Florida Medicaid

Managed Medical Assistance Waiver

1115 Research and Demonstration Waiver
#11-W-00206/4

Combined Q3 and Annual Report

July 1, 2019 – June 30, 2020
Demonstration Year 14

Agency for Health Care Administration

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Executive Summary

The Managed Medical Assistance (MMA) program is one component of the Statewide Medicaid Managed Care (SMMC) program. A version of the MMA program was initially approved by the Centers for Medicare & Medicaid Services (CMS) as a pilot program in 2005, under the 1115 Research and Demonstration Waiver authority. In 2014, CMS approved the renewal for the MMA 1115 Research and Demonstration Waiver, and the MMA program rolled out statewide.

The Agency for Health Care Administration (Agency) is required to submit an Annual Report at the end of each Waiver Demonstration Year. This report summarizes events that occurred throughout the demonstration year that affected the health care delivery system. Additionally, the report outlines future events, which are anticipated to occur, that will also affect the health care delivery system moving forward. This Annual Report is for Waiver Demonstration Year 14 (DY14) covering July 1, 2019, through June 30, 2020.

Additional detailed information regarding previous waiver activities and reports is available under the MMA Quarterly and Annual Reports section of the Agency's website: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml.

The MMA program improves health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. This is achieved through care coordination, patient engagement in their health care, enhancing fiscal predictability and financial management, improving access to coordinated care, and improving overall program performance.

Managed Medical Assistance Program Overview

Telemedicine

Florida has adopted the use of telemedicine, or telehealth, to increase recipient access to health care practitioners and to make accessing health care services a more convenient process. The Florida Medicaid contracts require MMA plans to reimburse network providers for covered services provided via telehealth technology.

During DY14, telemedicine was expanded to assist the Agency in combating the challenges presented by the COVID-19 pandemic and Public Health Emergency (PHE). Below are a few examples of the actions taken by the Agency in order to maintain the high standard of medical care and accessibility for all Medicaid recipients. The Agency:

- Expanded telemedicine coverage to:
  - Therapy Services
  - Specified Behavioral Health Services
  - Early Intervention Services
- Issued additional guidance, disseminated to Behavioral Health providers, related to telemedicine services
- Implemented payment parity for services delivered via telemedicine (audio and video) in the MMA program
- Permitted telemedicine services to be delivered via telephone-only communications, and established and disseminated requirements for this type of service delivery
- Permitted the delivery of well-child visits via telemedicine

State COVID-19 Strategies

In addition to expanding the use of telemedicine to address challenges presented by the COVID-19 pandemic, the Agency also took the following actions:

Eligibility

- Extended Medicaid recipient eligibility to ensure all Medicaid enrollees remain eligible throughout the duration of the PHE
- Extended the timeline to complete the Medicaid application process

Fair Hearings

- Allowed enrollees more time to request a fair hearing or health plan appeals

Provider Enrollment

- Enacted provisional enrollment to allow the Agency to quickly enroll providers

- Waived the requirement that Florida Medicaid providers be licensed in-state
- Extended the timeline for provider enrollment revalidation

Expansion of Service Limitations/Expanded Coverage

- Authorized service limits expansion in order to maintain the health and safety of recipients diagnosed with COVID-19, or when services beyond the set limits are necessary to maintain a recipient safely in their home
- Permitted early refills of maintenance medication, excluding controlled substances
- Encouraged the use of mail order delivery for maintenance medications
- Allowed recipients to request a 90-day supply of medications, when that quantity is available at the pharmacy, and recipients may also request a 90-day supply of their medications be delivered via mail order
- Waived the behavioral health frequency and duration service limits

COVID-19 Testing

- Added coverage of the COVID-19 lab test codes
- Released a COVID-19 diagnosis code guidance
- Added coverage of the COVID-19 rapid lab test and antibody test
- Released additional guidance on coverage of COVID-19 antibody testing

Co-Payments and Prior Authorizations

- Waived all co-payment requirements
- Waived prior authorization requirements for hospital services (including long-term care hospitals), physician services, advanced practice registered nursing services, home health services, nursing facility services, and durable medical equipment and supplies
- Prohibited the managed care plans from applying and implementing pre-payment and post-payment claim reviews for services in which prior authorization requirements have been waived during the PHE, unless certain criteria are met
- Waived prior authorization requirements for behavioral health services

Health Care Plan Contract Procurement

The SMMC program began in 2013, with 5-year contracts awarded to managed care plans; these contracts were set to expire in 2018. Thus, Florida's first SMMC plan reprocurement effort began in 2017. The contracts resulting from the reprocurement had an effective date in December 2018. DY14 was the first full demonstration year operating under the new managed care contracts. During the 2020 Florida Legislative Session, legislation was passed extending the contract term from five-years to six-years; thus, the contracts implemented in December 2018 will be in effect until 2024.

There are five different SMMC program plan types for this contract term, all of which fall into one of the following classifications:

1. **Comprehensive Plans**: Provides MMA services and Long-Term Care (LTC) services to eligible recipients.
2. **Long-Term Care Plus Plans**: Provides MMA services and LTC services to recipients enrolled in the LTC program. This plan type cannot provide services to recipients who are only eligible for MMA services.
3. **Managed Medical Assistance Plans**: Provides MMA services to eligible recipients. This plan type cannot provide services to recipients who are eligible for LTC services.
4. **Specialty Plans**: Provides MMA services to eligible recipients who qualify as a member to a specialty population.
5. **Dental Plans**: Provides preventive and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

During contract negotiation, the Agency made significant gains for both recipients and providers. For example, recipients' access to care expanded by doubling the number of primary care providers available in each network, guaranteeing patients' access to after-hours care, the expansion of telemedicine, and the addition of a vast array of expanded benefit services. Examples of new benefits for service providers include an expedited provider credentialing process, under which credentialing must be completed by the MMA plans within 60 days, and a waiver of prior authorization requirements available to high performing providers. High performing providers are determined as such based on their past accuracy and consistency in treating and diagnosing their patients.

Expanded Benefits

The MMA health and dental plans provide many additional benefits to their enrollees; there are currently 55 expanded benefit options. Expanded benefits are services covered by the MMA plans beyond the mandatory services contained in the Medicaid State Plan. The health and dental plans pay for the expanded benefits, thus there is no additional cost to the State for these services.

Attachment I provides a comprehensive list of the expanded benefit services health and dental plans may choose to cover. Plans are not required to offer all of the expanded benefits contained in Attachment I; each plan publishes and distributes their list of expanded benefit service options, along with information regarding prior authorization requirements, to each of their enrollees via the Enrollee Handbook.

The addition of expanded benefit services, such as additional home health nursing visits, transportation services, home delivered meals, physical therapy, and housing assistance, which includes grocery assistance, supports and furthers the Agency's goal of increasing the percentage of individuals able to receive services in their homes and within their communities instead of being institutionalized.

There are also a number of additional substance abuse, mental health, and behavioral health treatment services now available to recipients through the expanded benefits packages. These services range from screening/evaluation and case management to intensive outpatient services including alternative pain management services.

The increase of services available through expanded benefit packages has broadened the array of services available to Medicaid recipients and enhanced recipient access to care.

Enhanced Quality and Health Outcomes

During contract negotiations, each of the MMA plans committed to higher performance goals. The health plans committed to reducing potentially preventable admissions, readmissions, and emergency department visits as well as reducing primary C-section rates, pre-term deliveries, and the number of babies born with neonatal abstinence syndrome.

Similarly, the dental plans committed to decreasing the dental emergency department visit rate, while increasing annual visits and preventive dental care visit rates.

The charts below detail the health and dental plans' commitments for the 5-year contract period.

Health Plans	
Avg. Reduction	**Quality Outcome**
22%	Preventable Admissions
21%	Preventable Re-Admissions
14%	Preventable Emergency Department Visits
12%	Primary C-Section Rate
10%	Pre-Term Deliveries
15%	Babies Born with Neonatal Abstinence Syndrome

Dental Plans	
Avg. Increase	**Service Type**
3%	Annual Dental Visits-Above the Annual ITN Target
1%	Preventive Dental Care-Above the Annual ITN Target
Reduction	**Potentially Preventable Event**
5%	Dental Related Emergency Department Visits Within the First Year
9%	Emergency Department Visits Within the 5-year Contract

Prepaid Dental Health Program

CMS approved the Agency's request on November 30, 2018, via amendment to the MMA Waiver, for authority to implement a separate Prepaid Dental Health Managed Care Program

available to all Florida Medicaid recipients. The dental plans were procured at the same time as the MMA health plan contracts, and the program implementation began in December 2018. The dental program implementation schedule was concurrent with the implementation schedule of the MMA contracts for the new contract term.

Through the Prepaid Dental Health Program, Florida Medicaid now covers preventive and therapeutic dental services to all recipients enrolled in managed care as well as for all fully eligible fee-for-service individuals. An important gain for adult recipients was the addition of expanded benefits available through the dental managed care plans. These services include but are not limited to preventive, diagnostic and restorative care services, including periodontics, oral, maxillofacial surgery, and diabetic testing. Previously, adults enrolled in Florida Medicaid only received dental services related to dentures and emergency services to relieve pain and infection.

Section I: Operational Updates

1.1 Agency Contracting Activities

Plan Contracting Status

The Agency's new contract term, with both health and dental managed care plans, began the implementation process during DY13, and DY14 was the first full demonstration year in which the contracts were in effect. Under the SMMC contracts, the Agency's focus is fully integrating health care, and as such, health plans are now responsible for covering services, which were previously covered under the fee-for-service delivery system. These services include:

- Early Intervention Services
- Medical Foster Care
- Short-Term Nursing Facility Services
- Child Health Services Targeted Case Management

Additionally, all managed care plans participating in the SMMC program offer enhanced expanded benefit packages, which focus on a variety of areas important to the State such as substance abuse, mental health treatment, and alternative pain management services. The services covered under the expanded benefit packages have significantly increased with the updated contracts and are provided by the MMA plans at no additional charge to the State.

Each plan has a unique offering of expanded benefits, as the plans are not required to cover all of the expanded benefit services enumerated on the comprehensive list contained in **Attachment I**. Information regarding the particulars of each of the plan's expanded benefit service, including prior authorization, is provided to recipients in their Enrollee Handbook. Each plan has also doubled the number of primary care physicians available in their networks and embraced the use of telemedicine, which expands recipient access to care and health specialists.

The SMMC contracts went into effect in December of 2018 and are set to expire on December 31, 2024. The contracts awarded include:

- **7 Comprehensive Plans** – MMA services and LTC services
- **1 Long-Term Care (LTC) Plus Plan** – MMA services and LTC services (MMA only recipients are not eligible for this plan)
- **4 MMA-Only Plans** – MMA services (LTC recipients are not eligible for this plan)
- **5 Specialty Plans** – MMA services to recipients who qualify under a specialty population
- **3 Dental Plans** - Provide preventive and therapeutic dental services to all MMA recipients and all fully eligible fee-for-service individuals

Information pertaining to the specific health and dental plans awarded contracts for the 2018-2024 contract term are included on the following pages.

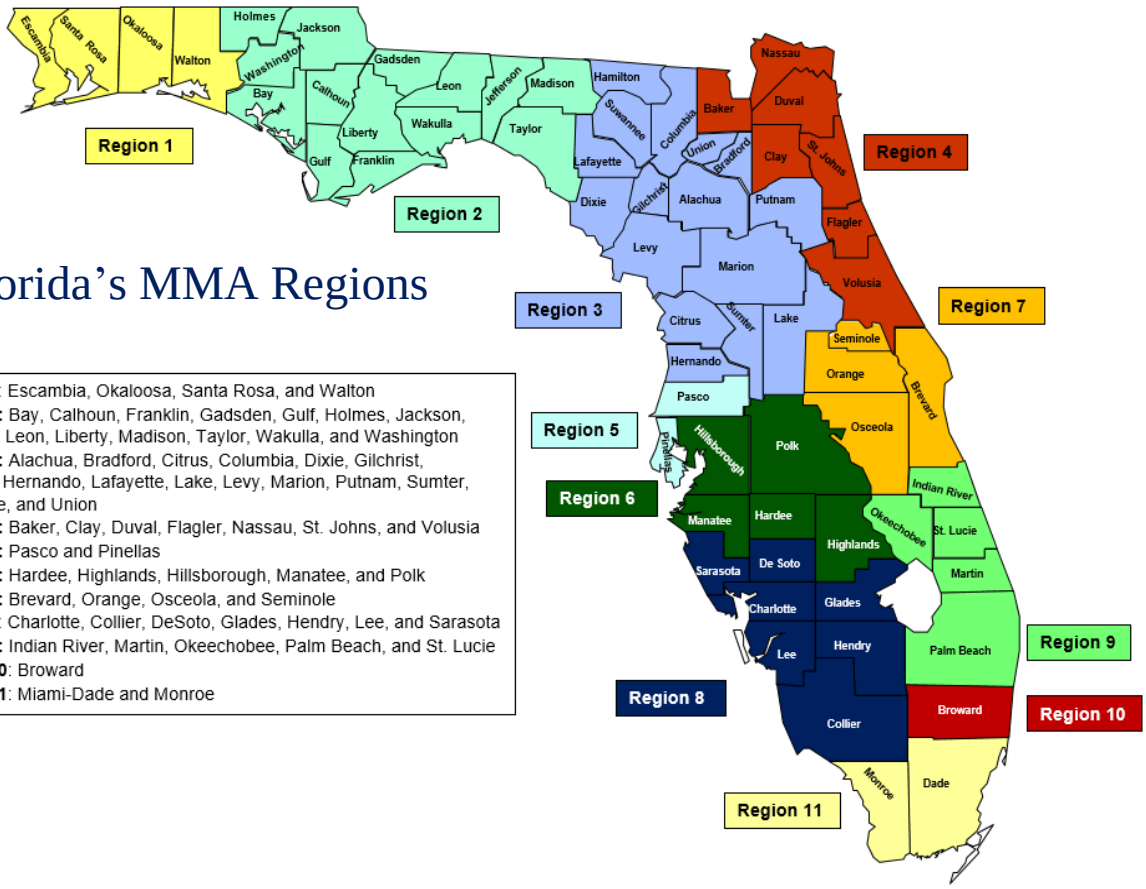
Participating Health and Dental Plan Types

Plan Types
Comprehensive Plans
Long-Term Care Plus Plans
Managed Medical Assistance Plans
Specialty Plans
Dental Plans

SMMC Participating Health and Dental Plans	
Known as:	**Full Business Name:**
Aetna	Coventry Health Care of Florida D/B/A/ Aetna Better Health of Florida
Humana	Humana Medical Plan
Molina	Molina Health Care of Florida
Simply	Simply Healthcare Plan **(Formerly Amerigroup and Better Health)**
Staywell	Wellcare of Florida D/B/A Staywell Health Plan of Florida
Sunshine	Sunshine State Health Plan
United	United Health Care of Florida
FCC	Florida Community Care
Vivida	Best Care Assurance D/B/A Vivida Health
Prestige	Florida True Health D/B/A/ Prestige Health Choice
CCP	SFCCN D/B/A Community Care Plan
Lighthouse	Lighthouse Health Plan
Miami Children's	Miami Children's Health Plan
Sunshine - Child Welfare Specialty Plan	Sunshine - Child Welfare Specialty Plan
Children's Medical Services Network	Children's Medical Services Network
Clear Health Alliance- HIV/AIDs Specialty Plan	Clear Health Alliance- HIV/AIDs Specialty Plan
Staywell- Serious Mental Illness Specialty Plan	Staywell- Serious Mental Illness Specialty Plan
MCNA	Managed Care of North America
DentaQuest	DentaQuest of Florida
Liberty	Liberty Dental Plan of Florida

Florida Medicaid Regions and MMA Plan Options

(Contract years 2018 – 2024)



Florida's MMA Regions

Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

Health Plans by Region

REGION	AETNA BETTER HEALTH	COMMUNITY CARE PLAN	FLORIDA COMMUNITY CARE	HUMANA MEDICAL PLAN	LIGHTHOUSE HEALTH PLAN	MIAMI CHILDREN'S	MOLINA HEALTHCARE	PRESTIGE	SIMPLY HEALTHCARE	STAYWELL	SUNSHINE HEALTH	UNITEDHEALTHCARE	VIVIDA HEALTH
1			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
2			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
3			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
4			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
5			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
6	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
7	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
8			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP			MOLINA HEALTHCARE COMP			STAYWELL COMP	SUNSHINE HEALTH COMP		VIVIDA HEALTH MMA
9			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA		PRESTIGE MMA		STAYWELL COMP	SUNSHINE HEALTH COMP		
10		COMMUNITY CARE PLAN MMA	FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP		SUNSHINE HEALTH COMP		
11	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA	MOLINA HEALTHCARE COMP	PRESTIGE MMA	SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	

Specialty Plans

Dental Plans

REGION	CHILDREN'S MEDICAL SERVICES PLAN – CHILDREN WITH CHRONIC CONDITIONS	CLEAR HEALTH ALLIANCE – HIV/AIDS	MAGELLAN COMPLETE CARE – SERIOUS MENTAL ILLNESS (SMI)	STAYWELL – SERIOUS MENTAL ILLNESS (SMI)	SUNSHINE HEALTH – CHILD WELFARE	DENTAQUEST	LIBERTY	MCNA DENTAL
1	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
2	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
3	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
4	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
5	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
6	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
7	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
8	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
9	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
10	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN

Contract Amendments

In February 2020, the Agency finalized an MMA plan General Contract Amendment.

In addition, the Agency executed updated Business Associate Agreement (BAA) amendments for each of the MMA Contracts. The BAA amendments have differing execution dates, which all occurred during Spring 2020.

There were also intermittent amendments processed for some of the SMMC plans for various administrative reasons, such as contract manager changes, plan address changes, etc.

In November 2019, the Agency amended its Department of Health (DOH) Children's Medical Services Plan Contract to address the Department's Specialty Plan and amended the contract again in May 2020 to reflect Children's Medical Services' Health Plan-specific rate changes.

