expected to meet the standards for provider credentialing and recredentialing required by a recognized independent accrediting entity. At a minimum, the plans must:

- Maintain written policies and procedures for credentialing and recredentialing providers;
- Require that providers:
    - Have a current state license or authority to do business in the state in which they practice;
    - Have no revocation, moratorium or suspension of their license imposed in Florida or any other state;
    - 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;
    - Provide evidence of professional liability claims history;
    - Provide disclosures related to ownership and management, business transactions and conviction of crimes;
    - Not be on the state or federal exclusions lists; and
    - Not have had Medicaid prescribing rights suspended by the Florida Agency for Health Care Administration.
- Require behavioral health services providers to meet the minimal licensure and credentialing standards set forth in Florida statute and Department of Children and Families, Department of Health, and Agency for Health Care Administration rules pertinent to the treatment and prevention of mental health and substance abuse disorders in children and adolescents;

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- Have a system in place for the verification and examination of each provider's credentials, including maintaining documentation of the provider requirements listed above, as well as each provider's:
    - Education;
    - Experience;
    - Prior training;
    - Ongoing service training; and
    - National Provider Identifier (NPI) and taxonomy.
- Monitor providers for compliance with the provider contract, including
    - Appointment timeliness standards;
    - Maintenance of accurate directory information, including
        - Office hours;
        - Street address; and
        - Phone number;
    - Acceptance of new patients;
- Have a process for identifying quality deficiencies, including
    - Monitoring and evaluating claims and encounter data for patterns of care by individual providers; and
    - Conducting ongoing reviews of providers;
- Take appropriate corrective action with providers;
- Impose appropriate sanctions, suspension, restriction and termination of providers; and
- Ensure primary care providers without board certification are removed from the network or receive an FHKC-approved exemption timely.

**Primary Care Providers**

Enrollees must have access to a primary care provider (PCP) who is the designated and ongoing source of care and care coordination. To help ensure enrollees receive care from high-quality providers, the Health Plans may only allow the following providers to act as network PCPs:

- Board-certified pediatricians;
- Board-certified family practitioners; and



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- 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 medicine and who are eligible for, but have not yet received, board certification.
    - If such a provider does not achieve board certification within three years of initial credentialing, the Plan must remove the provider from the network or request a board-certification waiver from FHKC.

To help ensure network adequacy, FHKC allows the Health Plans to request waivers to the board-certification requirement for PCPs. The requesting Plan must provide documentation showing that waiving the requirement is in the best interest of enrollees and that the physician is qualified to provide quality care. FHKC then reviews this documentation and additional publicly available documentation before making a determination. Waivers are valid for two years and are specific to both the physician and Plan. This enables FHKC to closely watch for potential issues and trends.

The Health Plans' PCPs are also required to provide all covered immunizations to enrollees and to be enrolled in and maintain updated records in the Florida State Health Online Tracking System (SHOTS). SHOTS is Florida's free statewide centralized online immunization registry used by health care providers and schools to keep track of immunization records. The Health Plans are required to provide annual confirmation of compliance with this requirement.

**Mental Health Care and Substance Abuse Providers**

In addition to meeting the credentialing and recredentialing standards listed above specific to providers of behavioral health and substance abuse services, the Health Plans and their subcontractors are required to adopt section 394.491 and Chapter 397, Florida Statutes, as guiding principles in the delivery of services and supports to enrollees with mental health and substance abuse disorders.

At a minimum, the Plans must also include the following in the provider network:

- A psychiatric hospital licensed under Chapter 395, Florida Statutes;
- A crisis stabilization unit licensed under Chapter 394, Florida Statutes;
- An addiction receiving facility licensed under Chapter 397, Florida Statutes;
- Providers that are either:
    - Board-certified child psychiatrists; or
    - Licensed to practice medicine, osteopathic medicine, psychology, clinical social work, mental health counseling, or marriage and family therapy who have a minimum of two years' full-time, post graduate, paid experience providing mental health and/or substance abuse services in a setting that specializes in providing mental health and/or substance abuse services to children and/or adolescents or who is a certified addiction

professional, certified in accordance with Chapter 397, Florida Statutes, to provide substance abuse services in a setting that specializes in providing substance abuse services to children and/or adolescents.

**Facility Standards**

The Plans are required to use only facilities meeting applicable accreditation and licensure requirements and regulations specified by the Agency for Health Care Administration to provide services to enrollees.