Examples of changes made to the MMA contracts during DY14 include:

- Incorporating provisions for Enrollment Services in response to the federal CMS Checklist Item I.F.16.05.
- Technical corrections for Coverage and Authorization of Services to reflect 42 CFR 438.
- Added Early Intervention Service (EIS), Medical Foster Care (MFC) and Personal Care Services.
- Clarifying applicability of Child Health Targeted Case Management (TCM) services to all enrollees eligible for, or enrolled in, Early Steps.
- Requiring compliance with 42 CFR 438.14 (c)(3) regarding Indian Health Care Providers.
- Specifying plans' financial responsibility for post-stabilization care services to comply with 42 CFR 438 and 42 CFR 422.
- Incorporating CMS measures for Medicaid Managed Long-Term Services and Supports Plans (LTSS) Technical Specifications and Resource Manual, May 2019, and clarification of LTSS reporting requirements for transition period (across initial 2014-2018 SMMC Contracts and current 2018-2024 SMMC Contracts).
- Incorporating CAHPS for Children with Chronic Conditions Enrollee Satisfaction Survey requirements.
- Language added to reflect Program for All-Inclusive Care for Children (PACC) services as required, as well as incorporating Provider-Specific Performance Monitoring requirements for PACC.
- Modifying provisions for Network Management required by 42 CFR 438.12(a)(1) and item I.E.3.01 of the federal CMS checklist.
- Modifying provisions for Information Management and Systems to conform to 42 CFR 438.
- Technical corrections for Financial Requirements to reflect Florida statutory citation.

- Technical correction for Special Terms and Conditions to reflect federal regulation citation as 42 CFR 438.608(c)(d) regarding confidentiality.
- Modifying provisions for Reporting Requirements to comply with 42 CFR 457.1201(o).

The Model Contracts for both health and dental plans are available on the Agency's website: http://ahca.myflorida.com/SMMC

Communication to the MMA Plans

During DY14, the Agency released 53 plan communications. This included 50 policy transmittals and 3 contract interpretations.

Examples of DY14 Policy Transmittal Topics include:

- COVID-19 State of Emergency: Guidance, Coverage of Services, Temporary Expansion of Services, etc.
- Performance Measures for July Reporting
- Provider Satisfaction Survey
- Ad Hoc Requests for Information

A complete listing of the Agency's communications to the MMA plans is contained in **Attachment II**, and they are also available on the Agency's website: http://ahca.myflorida.com/SMMC.

1.2 MMA Plan Outreach

The MMA program facilitates outreach and informational opportunities for Florida Medicaid recipients. During the DY14 reporting period, plans either sponsored, co-sponsored, or participated in 3,612 events. This represents a 51% increase in events held in DY14 when compared to DY13 (2,398).

There are three types of events: public, educational, and marketing. The table below details the events held by each of the MMA plans.

Public, Educational, and Marketing Events Held by the MMA Plans

Plan	Marketing Events	Public Events	Educational Events	*Total*
Best Care Assurance, LLC/ Vivida Health	461	0	0	***461***
Florida Department of Health Children's Medical Services	108	0	0	***108***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	8	0	0	***8***
DentaQuest of Florida, Inc.	0	5	0	***5***
Florida Community Care, LLC	23	2	0	***25***
Humana Medical Plan, Inc.	0	56	5	***61***
Lighthouse Health Plan	427	23	4	***454***
Liberty Dental Plan of Florida, Inc.	0	7	1	***8***
Managed Care Plan of North America, Inc.	0	52	0	***52***
Florida MHS, Inc./Magellan Complete Care	39	17	0	***56***
Miami Children's Health Plan, Inc.	456	33	0	***489***
Molina Health Care of Florida, Inc.	11	16	4	***31***
South Florida Community Care Network, LLC/ Community Care Plan	0	22	0	***22***
Florida True Health Inc./Prestige Health Choice	0	4	2	***6***
Simply Healthcare Plans, Inc.	486	10	0	***496***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	1,120	3	0	***1,123***
Sunshine State Health Plan, Inc.	63	96	0	***159***
United Health Care of Florida, Inc.	31	17	0	***48***
Total	***3,233***	***363***	***16***	***3,612***

The MMA plans also produce and distribute marketing materials, which must be submitted to the Agency for approval prior to distribution. The MMA plans submitted 695 marketing materials in DY14, which was a 69% decrease from those submitted in DY13 (1,176).

There are four marketing material categories:

- **Branding:** Marketing through mass communication in some form of print media, such as newspapers, magazines, billboards, etc., with the purpose of influencing a potential enrollee to enroll and to contact the managed care plan for more information.
- **Nominal gifts:** An individual item or service worth fifteen dollars or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars per person, per year that is given away at events.
- **Scripts:** Written text of messages transferred or transmitted to a large group of people by managed care plan staff through a form of mass communication media, such as television, radio, or social networking. These messages are designed to promote the managed care plan and influence individuals to enroll in the managed care plan. Scripts also include the standardized text used by managed care plan staff in verbal interactions with potential enrollees designed to provide information and/or to respond to questions and requests, and that are intended to influence such individual to enroll in the managed care plan. Additionally, marketing scripts include any text included in interactive voice recognition and on-hold messages.
- **Written:** Printed informational material targeted to potential enrollees, which promotes the managed care plan, including, but not limited to brochures, flyers, leaflets or other printed information about the managed care plan. Written marketing material includes materials for circulation by physicians, other providers, or third parties.

The table on the following page details the types of materials the MMA plans submitted to the Agency, which were subsequently approved and utilized by the MMA plans.

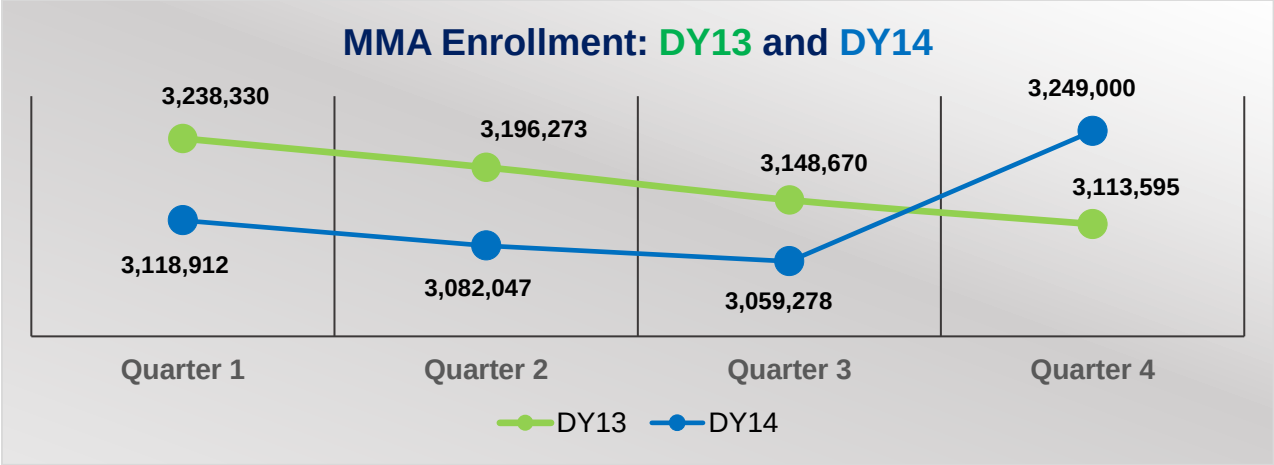
MMA Plan Materials Submitted to the Agency

SMMC Plan	Branding	Nominal Gifts	Scripts	Written	*Total*
Best Care Assurance, LLC/Vivida Health	0	27	59	8	***94***
Florida Department of Health Children's Medical Services	0	33	0	4	***37***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	0	0	0	2	***2***
DentaQuest of Florida, Inc.	0	0	0	0	***0***
Florida Community Care, LLC	0	7	0	1	***8***
Humana Medical Plan, Inc.	0	10	2	0	***12***
Lighthouse Health Plan	0	6	61	9	***76***
Liberty Dental Plan of Florida, Inc.	0	0	0	0	***0***
Managed Care Plan of North America, Inc.	0	0	0	0	***0***
Florida MHS, Inc./Magellan Complete Care	0	0	0	4	***4***
Miami Children's Health Plan, Inc.	4	0	11	1	***16***
Molina Health Care of Florida, Inc.	1	0	8	0	***9***
South Florida Community Care Network, LLC/ Community Care Plan	15	7	73	3	***98***
Florida True Health Inc./Prestige Health Choice	0	8	0	0	***8***
Simply Healthcare Plans, Inc.	18	48	48	11	***125***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	1	42	0	3	***46***
Sunshine State Health Plan, Inc.	2	40	70	4	***116***
United Health Care of Florida, Inc.	0	44	0	0	***44***
Total	***41***	***272***	***332***	***50***	***695***

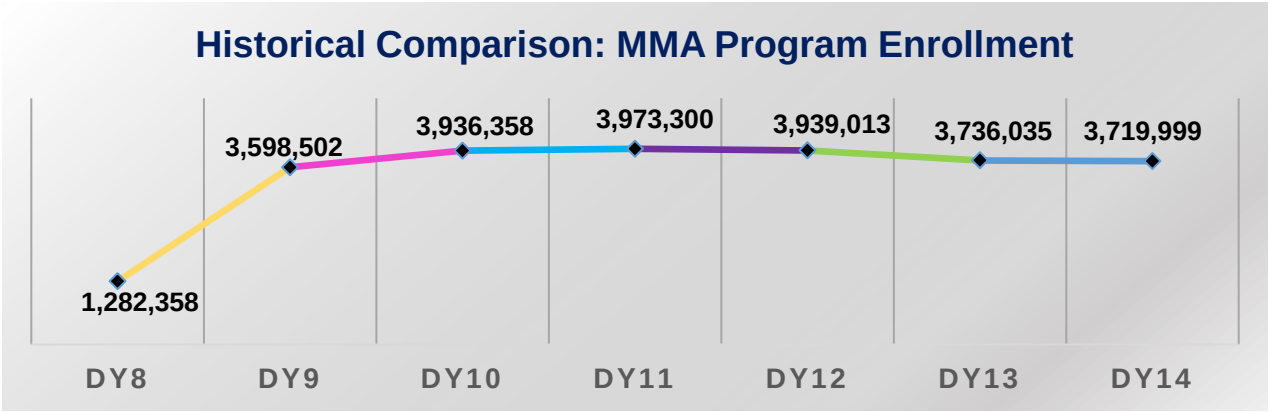
1.3 Enrollment and Disenrollment

Managed Medical Assistance Enrollment

Upon determination that an individual is eligible for Florida Medicaid, and that they are in an enrollment group designated as mandatory for managed care enrollment, the Agency immediately enrolls them into MMA health and dental plans. This enrollment process provides the individual immediate access to care, through an integrated delivery system, and grants them access to the expanded benefits available through their MMA plan. The following graph illustrates DY14 enrollment. There was a slight decline in enrollment during the first three quarters of DY14 followed by an increase during the fourth quarter. The first three quarters of DY14's enrollment decline is consistent with the overall Florida Medicaid enrollment trend of DY13, and the increase in enrollment during the fourth quarter is one of the impacts to Medicaid resulting from COVID-19 and the PHE. This upward trend is expected to continue into DY15, as one of the stipulations for the Agency to receive the increase to the Federal Medical Assistance Percentage (FMAP) was the implementation of the Maintenance of Effort requirements contained in Section 6008 of the CARES Act, which prohibits the disenrollment of Medicaid recipients during the PHE.



The following graph demonstrates enrollment in the MMA program since the program rolled out statewide in DY8. Enrollment trends in the MMA program typically follows overall Florida Medicaid enrollment trends.



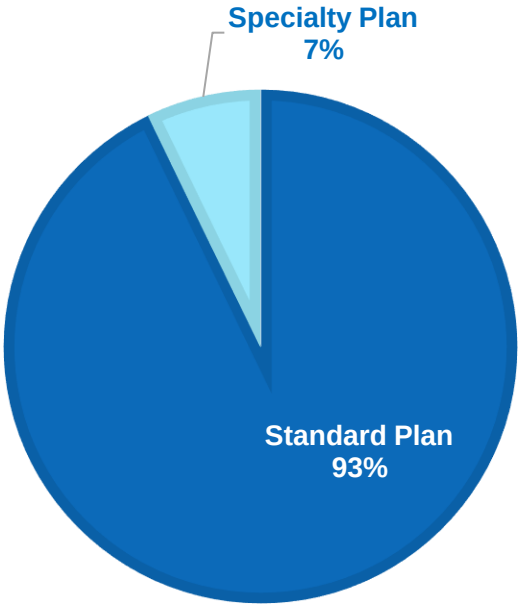
Specialty Plan Enrollment

Individuals eligible for the MMA program who have certain special conditions may enroll into one of the MMA specialty plans, if a specialty plan, focusing on their condition is available in their Medicaid region. Specialty plans are designed for target populations, such as children with chronic conditions or recipients who have been diagnosed with HIV/AIDS. Specialty health plan provider networks incorporate specialized clinical programs and/or providers with expertise to serve their target population. As the graph below illustrates, specialty plan enrollment represents 7% of the total MMA program population.

DY14 MMA Specialty Plan Enrollment

Enrollment Statistics:

Specialty Plan	267,122
Standard Plan	3,452,877
Total	3,719,999



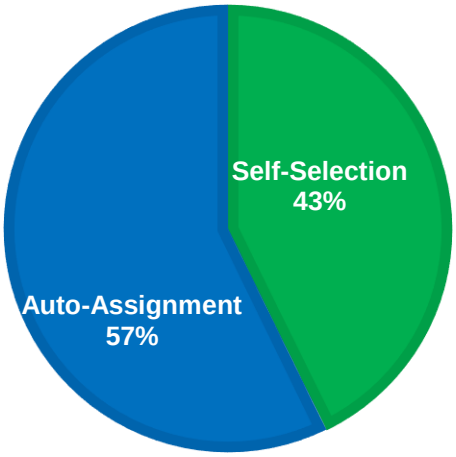
The complete MMA Enrollment Report is contained in **Attachment III.**

Self-Selection and Auto-Assignment

Florida encourages individuals to take an active role in the MMA plan selection process prior to or upon their eligibility determination. Information regarding the MMA plan enrollment process, as well as plan availability in their area, is provided upon submission of their Florida Medicaid eligibility application. If the individual does not select an MMA plan prior to being determined Medicaid eligible, the Agency utilizes an algorithm to select an MMA plan that fits their needs, and immediately enrolls them into that plan. This enrollment process ensures that there is no lag time in between eligibility determination and MMA plan enrollment, which grants recipients immediate access to care.

Individuals have 120 days after Medicaid enrollment to change managed care plans. Recipients who select their MMA plan prior to their eligibility determination or changed their plan during the 120-day post enrollment period, are categorized as self-selected and recipients who do not select an MMA plan are categorized as auto-assigned. The following chart details the self-selection and auto-assignment rates for DY14 and the subsequent graph illustrates past demonstration year data.

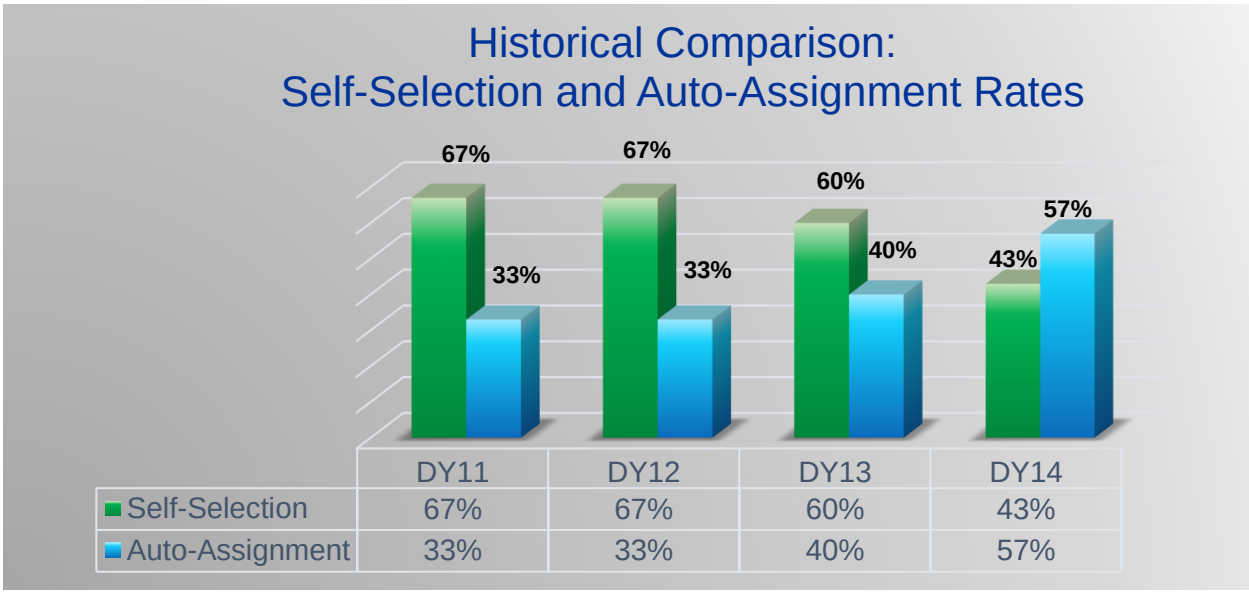
DY14
Self-Selection and Auto-Assignment



Auto-Assignment	427,745
Self-Selection	319,678

Auto-assignments outnumbered self-selections in DY14. During past demonstration years, self-selections outnumbered auto-assignments, and the rates of self-selection and auto-assignments have remained fairly consistent, with 60-67% of participants self-selecting and 33-40% being auto-assigned.

As illustrated below, in DY14 the self-selection and auto-assignment rates deviated from past trends, with the majority of individuals being auto-assigned to an MMA plan. This shift is due to the exclusion of reinstated individuals in self-selection data; reinstated individuals are those being reinstated with the plan they were enrolled with at the time they lost coverage. The Agency is excluding these individuals from the data, as they are not new enrollees. The exclusion of this group began this demonstration year, and the reinstated group is not reflected in either of the enrollment choice categories.



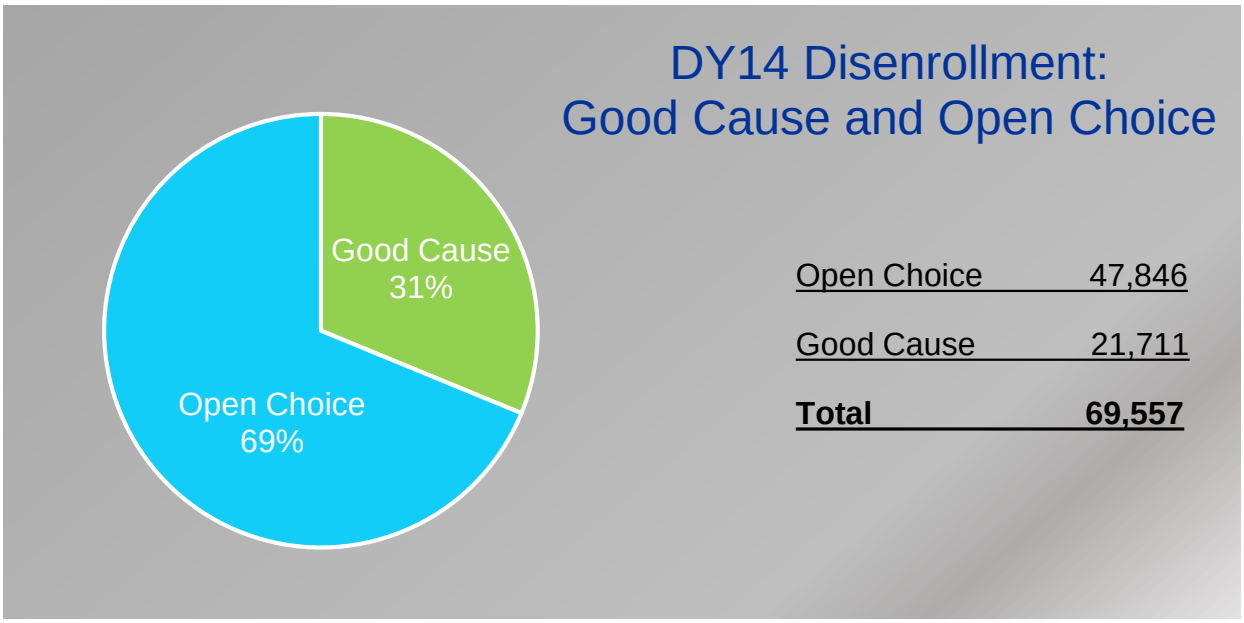
The increase in auto-assignments during DY14 can also be attributed to the success of the Agency's MMA plan assignment algorithm, as most recipients are not utilizing the 120-day post enrollment period to change their MMA plan, which would categorize them as a self-selection choice. This indicates that recipients are satisfied with the plan they are assigned based on the algorithm.

Managed Medical Assistance Disenrollment

The Agency differentiates disenrollment from an MMA plan in two ways:

1. Good Cause Disenrollment
2. Open Choice Period Disenrollment

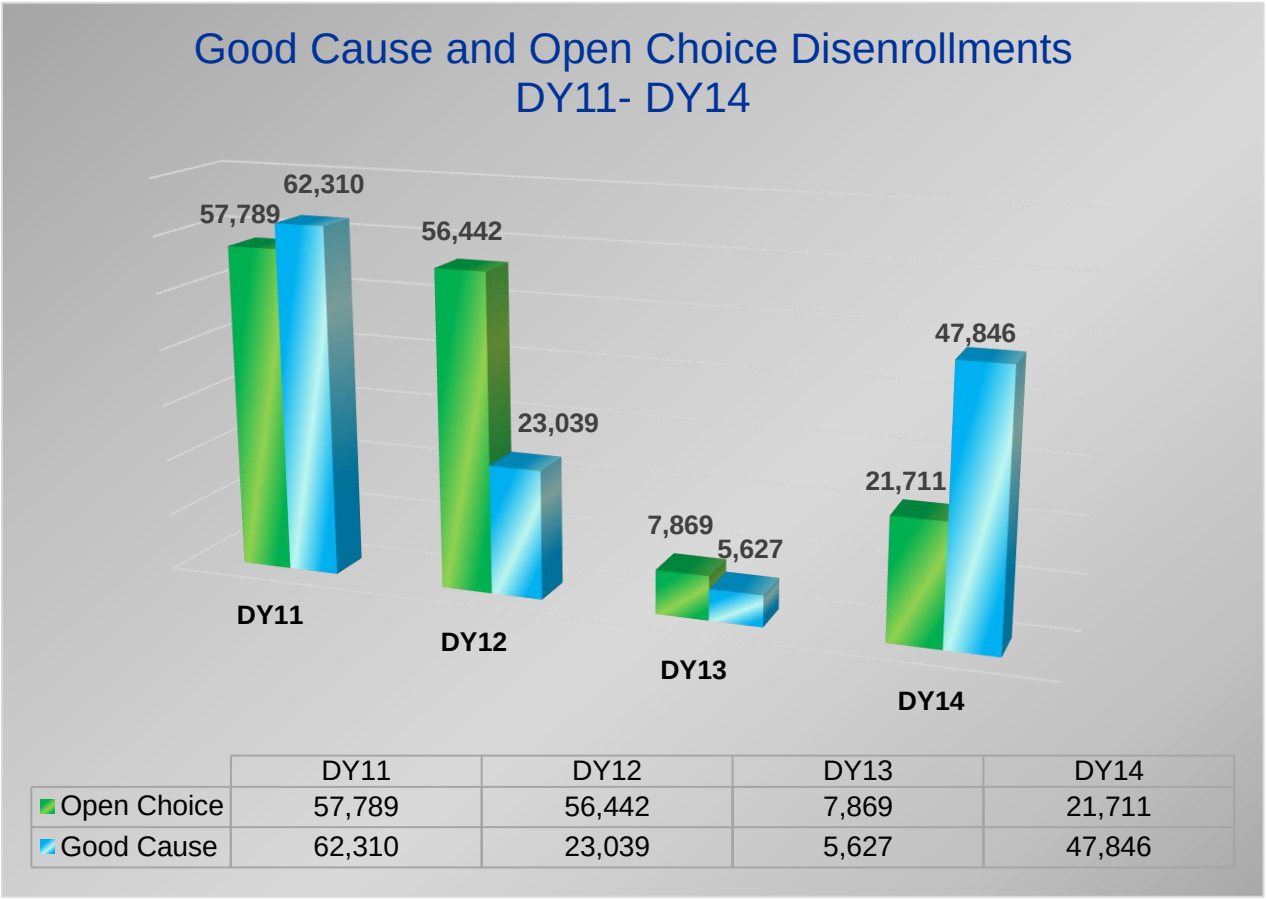
Good cause disenrollment occurs when an enrollee disenrolls from their MMA plan either outside of the 120-day post enrollment window or outside of their open enrollment period. Beyond the initial 120-days, and outside of the annual open enrollment period, disenrollment from an MMA plan is only permitted when there is good cause; good cause is defined in the Code of Federal Regulations. Open choice disenrollments are disenrollments that occur during the initial 120-day open choice period and/or during the annual open enrollment period, when recipients are permitted to change their MMA plans without cause. In DY14, open enrollment disenrollments accounted for approximately 69% of disenrollments.



Consistent with DY13, the DY14 disenrollment rate for open choice was greater than the good cause disenrollment rate. DY14 open choice disenrollments increased over those in DY13 (58%) and rose to a rate similar to the one experienced in DY12 (71%).

During DY13, the Agency was transitioning to new MMA health plan contracts; thus, good cause disenrollments were suspended for a portion of the year as individuals were given the opportunity to switch to new MMA plans. Similarly, and for the same reason, the normal open enrollment period was also suspended. This led to a decrease in disenrollments in DY13. The lifting of these suspensions led to the illusion of an increase in disenrollments in DY14 due to the return of normal open enrollment and good cause disenrollment procedures post-2018 MMA

plan contract implementation. However, the disenrollment numbers for DY14 represent a decrease when compared to DY11 and DY12.



	DY11	DY12	DY13	DY14
Open Choice	57,789	56,442	7,869	21,711
Good Cause	62,310	23,039	5,627	47,846

Dual Integration for Medicare Recipients

Individuals fully eligible for both Medicare and Florida Medicaid (dually eligible recipients) are required to enroll in an MMA plan to receive Florida Medicaid services. Dually eligible recipients who do not choose an MMA plan are auto-assigned to a plan using the dual integration auto-assignment algorithm. The algorithm promotes provider and service alignment between Medicare and Medicaid by enrolling dually eligible recipients who are enrolled in a Medicare Advantage plan into the MMA plan considered to be a "sister plan" to their Medicare Advantage plan, when available.

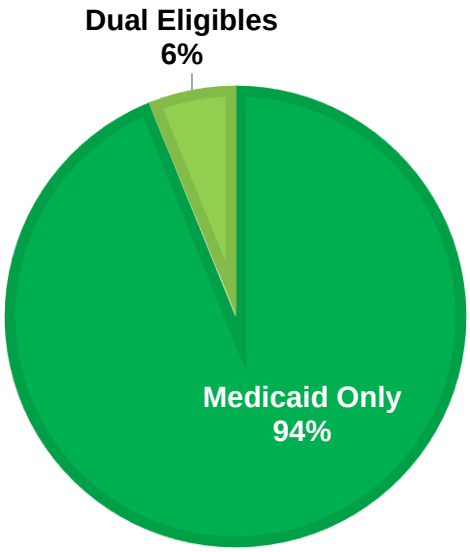
Dual integration enrollments primarily occur during the third quarter, which is when the Medicare open enrollment period occurs. However, in DY14, more dual eligible enrollments occurred in the fourth quarter.

The number of dually eligible recipients enrolled in MMA plans during DY14 was 228,014, which represents 6% of total MMA program enrollment. This enrollment figure is slightly lower than in DY13 when the dually eligible enrollment was 254,758, representing 7% of the total DY13 MMA program enrollment.

Dual Eligiblity Enrollment DY14

Eligibility Statistics:

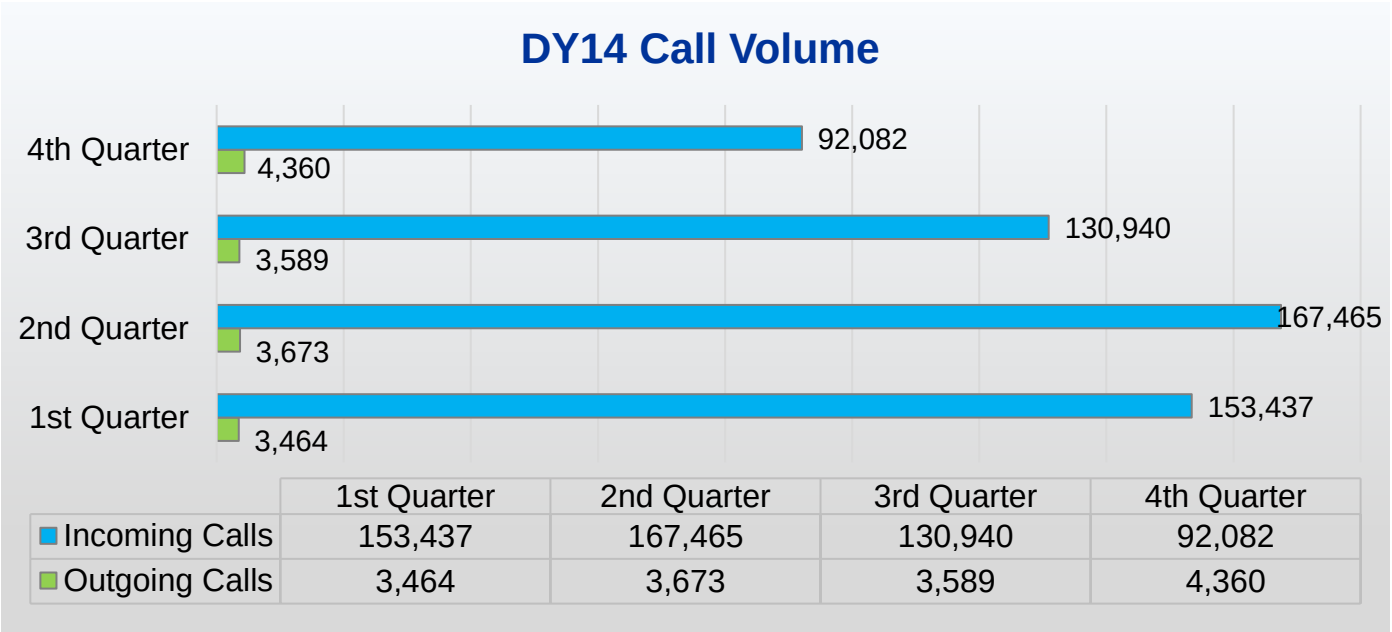
Medicaid Only	3,491,985
Dual Eligibles	228,014
Total	3,719,999



1.4 Choice Counseling Activities

The Agency contracts with an enrollment broker/choice counseling vendor to manage Florida Medicaid recipients' enrollment in, and disenrollment from, managed care plans. This includes the operation of the call center, enrollment website and member portal, and other outreach activities, such as mailings.

Choice Counseling Call Center



	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Incoming Calls	153,437	167,465	130,940	92,082
Outgoing Calls	3,464	3,673	3,589	4,360

Incoming calls represented approximately 97% of all call volume during DY14. As illustrated above, incoming call volume was higher during the first and second quarters of DY14 due to Open Enrollment and outgoing calls remained consistent throughout all four quarters.

DY14 call center trends are a deviation from past demonstration year call volumes. During DY12 and DY13, incoming call volume increased during the second and third quarters and were followed by an increase in outgoing calls during the third and fourth quarters, as shown in the below tables.

DY12 – DY14 Incoming Call Data

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DY12	179,051	190,081	232,108	205,394
DY13	197,946	246,427	268,406	159,582
DY14	153,437	167,465	130,940	92,082

DY12 – DY14 Outgoing Call Data

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DY12	549	549	4,053	2,091
DY13	1,851	2,745	3,529	3,493
DY14	3,464	3,673	3,589	4,360

However, DY12 and DY13 call activities were not indicative of a trend but are instead attributable to unique activities occurring during the same timeframes, second and third quarters, of the demonstration years.

In DY12, the call volume increases were due to consolidation of the 1915(c) Project AIDS Care Waiver, Adults with Cystic Fibrosis Waiver, and Traumatic Brain and Spinal Cord Injury Waiver into the SMMC program. During the second and third quarters, a large percentage of MMA recipients were permitted to change their MMA plans during open enrollment. This resulted in the higher incoming call volume initially and the higher outgoing call volume subsequently.

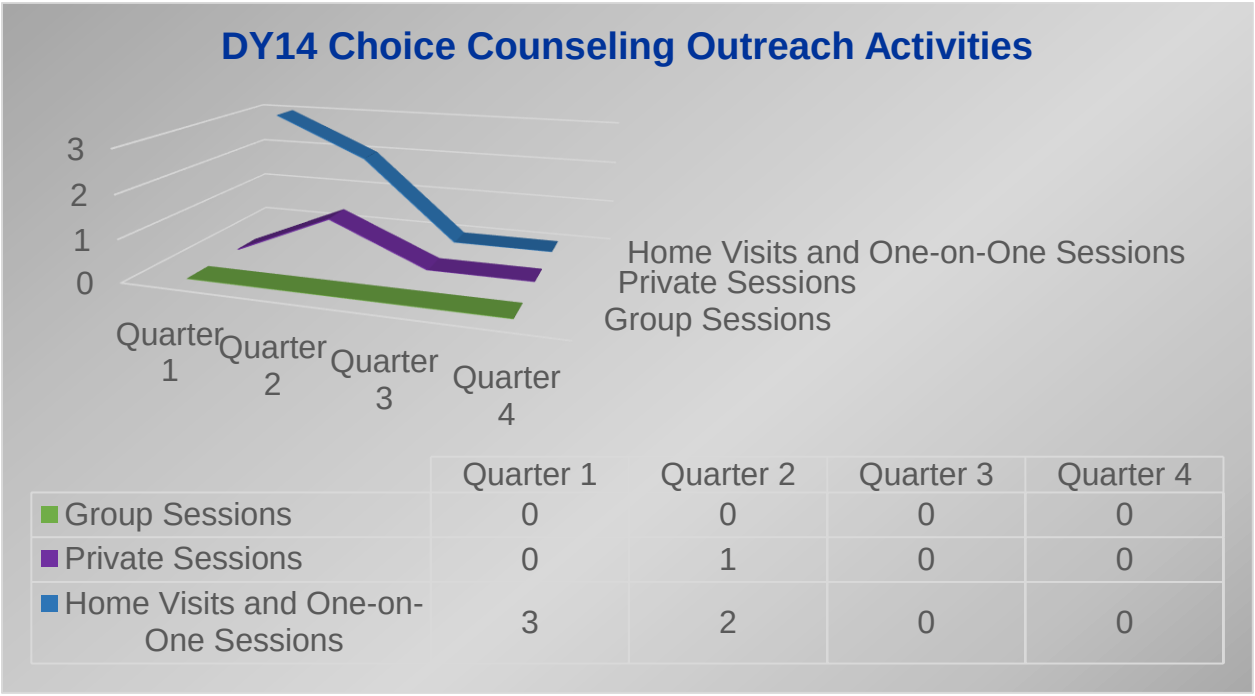
Similarly, in DY13 the Agency was transitioning to new MMA plan contracts, which involved MMA recipients selecting new MMA health plans. In both years, the Agency disseminated information and correspondence, during the second and third quarters, instructing MMA

recipients to select a new MMA health plan. This is what led to the increased call volume, both incoming and outgoing in DY12 as well as DY13.

DY14's call center volume followed the expected trend of outgoing calls remaining consistent throughout all four quarters and incoming call volume increasing during the second quarter, which is when the open enrollment period occurs.