## Children with Special Health Care Needs

In accordance with section 409.811, Florida Statutes, children with special health care needs means a child whose serious or chronic physical or developmental condition requires extensive preventive and maintenance care beyond that required by typically healthy children. Health care utilization by such a child exceeds the statistically expected usage of the normal child adjusted for chronological age, and such a child often needs complex care requiring multiple providers, rehabilitation services, and specialized equipment in a number of different settings.

Florida KidCare provides services to children with special health care needs primarily through the Children's Medical Services Managed Care Plan administered by the Florida Department of Health to provide a comprehensive system of care to Medicaid and CHIP eligible children with special health care needs. Children with special health care needs are identified through the KidCare application process. If a child is found to be potentially eligible for the Children's Medical Services Managed Care Plan based on the information provided in the application, the child is referred to the Florida Department of Health for a clinical eligibility determination. A child may be determined to be clinically eligible two ways: a parent-based survey conducted by a Children's Medical Services Plan Area Office or a physician's attestation of the child's qualifying medical condition in accordance with the physician attestation process.

Not all children with special health care needs choose to enroll in the Children's Medical Services Plan or have special health care needs at the time of initial enrollment. The Florida Healthy Kids Plans are also required to have mechanisms in place to provide enrollees determined to have special health care needs with direct access to a specialist in a manner that is appropriate for the Enrollee's condition and identified needs. Direct access may include, but is not limited to, a standing referral or an approved number of visits. The Plans generally identify children with special health care needs by analyzing claims data, through health risk assessments, provider referrals, and calls from parents or caregivers.

## Transition of Care

The Plans follow a standardized transition of care policy for Florida Healthy Kids enrollees.

When enrollees move from one Florida Healthy Kids subsidized plan to another Florida Healthy Kids subsidized plan without a break in coverage, the new Plan will continue to cover any ongoing course of treatment authorized by the prior Plan for a certain period of time.

This continuation of coverage includes:

- Allowing enrollees to continue to see the same provider(s) even if the provider is not in the new Plan's network;
- When an appointment is scheduled prior to the continuation of care period for a time after the continuation of care period, the Plan will ensure the enrollee's PCP or other appropriate physician reviews the treatment plan within the continuity of care period to ensure that needed services continue to be authorized;
- Allowing enrollees to continue to receive prescription benefits, including refills.

The standard continuation of care period is 60 days. Exceptions to the standard continuation of care period include:

- Maternity care, including prenatal and postpartum care, is through completion of postpartum care;
- Transplant services is through first year post-transplant;
- Radiation and/or chemotherapy is through current round of treatment;
- Orthodontia is covered through the enrollee's current provider through the standard 60-day period. After the initial 60-day period, the Plan may require the enrollee to see a network provider through completion of the services so long as services are not interrupted.

The Plans are responsible for coordinating the transfer of medical records and necessary utilization information between themselves and then assisting providers with obtaining necessary medical records, in accordance with all applicable laws.

## Benefit Decisions

The Plans must follow written policies, procedures and clinical practice guidelines when making benefit determinations. Clinical practice guidelines adopted by the plans must:

- Be based on valid, reliable evidence;
- Consider the needs of enrollees;
- Be adopted in consultation with contracting health care professionals;
- Be reviewed and updated periodically, as appropriate.

Utilization management activities must be conducted by individuals with clinically appropriate backgrounds in a manner that results in interrater reliability (or the extent that people doing the same job agree) sufficient to indicate the appropriateness and validity of the process.

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### Grievances and Appeals

The Plans are required to maintain a grievance and appeal process consistent with the requirements of 42 CFR 457.1260. The Plans' grievance and appeals policies are submitted to FHKC for approval annually and prior to making any changes.

The Plans must acknowledge receipt of each grievance and appeal and provide timely notification of the grievance or appeal outcome. The Plans must adhere to the following timeframes when making a determination, except as appropriately extended:

- Grievances – within ninety days;
- Standard appeals – within 30 days;
- Expedited appeals – within 72 hours.

Notification of an appeal determination must include the result of the appeal process, the date the appeal was resolved, and information about the enrollee's right to request a statewide standard review, including how to request such a review. Statewide standard reviews are conducted through the statewide Subscriber Assistance Panel.

Individuals making decisions about grievances and appeals:

- May not have been involved in any previous level of review or decision-making related to the grievance or appeal and may not be a subordinate of any such individual;
- Must also have appropriate clinical expertise related to the grievance or appeal; and
- Must take all comments, documents, records and other information submitted by the enrollee or enrollee's representative into account without regard to whether such information was previously submitted or considered.