Choice Counseling Outreach Activities

Choice counseling outreach activities include group counseling sessions, private counseling sessions, and home visits, which entail one-on-one counseling sessions. As illustrated in the following graphs, the overall demand for home visits and one-on-one choice counseling sessions continued to decrease in DY14; the maximum demand in DY14 was approximately 66% lower than DY13.



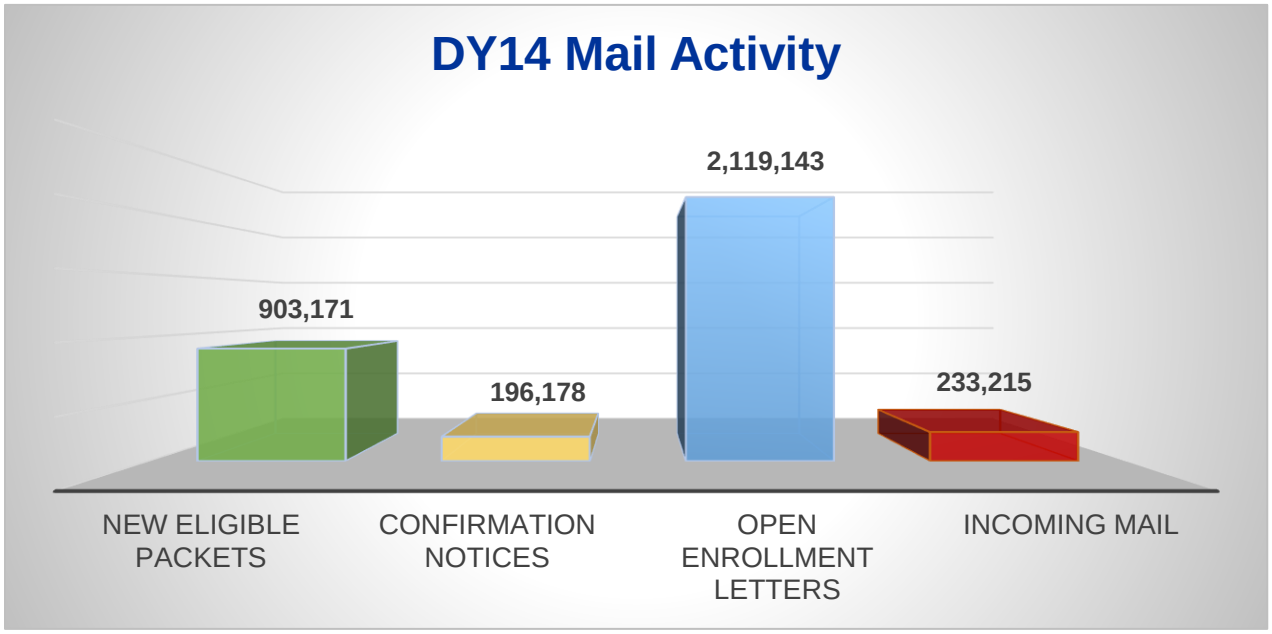
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Group Sessions	0	0	0	0
Private Sessions	0	1	0	0
Home Visits and One-on-One Sessions	3	2	0	0

The downward trend of recipients selecting the above in-person choice counseling outreach methods in DY14 is a continuation of a larger trend. This downward shift is due to recipients opting to access choice counseling services through the online portal, which now features a chat bot interface for recipients to ask questions or receive further personalized guidance, or the call center. Additionally, the drop across all three in-person choice counseling service options during the third and fourth quarters may also be attributable to the PHE as recipients are social distancing and limiting their in-person interactions.

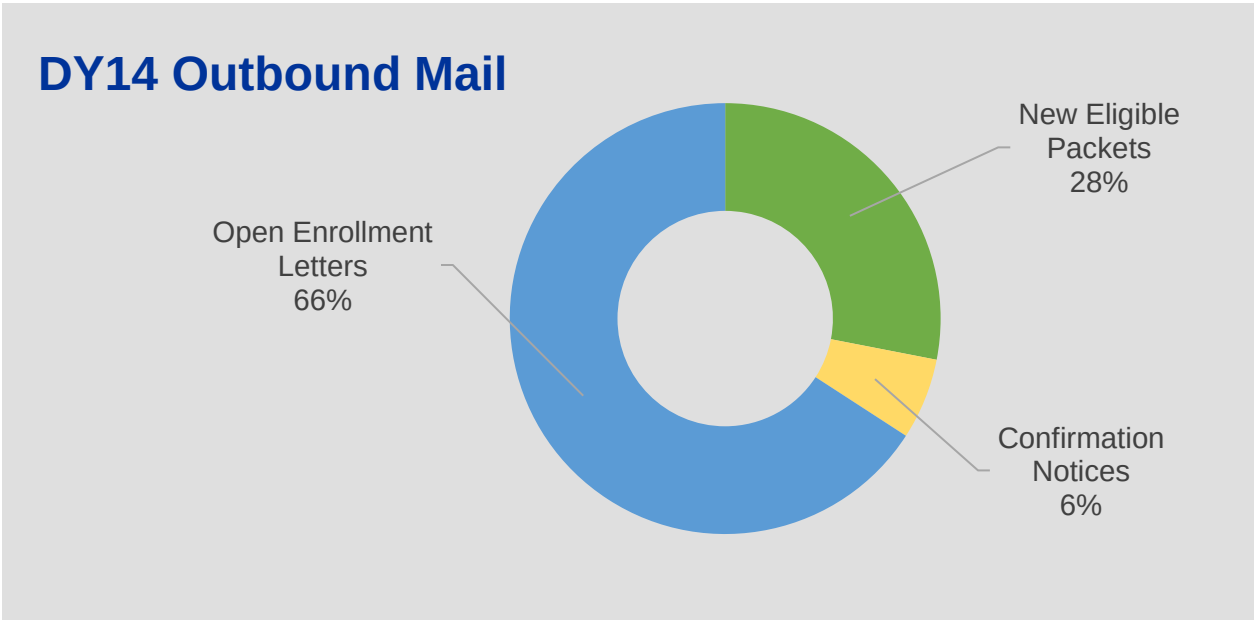
The decrease in recipients accessing these services is expected as the MMA program matures, and recipients become more comfortable and familiar with the program, including how to access assistance from the choice counseling vendor.

Choice Counseling Mail Activities

In addition to the other choice counseling activities listed previously, the Agency's choice counseling vendor conducts the mailing of the following items to MMA participants: SMMC transition letters, new eligible packets, transition packets, confirmation notices, and open enrollment letters. They are also responsible for processing incoming mail received from MMA participants. The DY14 mailing activity is as follows:



During DY14, the choice counseling vendor mailed 3,218,492 pieces to Medicaid recipients. Open Enrollment letters accounted for 66% of the total outgoing mail.



1.6 Demonstration Programs

1.6.1 Healthy Behaviors

In an effort to encourage Medicaid recipients to adopt healthier lifestyles and make behavioral changes that lead to improved health, Florida implemented Healthy Behaviors Programs. These programs encourage and incentivize healthy behaviors by offering structured interventions with rewards for recipients who participate in or complete the program.

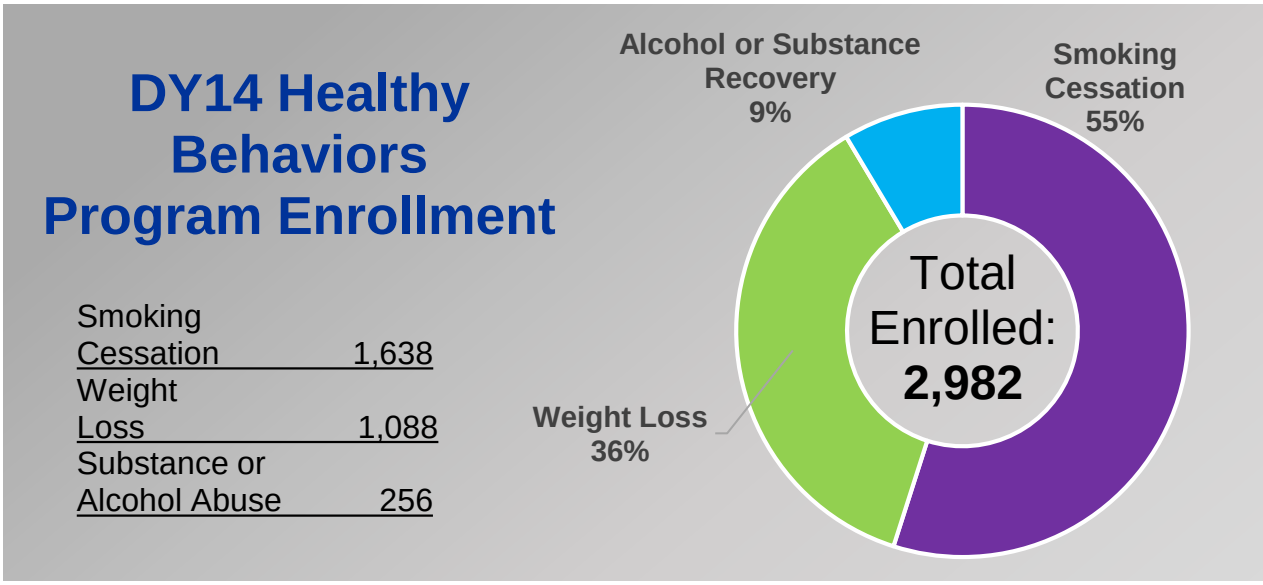
The MMA plans are required to offer the three following healthy behaviors programs:

- Medically Approved Smoking Cessation Program
- Medically Directed Weight Loss Program
- Alcohol or Substance Abuse Treatment Program

In addition to the required programs, the Agency encourages health plans to offer other healthy behaviors programs, and several plans offer additional programs such as managing diabetes, well child visits, and prenatal care, all of which are in line with the Agency's goals and areas of interest for the MMA program.

Itemized DY14 participation and completion data for the required Healthy Behaviors programs is in **Attachment IV**.

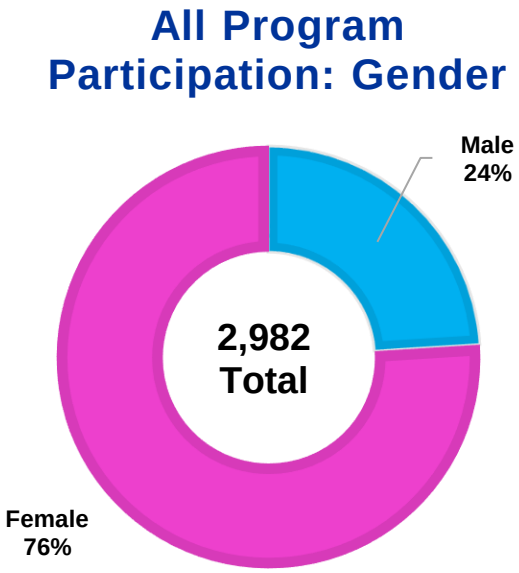
All of the Healthy Behaviors programs are voluntary for recipients and require written consent from each participant prior to enrollment into the program. The following charts provide participation data for the required programs in DY14.

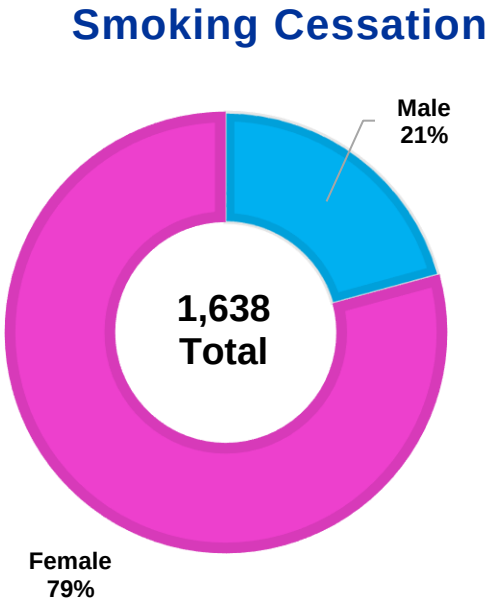


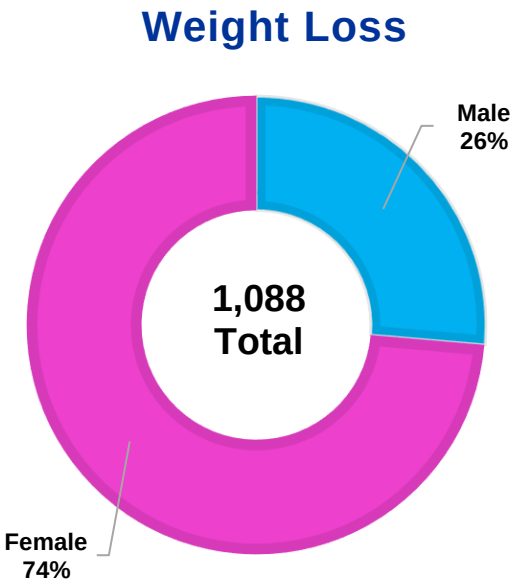
For the second consecutive demonstration year, the Medically Approved Smoking Cessation Program had the highest enrollment of all three of the Healthy Behaviors programs, followed by the Medically Directed Weight Loss Program. The Alcohol or Substance Recovery program continued to have the lowest overall enrollment in DY14.

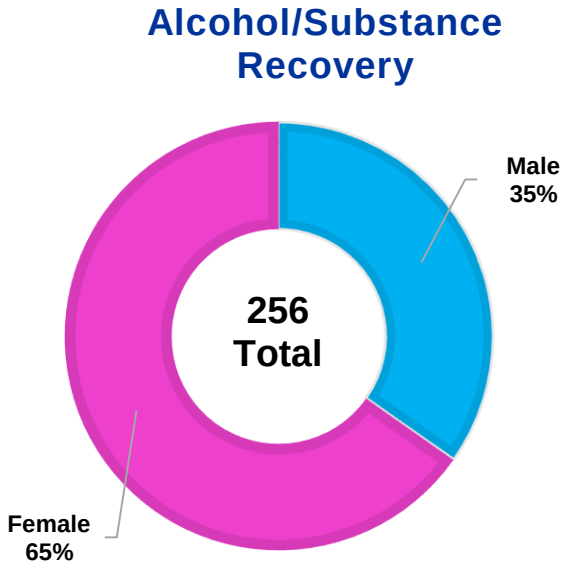
Healthy Behavior Program Participation: Gender

The demographic breakdown of Healthy Behaviors program enrollment by gender remained consistent with past demonstration years. Thus far, in the programs' history, females have made up a higher percentage of enrollees than males, overall and within each of the Healthy Behaviors programs, which remains true in DY14 as illustrated below.



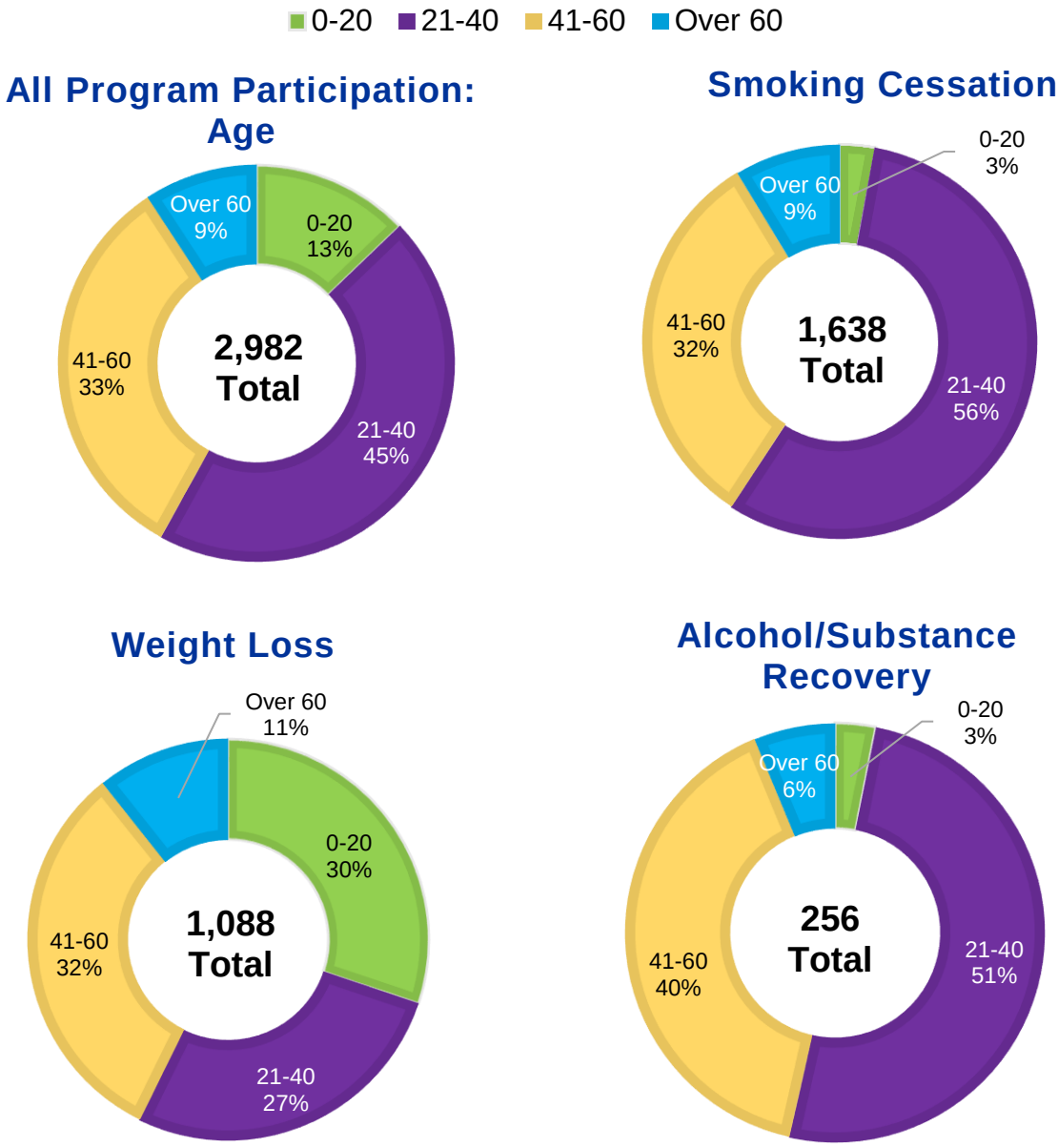






Healthy Behavior Program Participation: Age

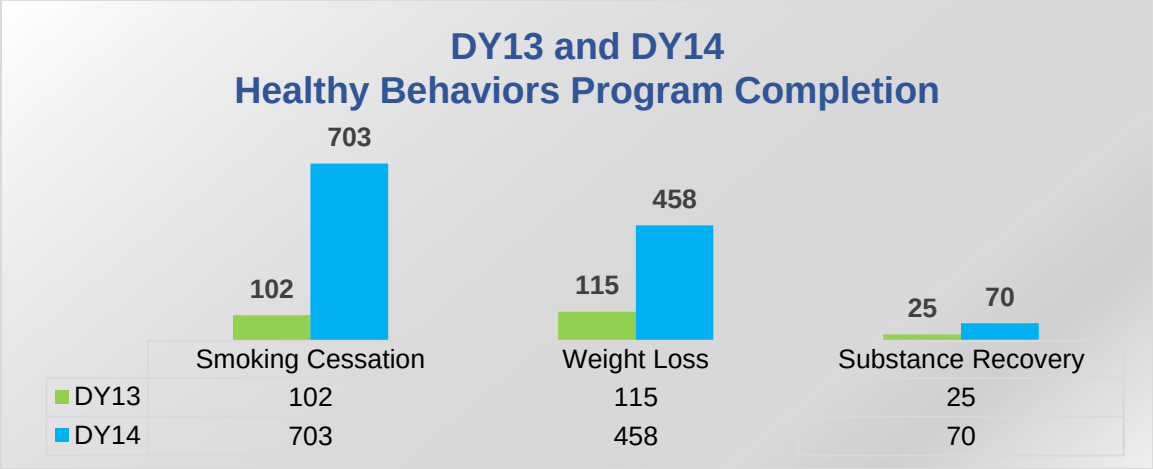
The demographic breakdown by age for the required Healthy Behaviors programs in DY14 was very similar to DY13. The 21-40 age bracket continued the increased enrollment trend, by increasing approximately 10 percentage points in DY14, and remained the age group with the highest enrollment rate. The only other age bracket to increase overall participation in DY14 was the 41-60 age bracket, which increased 5 percentage points. A notable change in the age distribution in DY14 compared to the previous demonstration year occurred within the weight loss program. While enrollees 0-20 years old made up 64% of participants in the weight loss program in DY13, they only made up 30% in DY14. Those ages 41-60 years only made up 13% of participants in DY13 but were 32% of participants in DY14.



DY14 Healthy Behavior Program Participation and Completion

Healthy Behaviors Programs	Program Enrollment	Program Completion	Percentage Completed
Medically Approved Smoking Cessation	1,638	703	43%
Medically Directed Weight Loss	1,088	458	42%
Medically Approved Alcohol or Substance Abuse Recovery	256	70	27%
Healthy Behaviors Program Total	**2,982**	**1,231**	**41%**

The Healthy Behaviors program completion rate increased drastically across all three of the required Healthy Behaviors programs from DY13 to DY14. In DY13, the completion rate for each of the required programs was less than 1%. In DY14, completion rates ranged from a low of approximately 27% (Medically Approved Alcohol or Substance Abuse Recovery) to a high of approximately 43% (Medically Approved Smoking Cessation). The overall completion rate among the three programs was 41%. The graph below illustrates Healthy Behaviors program completion for DY13 and DY14.



1.6.2 Low Income Pool (LIP)

Program Description

On October 19, 2005, CMS approved Florida's 1115 Research and Demonstration Waiver relating to Medicaid reform. In the original waiver, the Low Income Pool (LIP) program was established to ensure continued support for the provision of health care services to Medicaid recipients, the under insured, and uninsured populations. The LIP program has evolved

throughout the demonstration's operation and is now a charity care pool that can be used to compensate hospitals, medical school faculty practice plans, federally qualified health centers, rural health clinics, and community behavioral health providers for their uncompensated charity care.

Demonstration Year 14 Update

During DY14, the Agency submitted the following Final Reports on the LIP program to CMS:

- SFY 2020-21 Projected LIP Distribution
- SFY 2019-20 1115 Managed Medical Assistance Waiver, LIP FQHC Amendment
- SFY 2018-19 LIP Payments and FY 2018 Charity Care Report
- SFY 2018-19 Final Intergovernmental Transfer Report

Process and Findings

LIP funding supports providers that furnish uncompensated charity care to low-income individuals who are uninsured. Hospitals, federally qualified health centers (FQHCs), rural health clinics (RHCs), medical school faculty physicians, and community behavioral health providers are eligible to receive LIP funds. In order to receive LIP funds, providers must meet the participation requirements in STC #71.

The LIP Program pays providers based on their charity care cost. First, hospitals are ranked from high to low based on their percentage of charity care costs to commercial costs as well as statutory designations and ownership status. Then, providers are divided into tiers based on their level of charity care cost to commercial costs and are paid a prescribed percentage of their charity care cost. Providers may be paid up to 100% of their charity care costs.

The funding for the LIP program is contingent upon the availability of local government funds called intergovernmental transfers (IGTs) that must be contributed, as state match, to pull down federal matching funds. The state matching percentage is based on the FMAP.

IGT providers must sign a letter of agreement with the Agency. These agreements specify the amounts that the Agency can collect from each governmental entity, which then submit these funds via IGTs to the Agency. The Agency uses those funds for drawing down the federal matching share of LIP funds.

In DY14, there were 89 IGT providers that contributed IGTs in the amount of $327,505,871.

The total LIP allotment for each demonstration year (DY12 through DY16) is capped at $1,508,385,773.

- In DY14, $1,004,416,132 was paid out to eligible providers.
- In DY13, $857,693,316 was paid out to eligible providers.

1.6.3 Prepaid Dental Health Program

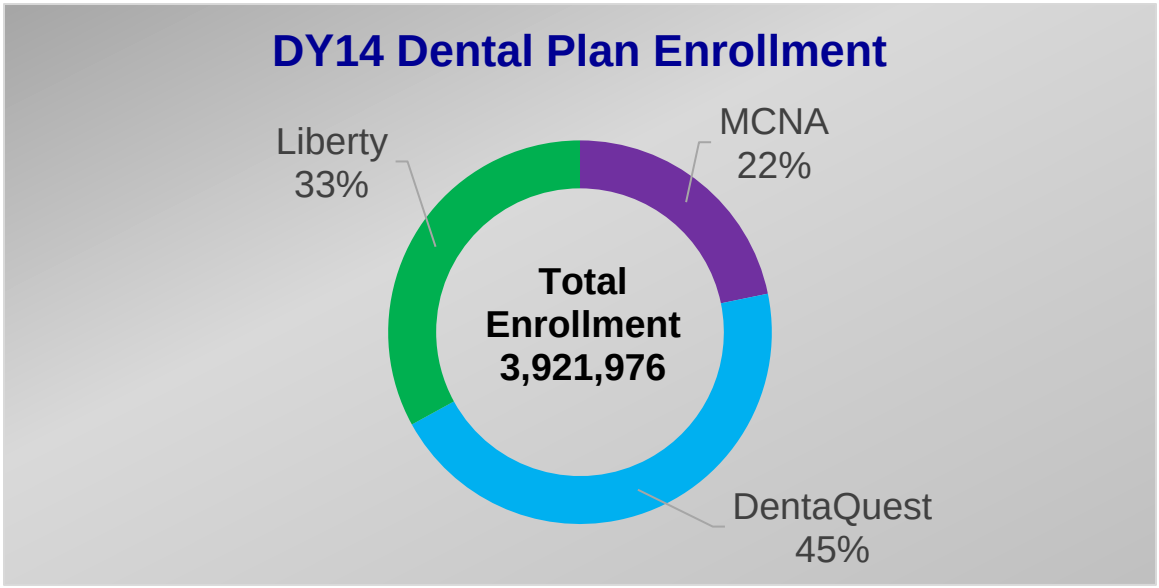
Operational Update

Following CMS' approval, the Agency completed the implementation of the Prepaid Dental Health Program during DY12. There are three prepaid dental health plans contracted with the Agency and each of the plans are available in all 11 Medicaid regions. The contracted dental plans are DentaQuest, Liberty, and MCNA Dental. Almost all Florida Medicaid recipients receive their dental services through the MMA dental health plans.

In addition to providing preventive and therapeutic dental coverage, the dental health plans also offer expanded benefit packages under which they provide preventive, diagnostic, and restorative care services, including periodontics, oral, maxillofacial surgery, and diabetic testing. This gain was significant for Florida Medicaid recipients, as previously, adults enrolled in Florida Medicaid received limited dental services including dentures and emergency services to relieve pain and infection.

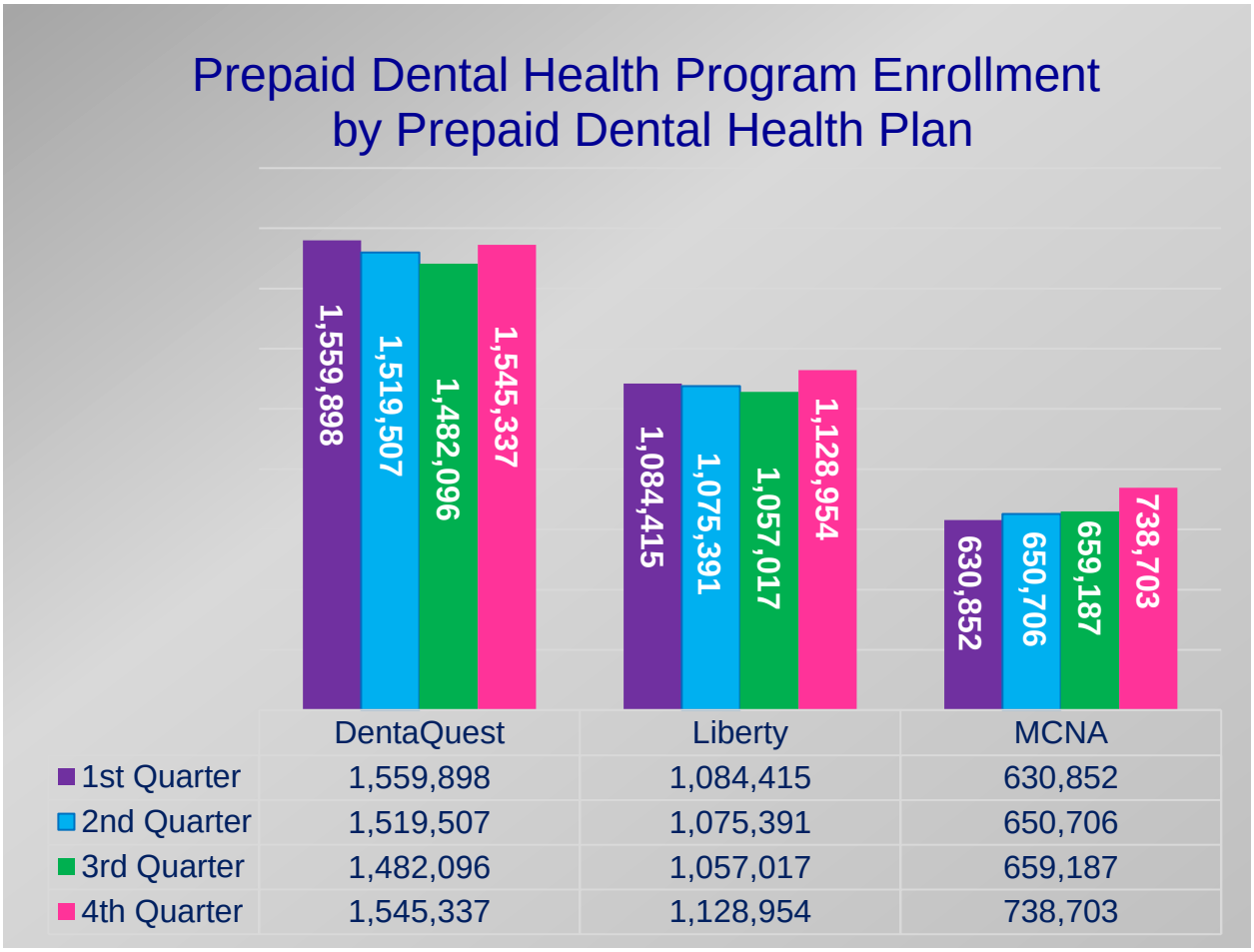
Prepaid Dental Health Plan Enrollment

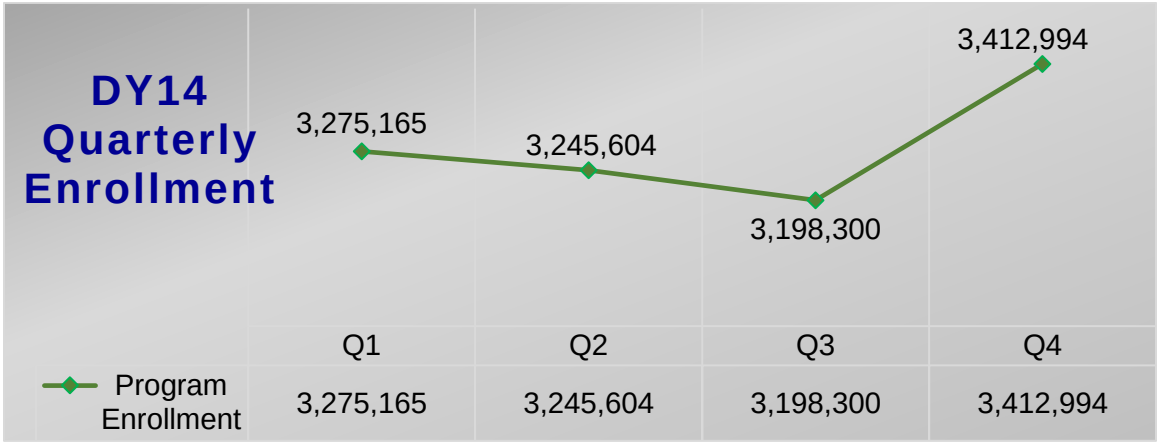
There were 3,921,976 Florida Medicaid recipients enrolled in the Prepaid Dental Health Program in DY14. The chart and table below illustrate the program enrollment by Dental plan, which is also contained in **Attachment III**.



DY14 Prepaid Dental Health Plan Enrollment	
Plan Name	**Enrollment**
Liberty	1,293839
DentaQuest	1,773,930
MCNA	854,207
Total	**3,921,976**

The graphs below detail DY14 enrollment, first by plan and quarter followed by the total quarterly enrollment, for the Prepaid Dental Health Program. As the graphs illustrate, enrollment in DentaQuest and Liberty decreased during the first three quarters of DY14 but increased during the fourth quarter to enrollment totals comparable to their first quarter enrollment figures. However, MCNA's enrollment steadily increased throughout all four demonstration year quarters, with the largest increase occurring during the fourth quarter. The fluctuations in the Prepaid Dental Health Program enrollment followed the expected trend as Medicaid enrollment decreased during the first three quarters and increased during the fourth quarter.

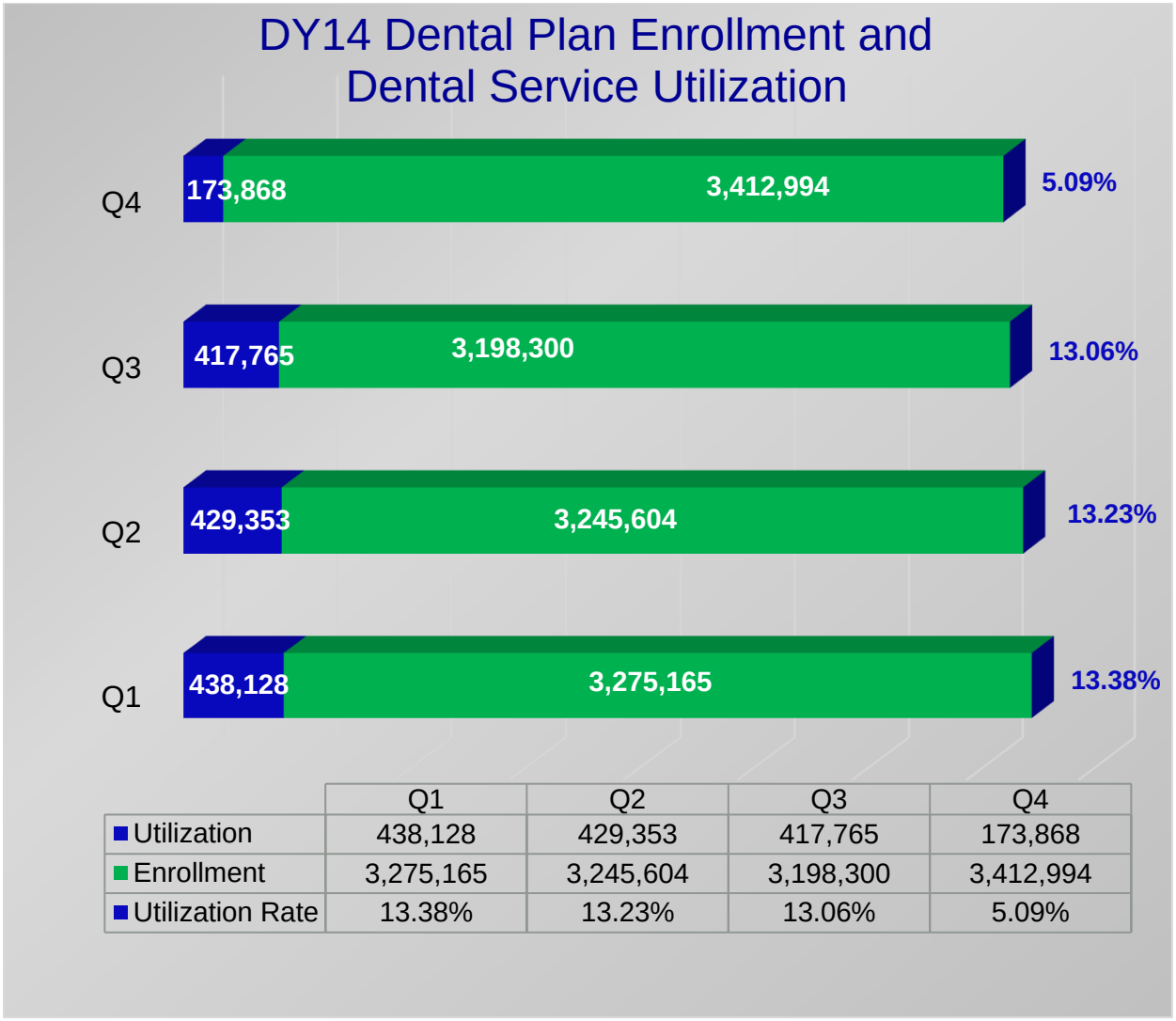




Utilization

Similar to the variations experienced in the Prepaid Dental Health Program's enrollment, service utilization steadily decreased throughout DY14, as the graph below demonstrates. However, the number and rate of service utilizations did not experience the same increase during the fourth quarter as the overall program enrollment did. This is due to the Public Health Emergency and the limitations implemented for public safety.