The Plans must provide reasonable assistance in completing forms and taking other procedural steps related to the grievance and appeals process, upon request.

Information on how to navigate the grievance and appeal process is required to be included in the Plans' enrollee handbooks and provided with any adverse benefit determinations.

The Plans must submit quarterly grievance and appeal reports to FHKC. The reports include a description of each appeal or grievance, relevant dates such as the date received and date resolved, and the disposition of the appeal or grievance. FHKC reviews these reports for response timeliness and trends indicative of larger issues. FHKC also uses these reports to help inform decisions relating to quality improvement.

## Reducing Health Disparities

FHKC's vision is that all Florida's children have comprehensive, quality health care services. Identifying and reducing health disparities based on age, race, ethnicity and primary language are key factors in



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realizing that vision. The Plans are required to maintain a comprehensive, written cultural competency plan describing:

- How the Plan ensures services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency; and
- How the Plan, its providers, employees and systems effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the enrollee and protects and preserves the dignity of each.

The Plans must provide their cultural competency plans to FHKC on an annual basis.

The Plans are also required to comply with the guidance issued by the Office for Civil Rights of the United States Department of Health and Human Services ("Policy Guidance on Title VI Prohibition against National Origin Discrimination as it Effects Persons with Limited English Proficiency") regarding the availability of information and assistance for persons with limited English proficiency.

FHKC is exploring opportunities for greater analysis of the Healthy Kids program's claims experience. This is expected to improve FHKC's abilities to make data-driven decisions to further the organization's mission of providing quality care to all Florida's children and help shrink health disparities.

# Quality Assurance

## Continuous Quality Improvement

FHKC's Plans must maintain an ongoing quality improvement plan that meets the following requirements:

- Objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered,
- Promotes quality of care and quality patient outcomes
- Demonstrates specific interventions to better manage the care of and promote healthier outcomes for enrollees.

These quality improvement plans include the Plans' written policies and procedures for effective health care management including anticipation, identification, monitoring, measurement, and evaluation of enrollees' health care needs, as well as effective action to promote quality of care. The Plans define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management. The quality improvement plans must be provided to FHKC annually.

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## Accreditation

FHKC is pleased to offer Health Plans and Dental Plans that have been accredited or certified by private independent accrediting entities. The Plans are required to provide FHKC with their accreditation information, including when their accreditation status changes.

The External Quality Review Organization (EQRO) reviews the Plans' accreditations to determine if any accreditation activities are comparable to external quality review (EQR) activities. An accreditation activity must cover the same subject matter and be conducted by a recognized independent accrediting entity using an industry-accepted methodology that is at least as stringent as the equivalent EQR activity to be considered comparable. Should any accreditation activities be found to be comparable to EQR activities, the EQRO does not duplicate the work. Some EQR activities that have specific regulatory requirements or are higher risk in some way, such as network access activities, may have a comparable accrediting activity but are still conducted by the EQRO. This process reduces cost, time and resources spent on EQR activities for the plans, the EQRO and FHKC, ultimately avoiding cost for taxpayers, without introducing additional risk.

## External Quality Review

### Assessment of Compliance

FHKC's EQRO conducts an annual assessment of compliance in accordance with CMS' Protocol 1 for mandatory EQR-related activities and produces a report for FHKC detailing any findings and recommendations.

FHKC's contracted EQRO will conduct the assessment in annual stages over a three-year period. The process is stratified based on risk and importance, as determined by FHKC with the EQRO's assistance. Higher risk compliance activities are conducted in the first year while the lowest risk activities are conducted in the last year. Any findings are reviewed again the next year. The exception to this risk-stratified activity grouping is validation of network adequacy, which is conducted annually.

In accordance with 42 CFR 438.360, FHKC's contracted EQRO will also avoid duplication of accreditation review activities. This means that if a Plan has a current accreditation from an independent accrediting entity recognized by CMS as applying standards at least as stringent as Medicare under the procedures in 42 CFR 422.158 for which the private accreditation review consisted of activities the EQRO would otherwise also conduct under this protocol, the EQRO will accept the results of the private accreditation review rather than conduct the same review. The standards for the private accreditation review must be comparable to standards established through the mandated EQRO protocols. The Plans will also be required to provide the appropriate, necessary information regarding these activities to FHKC's contracted EQRO.

FHKC has added more formal requirements for the EQRO to provide the Plans an opportunity to respond to the EQRO's findings. Any Plan responses will be incorporated into the annual report. The annual report in the third year of the assessment will include data from all three years.