Service utilization, in this instance, is based upon the number dental service claims submitted by Prepaid Dental Health Program providers, and as such, the figures reflected in the chart will increase over time, as providers may not yet have billed for services rendered during this time period. The graph below illustrates quarterly program enrollment, service utilization, and the utilization rate.



	Q1	Q2	Q3	Q4
Utilization	438,128	429,353	417,765	173,868
Enrollment	3,275,165	3,245,604	3,198,300	3,412,994
Utilization Rate	13.38%	13.23%	13.06%	5.09%

1.6.4 Retroactive Eligibility Waiver

Operational Update

Background

In 2018, the Florida Legislature directed the Agency to request federal approval to eliminate retroactive Medicaid coverage for non-pregnant adults. The Agency subsequently submitted an amendment request to CMS for approval, and the change took effect on February 1, 2019.

Per the approved waiver of retroactive eligibility, the MMA Waiver now states that the Agency shall make payments for Medicaid-covered services, for Medicaid eligible children and pregnant women, retroactively for up to 90-days prior to the month in which an application for Medicaid was submitted. For Medicaid eligible non-pregnant adults, payments for Medicaid-covered services are retroactive to the first day of the month in which the Medicaid application was submitted.

The Agency's analysis determined approximately 39,000 non-pregnant adult recipients were made retroactively eligible in DY10, representing less than 1% of all Florida Medicaid recipients.

Communication Strategies

The Agency has a robust outreach and communication system used to disseminate information to interested stakeholders about the Florida Medicaid program and the waiver of retroactive eligibility. The Agency's goal is to ensure potential recipients understand the importance of applying for Florida Medicaid timely, and to encourage providers and stakeholders, who help individuals enroll in Florida Medicaid, to ensure individuals apply at the earliest opportunity when in need of services. This promotes personal responsibility, as individuals are encouraged to secure and keep health coverage. The Agency continues to make Medicaid program information available by:

- Sending electronic provider alerts,
- Maintaining retroactive eligibility information on the Agency's and its partners' (e.g., the Department of Children and Families, which processes eligibility applications) websites,
- Communicating with associations representing hospitals and nursing facilities, and
- Ensuring appropriate State call center and information hub staff are trained, understand the policy change, and can answer caller questions.

The Department of Children and Families (Department) developed an internal spotlight communication available to both internal Department staff and interested external parties. The Department also engaged community partners with information sharing on the changes to retroactive eligibility policy.

In addition to specific outreach on the change to retroactive eligibility policy, the Department and the Agency continue to provide an array of outreach to raise awareness of available assistance programs and how to apply. Through the different educational programs and community networks, the Department provides awareness to a diverse population.

The Department has several Supplemental Nutrition Assistance Programs (SNAP) that include educational and outreach components to increase customers' ability to access SNAP program information, and if an individual applies for SNAP, they can use the same application process to apply for Medicaid.

The Department uses its network of Community Partner Liaisons (CPL) to engage in different pathways for outreach and increased awareness of resources customers can access, including but not limited to the Medicaid program. CPLs distribute Economic Self-Sufficiency (ESS) materials, conduct ESS presentations, and work directly with community members while networking with appropriate community organizations. The CPL's also assist in community outreach and health fair activities. The CPL's attend up to 80 community fair events a year, per region.

The Department has made extensive use of social media tools, press releases, and website alerts as pathways to increase outreach and engagement with customers accessing benefits.

The Agency has had success with the different forms of outreach through its contract with the Florida Healthy Kids Corporation. The Florida Healthy Kids Corporation is tasked in Florida statute with promoting Kidcare, the State of Florida's high-quality, low-cost health insurance for children, from birth through age 18. Although Florida Kidcare is primarily concerned with a different population than is impacted by the waiver of retroactive eligibility, the program has demonstrated multiple successful marketing strategies for targeted outreach to a traditionally difficult-to-contact population. Additionally, when an individual applies for Kidcare for a child, they can also apply for coverage for adult Medicaid. Research has shown that outreach and marketing for CHIP also increases enrollment in Medicaid, and vice versa, since the application process can be initiated through either program.

Florida Healthy Kids utilizes a broad network of community partners providing 'boots on the ground' and a trusted, one-on-one avenue for application. Healthy Kids has routinely employed newsletters, community events, text alerts, online alerts, and infographics, for the purpose of communicating targeted Medicaid information to a variety of audiences, including partnering with area non-profits and hospitals.

Additionally, digital and social media advertising expands awareness, generates applications and supports enrollment growth. Benefit-specific messaging differentiates Florida Kidcare plans from private market offerings, while encouraging utilization and retention. Between October 2018 and June 2019, paid search advertising generated 15,575 completed applications. During October 2018, a mental health awareness social media advertising campaign was launched on Facebook and Instagram to highlight the mental and behavioral health benefits available through Florida KidCare. This one-month campaign reached 670,799 Florida parents, and total of 141 new accounts were created.

Social media advertising has provided consistent outreach and can be a useful tool to use for outreach efforts in additional programs. A pilot paid advertising campaign leveraging a new online eligibility calculator ran in June 2019 on Facebook, Instagram, and Programmatic Display. The campaign generated 2,519,787 total impressions and 559 new accounts.

1.6.5 Behavior Health and Supportive Housing Assistance Program

Program Overview

In March 2019, the Agency received approval to operate the Behavioral Health and Supportive Housing Assistance pilot program in Medicaid Regions 5 and 7. This program provides housing support services to recipients who have a severe mental illness (SMI), substance use disorder (SUD), a combination of SUD and SMI, and are homeless or at risk of being homeless. The program went live on December 1, 2019.

- Region 5 consists of Pasco and Pinellas counties (St. Petersburg, Clearwater)
- Region 7 consists of Seminole, Brevard, Orange, and Osceola counties (Orlando, Kissimmee, Titusville)

Four MMA plans were selected to participate in the pilot program, and services are available to their enrollees who qualify and reside within Medicaid regions 5 and 7:

1. Magellan
2. Staywell
3. Aetna
4. Simply

Pilot Services

The following services are authorized under the Behavioral Health and Supportive Housing Assistance pilot:

- **Transitional Housing Services:** Services that support a member in the preparation for and transition into housing. This includes but is not limited to:
  - Conducting tenant screenings and housing assessments
  - Developing individualized housing support plans
  - Assisting with housing searches and the application process
  - Identifying resources to pay for on-going housing expenses such as rent
  - Ensuring that living environments are safe and ready for move-in
- **Tenancy Sustaining Services:** Services that support a member in being a successful tenant.
  - Early identification and interventions for behaviors that may jeopardize housing such as late rental payment or other lease violations
  - Education and training on the roles, rights and responsibilities of the tenant and landlord
  - Coaching on developing and maintaining key relationships with landlord/property managers
  - Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction, advocacy and linkage with community resources to prevent eviction,
  - Assistance with the housing recertification process
  - Coordinating with enrollees to review, update, and modify their housing support and crisis plans

- **Mobile Crisis Management:** The delivery of immediate de-escalation services for emotional symptoms, and/or behaviors at the location in which the crisis occurs. Provided by a team of behavioral health professionals who are available 24/7 for the purpose of preventing loss of a housing arrangement or emergency inpatient psychiatric service when possible.
- **Self-Help/Peer Support:** Person-centered service promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist.

DY14 Program Activities

In November 2019, the Agency held two kickoff events for the Behavioral Health and Supportive Housing Assistance pilot, one in Region 5 and one in Region 7. The then-Secretary of the Agency presented at both events, as well as representatives from the health plans participating in the pilot and local housing and homelessness stakeholders. The Agency also published a press release, which is available at: https://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/HousingPilotPressRelease.pdf. The MMA plans were awarded contracts and began working with individual healthcare providers and community partners to establish their networks for providing program services.

In December 2019, the MMA plans began enrolling members and providing services while continuing to build and expand their provider networks.

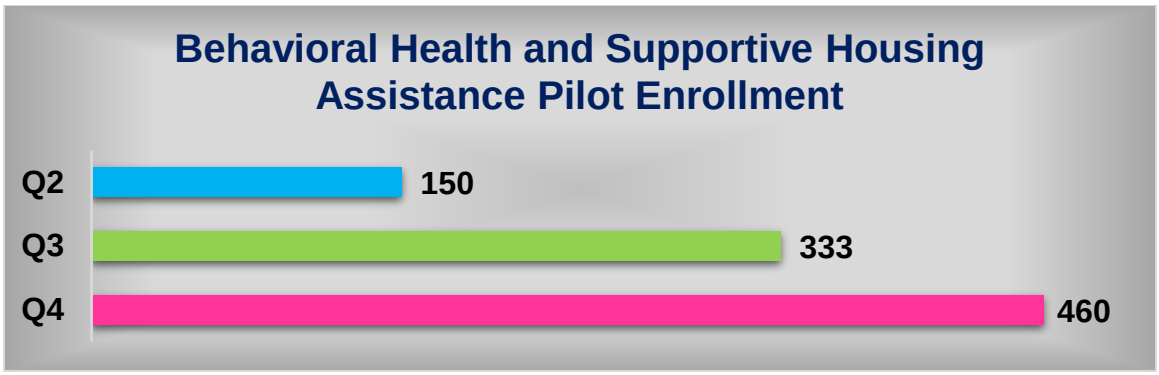
The Agency planned a check-in for both pilot regions in March 2020, but this was cancelled due to the COVID-19 pandemic. A conference call was held in lieu of the face-to-face meeting. This allowed the health plans an opportunity to discuss their individual housing programs and share the challenges and successes they had experienced thus far.

The MMA plans made adjustments in response to the impacts of COVID-19 including adapting communications to be conducive to telephonic delivery, altering the way potential participants are identified, and adjusting the methodologies in place for providing case management and pilot services such as permitting the use of telemedicine. Many methods were utilized by the MMA plans to ensure all individuals enrolled in this program were able to stay in contact with their case managers and utilize all available services as necessary.

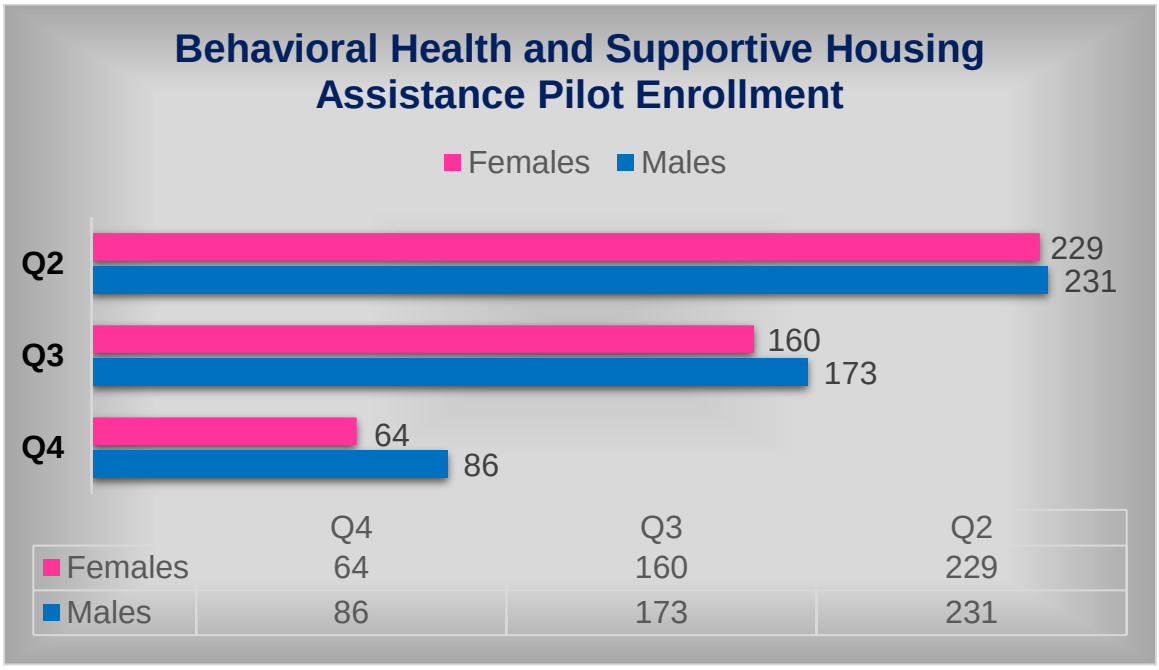
The MMA plans are continuing to enroll members and provide pilot services. As the pilot continues in the midst of COVID-19, the Agency and MMA plans are developing best practices for case management, service delivery, and implementation strategies.

Enrollment

As illustrated in the graph below, enrollment in the Behavioral Health and the Supportive Housing Assistance pilot continued to increase throughout all of the DY14 quarters in which the program was active. The second quarter enrollment data only includes the month of December.



Males outnumbered females enrolled in the program across all three DY14 quarters:



The average age of participants enrolled in the Behavioral Health and Supportive Assistance program was 47; enrollment by age group is detailed in the table below.

Participant Count by Age Group	Q2	Q3	Q4
Age 21-40	48	100	150
Age 41-60	88	195	263
Over 60	14	40	50

The Agency is actively monitoring utilization trends. It is important to recognize in regard to utilization that the pilot program has been operational for less than a year, during which the COVID pandemic also had significant impacts.

DY14 Performance Measures

The MMA plans participating in the Behavioral Health and Supportive Housing Assistance pilot report performance measures on a quarterly basis. For each of the performance measures, the plans report the number of participants, defined as those who were enrolled in the pilot for at least one month during the quarter, and the percentage of participants who took advantage of each of the pilot services.

It is important to note that reports of service utilization are based on claims/encounters, thus the data detailed in the following table may change as providers continue to file claims for services rendered with the MMA plans. Additionally, the enrollment totals for each of the quarters are slightly lower than those reported above as the plans reported additional enrollees after the performance measures were captured. In the following table, 'Rate across Plans' is the Service Utilization Rate.

DY14: Q2 – Q4 Quality Performance Measure Summary			
Measures	**Q2 (December 2019)**	**Q3**	**Q4**
	Rate across Plans	Rate across Plans	Rate across Plans
Participants with a Comprehensive Health Risk Assessment	83%	79%	74%
Participants that received at least one core pilot service	14%	11%	19%
Participants whose housing condition was upgraded	3%	9%	13%
Participants who had stable permanent housing	27%	23%	38%
Participants with an SUD diagnosis who received medication and behavioral therapy	6%	9%	8%
Participants with SUD diagnosis who report no drug use	62%	52%	40%
Participants with an SMI diagnosis who are compliant with medication management requirements	66%	63%	81%
Participants who achieved permanent housing	1%	2%	4%

Second Quarter

During the second quarter, which only includes the month of December, there were 146 beneficiaries enrolled in the pilot. Of those:

- 83% of pilot participants received a Comprehensive Health Risk Assessment;
- 14% received at least one core pilot service;
- 27% of participants had stable permanent housing;
- 3% of participants had their housing condition improve; and
- 1% achieved permanent housing.

Across all of the participating MMA plans, 93 pilot participants were diagnosed with a substance use disorder (SUD) and 137 participants were diagnosed with a serious mental illness (SMI).

Of the 93 participants diagnosed with a SUD, 6% received medication and/or behavioral therapy services, and 62% reported no drug use.

Of the 137 participants diagnosed with an SMI, 66% complied with their medication management requirements.

Third Quarter

During the third quarter, which was the first full quarter of the pilot, plans reported 322 participants enrolled in the pilot for at least one month of the quarter. Of those:

- 79% of participants received a Comprehensive Health Risk Assessment;
- 11% received at least one core pilot service;
- 23% of participants had stable permanent housing;
- 9% of participants had their housing condition improve; and
- 2% achieved permanent housing.

Across all of the participating MMA plans, 181 pilot participants were diagnosed with a SUD and 294 were diagnosed with an SMI.

Of the members diagnosed with a SUD, 9% received medication and/or behavioral therapy services and 52% reported no drug use.

Of the participants with an SMI diagnosis, 63% were compliant with medication management requirements.

Fourth Quarter

During the fourth quarter, the total pilot program enrollment as reported by the MMA plans was 409 participants. During this quarter:

- 74% of pilot participants received a Comprehensive Health Risk Assessment;
- 19% received at least one core pilot service;
- 38% of participants had stable permanent housing;
- 13% of participants had their housing condition improve; and
- 4% achieved permanent housing.

Across the plans, 207 of pilot participants were diagnosed with a SUD and 361 were diagnosed with an SMI.

Of the participants diagnosed with a SUD, 8% received medication and/or behavioral therapy services and 40% reported no drug use during the quarter.

Of the 361 participants with an SMI diagnosis, plans reported that 81% were compliant with medication management requirements.

When MMA plans reported data for the fourth quarter, there were several new performance measures. The new performance measures apply to participants who were enrolled in the previous quarter, and they assess whether the participant had a change from the third quarter to the fourth quarter. The MMA plans reported improvement across all three of the new performance measures.

New Q4 Performance Measures	
Measure	**Rate across Plans**
Percent of participants whose days of homelessness were reduced during the quarter	40%
Percent of participants with reduced emergency department (ED) visits during the quarter	67%
Percent of participants with reduced hospital admissions or readmissions during the quarter	71%

Section II: Performance Metrics

Quality Assurance and Monitoring Activities

Florida vs National Averages for Healthcare Effectiveness Data Information Set (HEDIS)

HEDIS is a set of performance measures for medical managed care, designed to allow customers to compare health plan performance, both regionally and nationally. The HEDIS measures were developed and are maintained by the National Committee for Quality Assurance (NCQA).

Each of the health plans are required to submit performance measure data to the Agency for review and comparison. The Agency compares the HEDIS National Medicaid Means and Percentiles to the performance measures submitted by Florida's MMA plans. These performance measures are in place to monitor health care service delivery and to provide a mechanism for assessing the effectiveness of the program. The Agency reviews the HEDIS quality performance measures to ensure the Agency's required measures, contained within the MMA contracts, are broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable. The HEDIS quality performance measures for calendar years 2018 and 2019 are contained in **Attachment V**.

The Agency has continued to see significant improvement in its Medicaid quality scores since the inception of the MMA program. The percentage of calendar year 2017 HEDIS scores at or above the national average increased by 10 percentage points over calendar year 2016.

Calendar year 2018 was a transition year from the previous contracts to the new contracts; however, in calendar year 2018, 58 percent of HEDIS scores were at or above the national average. Calendar year 2019 was the first full year under the new contracts, and 67 percent of HEDIS scores were at or above the national average.

- The Agency posts detailed MMA Plan scores on its website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.

Additionally, the Agency, to promote transparency, publishes a Medicaid Health Plan Report Card, which highlights key performance measures in a consumer-friendly format. The Report Card is updated annually and uses a five-star rating system, grouping HEDIS measures into related and understandable categories, such as Keeping Kids Healthy and Pregnancy-Related Care.

- The Health Plan Report Cards are available online at the Agency's award-winning Consumer Health Care Transparency website, www.FloridaHealthFinder.gov. A Report Card example is included on the following page:

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2018

◉ **Medicaid Health Plan Report Card**

To view individual measures in a category, click one of the following:

- ○ **Pregnancy-related Care**
- ○ **Keeping Kids Healthy**
- ○ **Children's Dental Care**
- ○ **Keeping Adults Healthy**
- ○ **Living with Illness**
- ○ **Behavioral Health Care**

Directions:

View the results below or click a column heading to sort by that column.

Statewide Information for Plans Currently Operating in Florida Counties

Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Children's Dental Care	Keeping Adults Healthy	Living with Illness	Behavioral Health Care
Aetna Better Health of Florida	★★★★★	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆
Children's Medical Services *	★☆☆☆☆	★★★☆☆	N/A	N/A	★★☆☆☆	★★★★☆
Clear Health Alliance *	★☆☆☆☆	N/A	★★☆☆☆	★★★★☆	★★★☆☆	★★☆☆☆
Community Care Plan	★★★★★	★★★★☆	★★★★★	★★★★☆	★★★★★	★★★☆☆
Florida Community Care ‡	N/R	N/R	N/R	N/R	N/R	N/R
Florida MHS (Magellan) *	★☆☆☆☆	★☆☆☆☆	★☆☆☆☆	★★☆☆☆	★★☆☆☆	★☆☆☆☆
Humana Medical Plan, Inc.	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆
Lighthouse Health Plan, LLC ‡	N/R	N/R	N/R	N/R	N/R	N/R
Miami Children's Health Plan, LLC ‡	N/R	N/R	N/R	N/R	N/R	N/R
Molina Healthcare of Florida, Inc.	★★★★★	★★★☆☆	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆
Prestige Health Choice	★★★★☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★☆☆☆
Simply Healthcare Plans, Inc.	★★★★☆	★★★★☆	★★★☆☆	★★★★☆	★★★★★	★★★☆☆
Staywell Health Plan	★★★★☆	★★★★☆	★★★☆☆	★★★★☆	★★★☆☆	★★☆☆☆
Staywell Health Plan of Florida - SMI * ‡	N/R	N/R	N/R	N/R	N/R	N/R
Sunshine Health Child Welfare Specialty Plan *	★☆☆☆☆	★★★☆☆	★★★★★	N/A	N/A	★★★★☆
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★☆☆
United Healthcare of Florida, Inc.	★★★★☆	★★★☆☆	★★☆☆☆	★★★★☆	★★★★☆	★★★☆☆
Vivida Health ‡	N/R	N/R	N/R	N/R	N/R	N/R

Ratings Key:

★★★★★	**Best**	at or above 50% of all Medicaid health plans' scores
★★★★☆	**Good**	better than at least 40% of all Medicaid health plans' scores
★★★☆☆	**Fair**	better than at least 25% of all Medicaid health plans' scores
★★☆☆☆	**Poor**	better than at least 10% of all Medicaid health plans' scores
★☆☆☆☆	**Very Poor**	worse than 90% of all Medicaid health plans' scores
N/A		Not Measurable/Small Population
N/R		Not Rated

Consumer Assessment of Healthcare Providers

The Consumer Assessment of Healthcare Providers Survey (CAHPS) is a program under the Agency for Healthcare Research and Quality, which consists of a series of patient surveys rating health care experiences. The CAHPS Statewide Survey averages, for both the adult and child surveys as well as the plan-specific rates for the reporting period, will be available at: www.FloridaHealthFinder.gov

The CAHPS Survey period for 2019 included the Agency's MMA reprocurement and health plan transition period. This is important to note as the survey only includes individuals who were enrolled in the same MMA health plan for at least six months. Results remained consistently high, as they have been in previous years. The following tables contain a few highlights from the survey results for 2020 along with the 2016-2019 results for comparison.

Adult Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019	2020*
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	73%	76%	76%	77%	75%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	80%	83%	81%	82%	81%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	82%	84%	82%	83%	83%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	88%	88%	88%	91%
Rating of Health Care	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	75%	77%	74%	76%	77%

*2020 statewide rates are preliminary and may change slightly.

Child Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019	2020*
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	84%	86%	85%	85%	84%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	83%	83%	84%	**	84%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	89%	89%	89%	89%	90%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	88%	90%	90%	89%
Rating of Health Care	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	86%	89%	87%	88%	89%

*2020 statewide rates are preliminary and may change slightly.
**Excluded item due to only one Health Plan having sufficient survey responses to produce a reportable rate.

CMS-416 Child Check Up Reporting

The Agency submitted the finalized CMS-416 Report for Federal Fiscal Year (FFY) 2017-18 to CMS in the Spring of 2018. This report included the highest dental scores in the history of the Florida Medicaid program.

Highlights include:

> 39.4% of eligible children aged 1 through 20 years, enrolled for 90 continuous days, received a preventive dental health service; as calculated using the Child Core Set PDENT measure. This is a 1-percentage point increase from last year and a 20.4 percentage point increase from the FFY 2011-12 report.
>
> More than 45% of eligible children accessed some form of oral health care through Florida Medicaid.

Please Note: This data only includes preventive dental services provided by a dentist. There is evidence, however, that many more children in Medicaid are receiving preventive dental services from registered dental hygienists operating in health access settings. Under Florida law, such hygienists bill separately for the services they provide, which include cleanings and sealants. Because of the specifications of the P-DENT measure, these services are not able to be reported in the quality metrics.

Florida's Comprehensive Quality Strategy

The Comprehensive Quality Strategy (CQS) outlines Florida's strategy for assessing and improving the quality of health care and services furnished by the MMA plans and other providers within the Florida Medicaid system. The most recent draft of the CQS was submitted to CMS on March 3, 2017. The CQS is available on the Agency's website:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/Draft_full_Amended_012317.pdf

CQS Update:

The Agency began the process of updating the CQS during DY13 and has continued this effort during DY14. The updated CQS will address various strategies to assess progress towards meeting the Agency's goals. The Agency's established goals seek to build upon the success of the SMMC program to date and to ensure that quality improvement is a continual process.

The Agency's goals include:

- Reducing potentially preventable hospital events, including admissions, readmissions, and emergency department visits;
- Improving birth outcomes, including primary C-section rate, pre-term birth rate, and rate of Neonatal Abstinence Syndrome; and
- Increasing the percentage of participants receiving long-term care services in their homes or within their communities opposed to an institutional care setting or nursing facility.

The updated CQS is anticipated to be submitted to CMS in Fall 2020.

External Quality Review

The Agency contracts with the Health Services Advisory Group (HSAG) as its External Quality Review Organization (EQRO) vendor. During DY14, HSAG submitted the following annual reports to the Agency:

- 2018-2019 Annual Technical Report
- 2019-2020 Performance Improvement Projects Annual Summary Report
  - Report findings include:
    - Seventy-two percent (23/32) of PIPs received an overall Met validation status, indicating improved performance over last year's validation where 50 percent of the PIPs received a Met validation status.
    - 13 of 15 health plans received an overall Met validation status for the Administration of the Transportation Benefit PIP.
    - All three dental plans received an overall Met validation status for the Preventive Dental Services for Children PIP.
- 2019-2020 Performance Measure Validation Findings Report
  - Report findings include:
    - For the Behavioral Health domain, 8 of the 15 statewide average rates (approximately 53 percent) that could be compared to national benchmarks ranked at or above the 50th percentile, with one of these rates (Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia) exceeding the 75th percentile.
    - In the Access/Availability of Care domain, four of five statewide average rates (80 percent) demonstrated significant increases from reporting year (RY) 2018 to RY 2019.
    - In the Women's Care domain, six of 13 statewide average rates (approximately 46 percent) that could be compared to the prior year's rates demonstrated significant increases from RY 2018 to RY 2019.

Post Award Forum

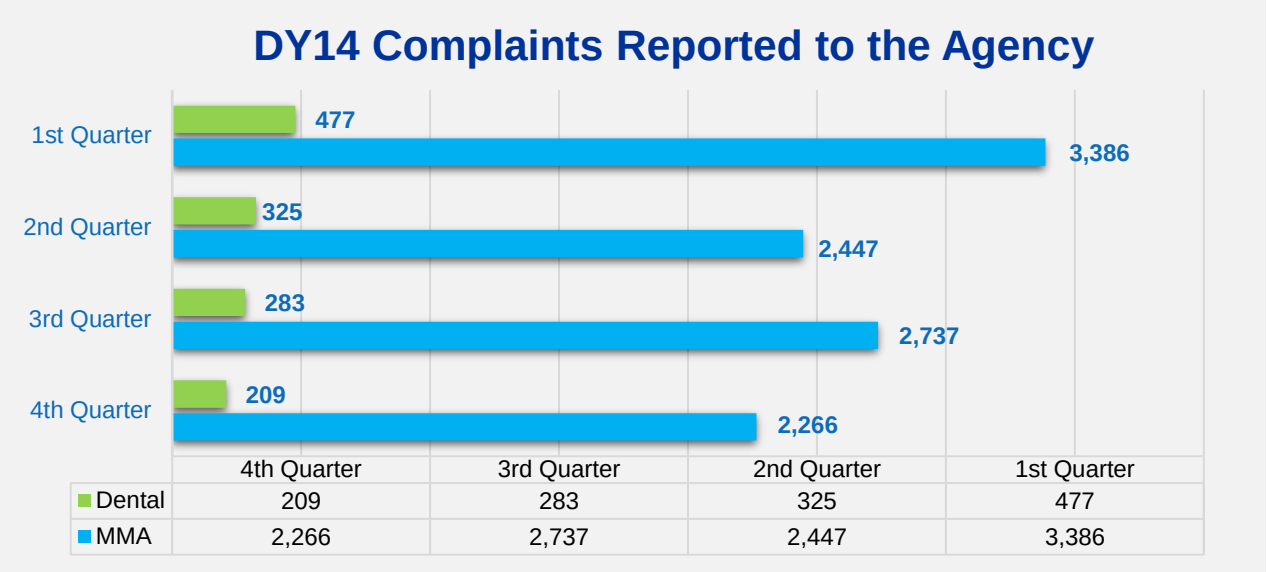
The annual post award public forum was conducted on October 30, 2019 during the Medical Care Advisory Committee meeting. The meeting was publicly noticed in the Florida Administrative Register. The Agency presented an overview of the MMA program, including information regarding amendments and key evaluation findings and accepted questions and comments from the public. The questions and comments received during the Post Award Forum were related to CAHPS data, the Behavioral Health and Supportive Housing Assistance pilot, the auto-assignment algorithm, and gains for providers resulting from the MMA plan reprocurement.

Complaints, Grievances, and Appeals

Complaints Reported to the Agency

The Agency has a centralized complaint operations center to resolve Medicaid complaints timely and to determine if plans are complying with the terms of their contracts. The Agency collects, aggregates, and trends the data for quality improvement initiatives.

The following graph details the complaints received by the Agency during DY14 by quarter, and the corresponding table represents the rate of complaints per 1,000 enrollees, for both the Dental and MMA programs. It is important to note that all complaints are captured, whether or not they were substantiated.



DY14 Complaints Received by the Agency per 1,000 Enrollees

DY14	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Dental Enrollment	3,079,131	3,052,385	3,024,258	3,395,611
Dental Complaints	477	325	283	209
DY14 Dental Complaints per 1000 Enrollees	**0.15**	**0.10**	**0.09**	**0.06**
MMA Enrollment	2,955,429	2,933,729	2,906,434	3,227,796
MMA Complaints	3,386	2,447	2,737	2,266
DY14 MMA Complaints per 1000 Enrollees	**1.14**	**0.83**	**0.94**	**0.70**

The following table provides the complaint rate per 1,000 enrollees for the MMA and Dental plans since DY12. For the Dental plan comparison, only DY14 and the third and fourth quarters of DY13 were included as the third quarter of DY13 was the first full quarter that the dental program was active.

Complaint Rate: Historical Comparison DY12 – DY14

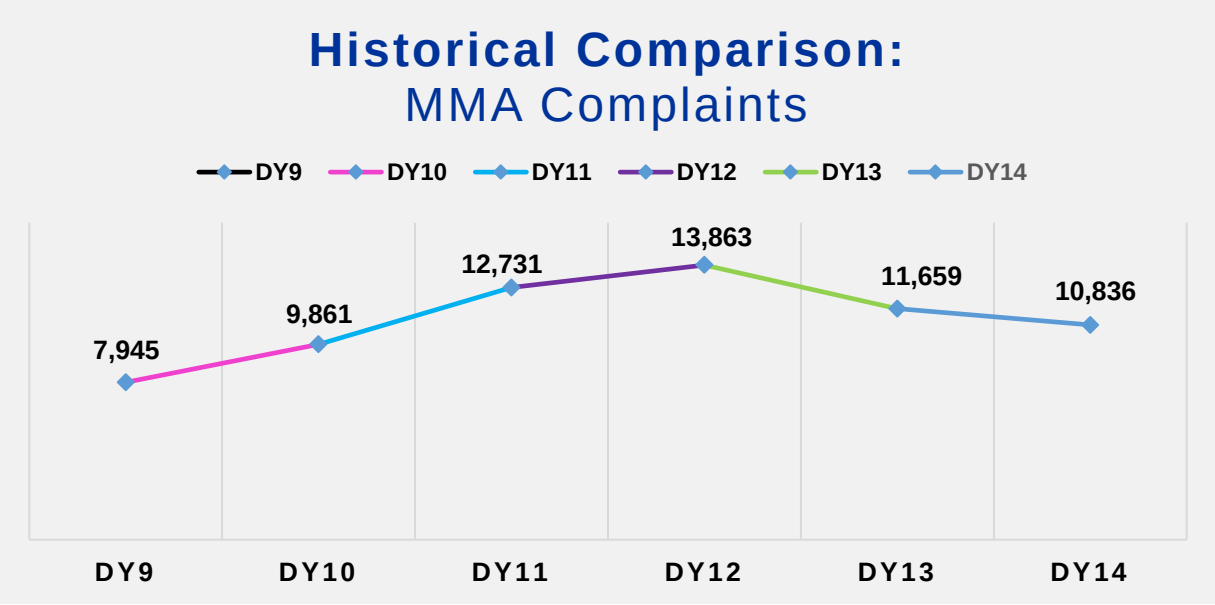
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
DY14 Dental	**0.15**	**0.11**	**0.09**	**0.06**
DY13 Dental	**Not Applicable***	**Not Applicable***	**0.01**	**0.12**
DY14 MMA	**1.15**	**0.83**	**0.94**	**0.70**
DY13 MMA	**0.83**	**0.80**	**1.22**	**0.82**
DY12 MMA	**0.95**	**1.01**	**1.33**	**1.11**

* Dental Plan enrollment began in December of 2018, which was the last month in the second quarter.

The dental program's complaint rate was lower in DY14 than it was in DY13. This is especially notable during the fourth quarter, as the program enrollment in DY14 was higher than in DY13 while the number of complaints filed were lower in DY14 than in DY13.

Additionally, as the table details the complaint rate for the MMA program in DY14 decreased, from DY13's rate, during the third and fourth quarters, and the DY14 rate was below the rate in DY12 in all but the first quarter. The demonstration year complaint average for DY14 was 200 less than the average number of complaints in DY13; thus, as illustrated below, the total number of complaints for DY14 was below that of DY13, and represents the lowest complaint figure experienced since DY10.

Complaints may have declined during the fourth quarter of DY14 because the COVID-19 pandemic significantly reduced the amount of health care being sought.