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This approach frees plan resources to focus on activities with a greater return in value, such as the performance improvement projects, or correct any findings that do occur, without materially increasing the risk of noncompliance.

### Annual Performance Metrics

FHKC uses performance metrics each year to assess Plan performance within the context of performance over time, performance in comparison to each Florida Healthy Kids Plan, and performance in relation to the national Medicaid average. The performance metrics primarily consist of a standard set but may occasionally change as national recommendations change or as FHKC's needs and focus change. Most of the performance metrics are Healthcare Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance and/or CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).

The Plans will calculate the performance measures and the EQRO will validate the results in accordance with CMS' Protocol 2 for mandatory EQR-related activities. This change is expected to reduce duplication of effort between the Plans and FHKC's contracted EQRO and streamline the review process, particularly in identification of potential data discrepancies.

For the 2016 plan year, the EQRO calculated more than 20 performance measures (and more than 40 sub-measures) in 6 categories:

- Access and availability of care
- Utilization
- Effectiveness of care – prevention and screening
- Effectiveness of care – respiratory conditions
- Effectiveness of care – behavioral health
- Effectiveness of care – overuse/appropriateness

FHKC's goal is to meet or exceed the 75$^{th}$ percentile for the national benchmark for the measures that have a national benchmark available.

### Performance Improvement Projects

The Health Plans and Dental Plans conduct performance improvement projects (PIPs) each year. The Plans are required to design PIPs that achieve sustained, significant improvement to health outcomes, enrollee satisfaction, access and quality of care by implementing interventions and measuring performance using objective quality indicators. FHKC's EQRO validates the Plans' PIPs and produces an annual PIP validation report.

The EQRO PIP validation process is conducted in accordance with CMS' protocol 3 for mandatory EQR-related activity protocols. CMS' protocol 3 includes 10 major points of evaluation for PIPs.

FHKC is committed improving plan performance and providing quality health care to enrollees. Consequently, FHKC is providing additional technical assistance and education to the Plans through a recently procured EQRO contract effective January 1, 2018. The EQRO will provide triannual training or education to meet this objective, and will be available to answer technical questions throughout the year.

The Plans, with the EQRO's assistance, will also incorporate plan-do-study-act (PDSA) components in their PIP approaches. PDSA is a proven method of quality improvement in health care. The addition of PDSA, or other proven quality improvement approaches, will not impact FHKC's expectations for the Plans' adherence to the PIP protocol. Formal PIP submission and validation will continue to be conducted on an annual basis, but the Plans will also be required to submit documentation of PIP activities and progress quarterly.

More frequent communication regarding the PIPs is expected to help the Plans spend less time on less valuable interventions, keep focus on the goals of the PIP and identify problems or potential problems while time remains to correct them.

FHKC's Quality Improvement and Data Analytics Committee approves PIP topics annually. For 2018, this committee reapproved the health Plans' PIP to increase the rate of well-child visits for children ages 5-6 and the dental Plans' PIP topic to improve the utilization of preventive dental services.

### Validation of Encounter Data

FHKC's EQRO will conduct encounter data validation in accordance with CMS' protocol 4 for voluntary EQR-related activity protocols. This robust process involves, in part, an analysis of the Plans' encounter data for accuracy and completeness, as well as a review of medical records to confirm the electronic encounter data analysis, allowing FHKC confidence in the quality of the Plans' encounter data.

The EQRO is required to provide a report summarizing the encounter data validation, including any findings, and incorporate recommendations to improve the quality of the data.

### Other EQRO Activities

FHKC's EQRO contract allows FHKC to have the EQRO conduct any other optional CMS EQRO protocols, including administration or validation of consumer or provider quality of care surveys, calculation of performance measures, implementation of additional PIPs, and completion of studies on quality that focus on a particular aspect of clinical or nonclinical services as of a point in time. This option provides FHKC with the flexibility to have quality improvement activities and research conducted as needs are identified.

## Assuring Compliance

FHKC's Plans are subject to intermediate sanctions in accordance with 42 CFR Part 438, Subpart I. FHKC regularly monitors the Plans for compliance with the contract. Determinations of noncompliance are made based on findings from onsite visits, complaints by enrollees and others, financial status,

documentation submitted to FHKC, and other monitoring activities. FHKC makes a best effort to identify and prevent potential issues before they escalate to larger concerns. Should FHKC determine that any of the actions listed in 42 CFR Part 438, Subpart I have occurred, FHKC will evaluate and apply an intermediate sanction applicable to the situation, as appropriate.

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