Complaints, Grievances, and Appeals Reported to the MMA Plans

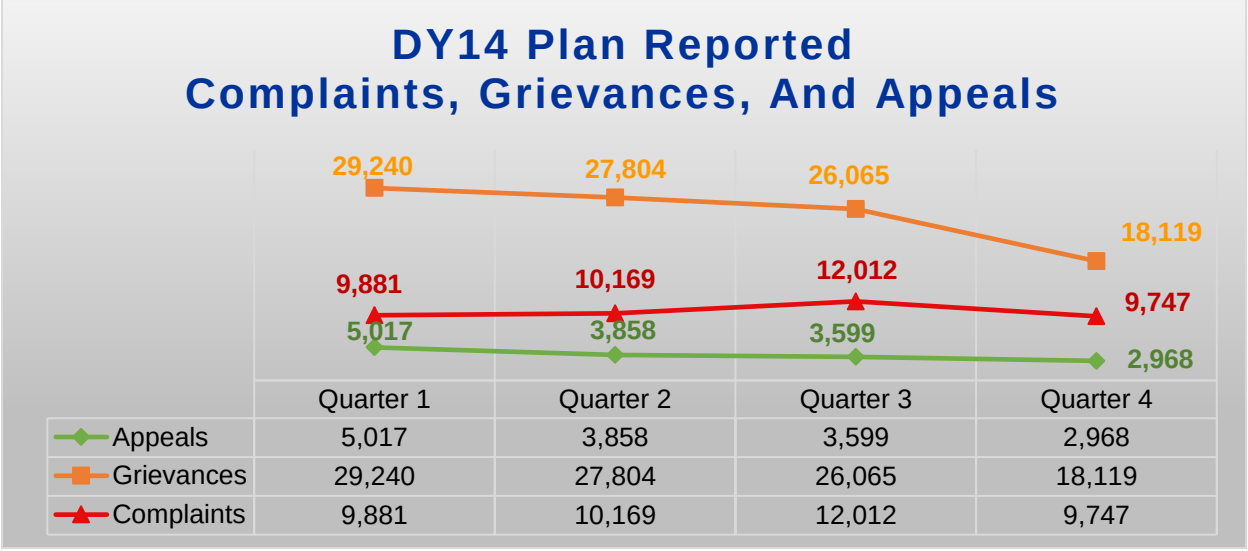
The MMA plans are required to report to the Agency all complaints, grievances, and appeals they receive monthly. If a complaint is not addressed by the MMA plan within one business day, it becomes a grievance. Complaints, grievances, and appeals are defined in the MMA contracts as well as in the Code of Federal Regulations:

- **Complaint** - Any oral or written expression of dissatisfaction by an enrollee submitted to the MMA plan or to a State agency and resolved by close of business the following business day. Possible topics for complaint include, but are not limited to, quality of care, quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or MMA plan employee, failure to respect the enrollee's rights, MMA plan administration, claim practices, and/or provision of services that relates to the quality of care rendered by a provider pursuant to the MMA plan's contract.
- **Grievance** - An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MMA plan to make an authorization decision.
- **Appeal** – A review of an adverse benefit determination.

The report submitted to the Agency by the plans must include new complaints received by the MMA plan during the reporting month as well as all pending complaints, grievances, and appeals from previous reporting months.

DY14 Complaints, Grievances, and Appeals

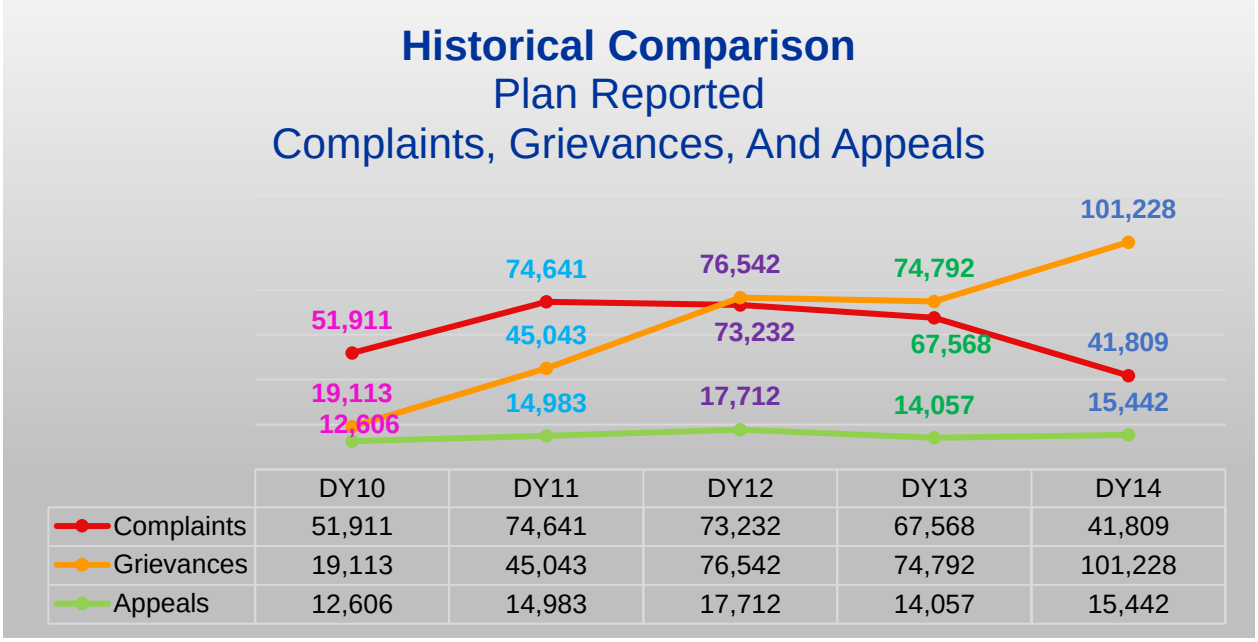
Complaints filed with the MMA plans followed a bell curve with increases during the second and third quarters. Grievances and appeals filed with the plans decreased throughout the demonstration year as evidenced in the below graph, which contains the complaints, grievances, and appeals filed with the MMA plans during DY14.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Appeals	5,017	3,858	3,599	2,968
Grievances	29,240	27,804	26,065	18,119
Complaints	9,881	10,169	12,012	9,747

Complaints become grievances if the issue is not resolved within one business day, and are thus not reported as complaints in subsequent reports. However, unlike complaints, grievances, if not resolved, carryover and continue to be reported until they are resolved.

MMA plan reported grievances and appeals increased in DY14 compared to DY13; however, the number of complaints decreased to the lowest rate since the MMA program's inception. See the chart below for details.

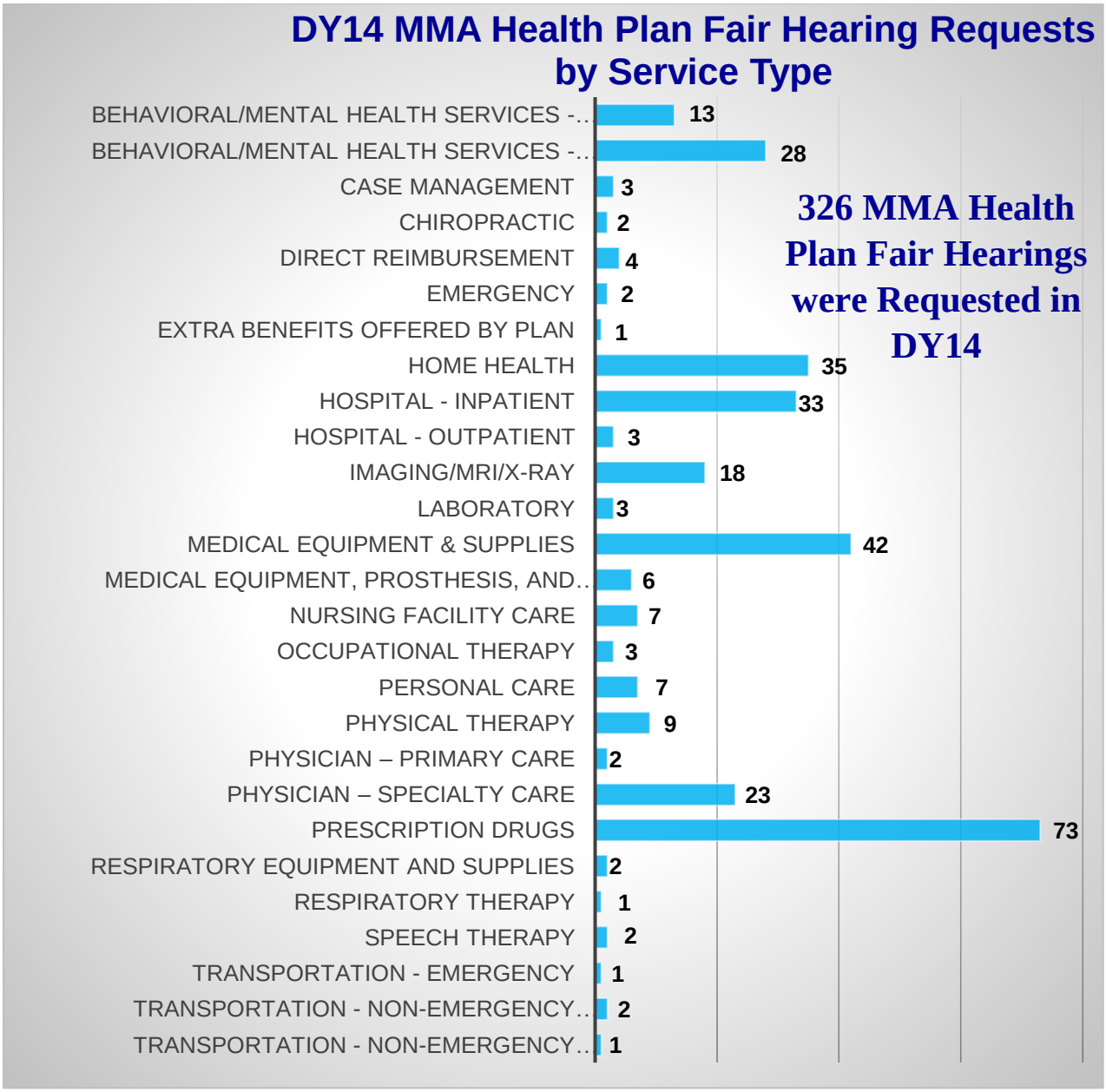


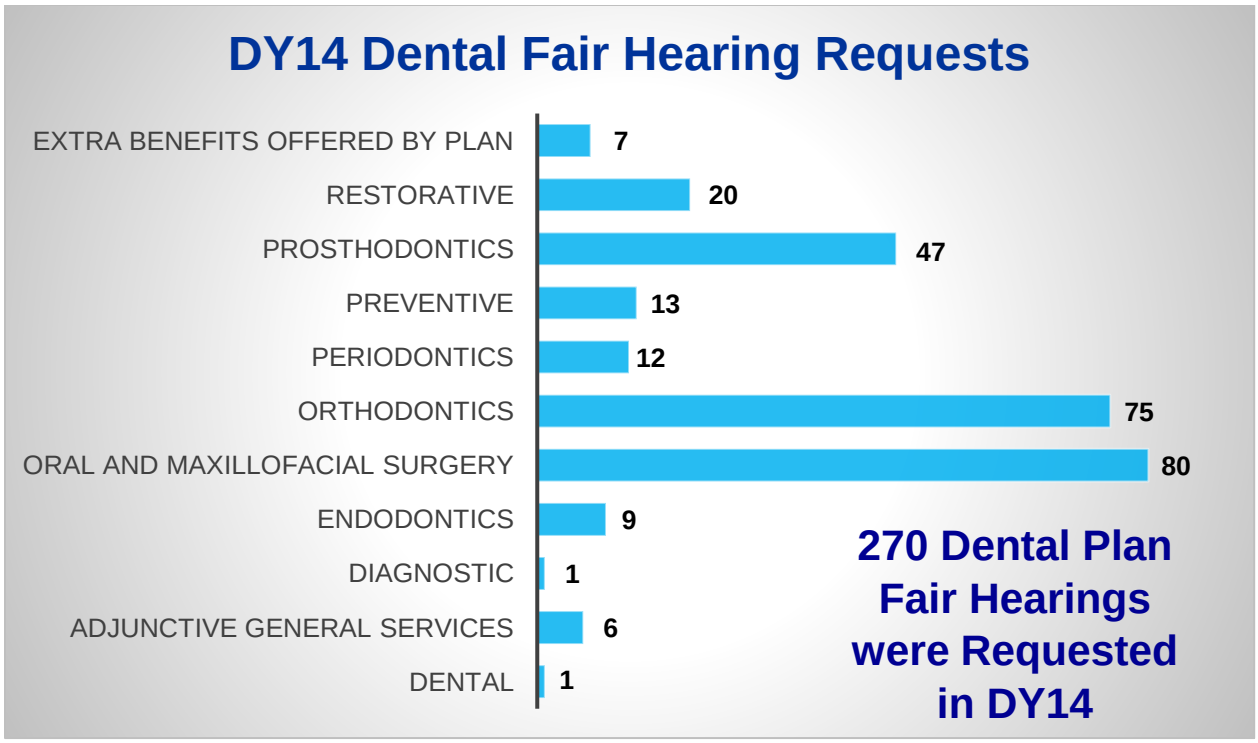
	DY10	DY11	DY12	DY13	DY14
Complaints	51,911	74,641	73,232	67,568	41,809
Grievances	19,113	45,043	76,542	74,792	101,228
Appeals	12,606	14,983	17,712	14,057	15,442

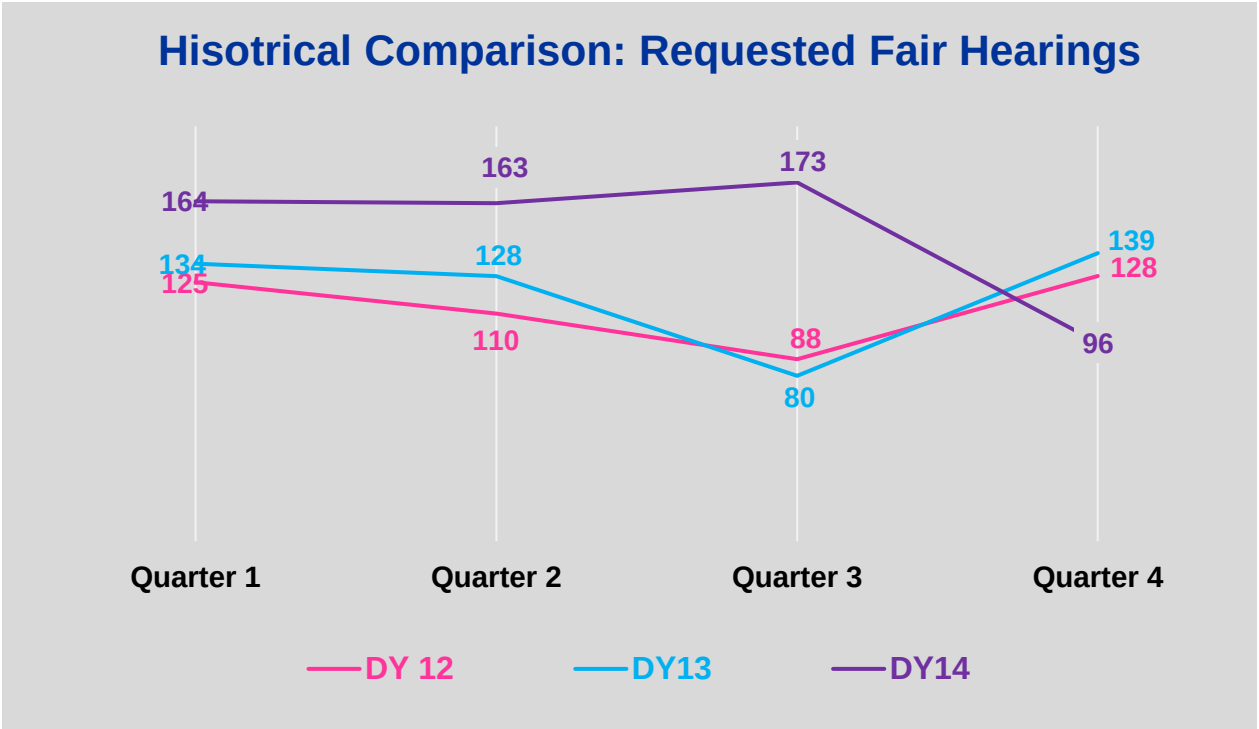
Fair Hearings

Fair Hearings may be requested when a recipient's claim for assistance or services is denied, reduced, suspended, or terminated by the Agency or the MMA plan, or if you disagree with the Agency's denial of a good cause MMA plan change request.

During DY14, there were a total of 596 fair hearings requested, 326 for the MMA plans and 270 for the dental plans. While the overall number of fair hearings requested increased from DY13, the number requested for the MMA health plans decreased. Additionally, enrollment for the dental plans did not begin in DY13 until the last month of the second quarter, which is what the DY14 increase, in both the overall and dental plan fair hearing requests totals, can be attributed to. The requested fair hearings for both the MMA health and dental plans are broken out on the following pages.


DY14 MMA Health Plan Fair Hearing Requests by Service Type
BEHAVIORAL/MENTAL HEALTH SERVICES -... 13
BEHAVIORAL/MENTAL HEALTH SERVICES -... 28
CASE MANAGEMENT 3
CHIROPRACTIC 2
DIRECT REIMBURSEMENT 4
EMERGENCY 2
EXTRA BENEFITS OFFERED BY PLAN 1
HOME HEALTH 35
HOSPITAL - INPATIENT 33
HOSPITAL - OUTPATIENT 3
IMAGING/MRI/X-RAY 18
LABORATORY 3
MEDICAL EQUIPMENT & SUPPLIES 42
MEDICAL EQUIPMENT, PROSTHESIS, AND... 6
NURSING FACILITY CARE 7
OCCUPATIONAL THERAPY 3
PERSONAL CARE 7
PHYSICAL THERAPY 9
PHYSICIAN – PRIMARY CARE 2
PHYSICIAN – SPECIALTY CARE 23
PRESCRIPTION DRUGS 73
RESPIRATORY EQUIPMENT AND SUPPLIES 2
RESPIRATORY THERAPY 1
SPEECH THERAPY 2
TRANSPORTATION - EMERGENCY 1
TRANSPORTATION - NON-EMERGENCY... 2
TRANSPORTATION - NON-EMERGENCY... 1
326 MMA Health Plan Fair Hearings were Requested in DY14

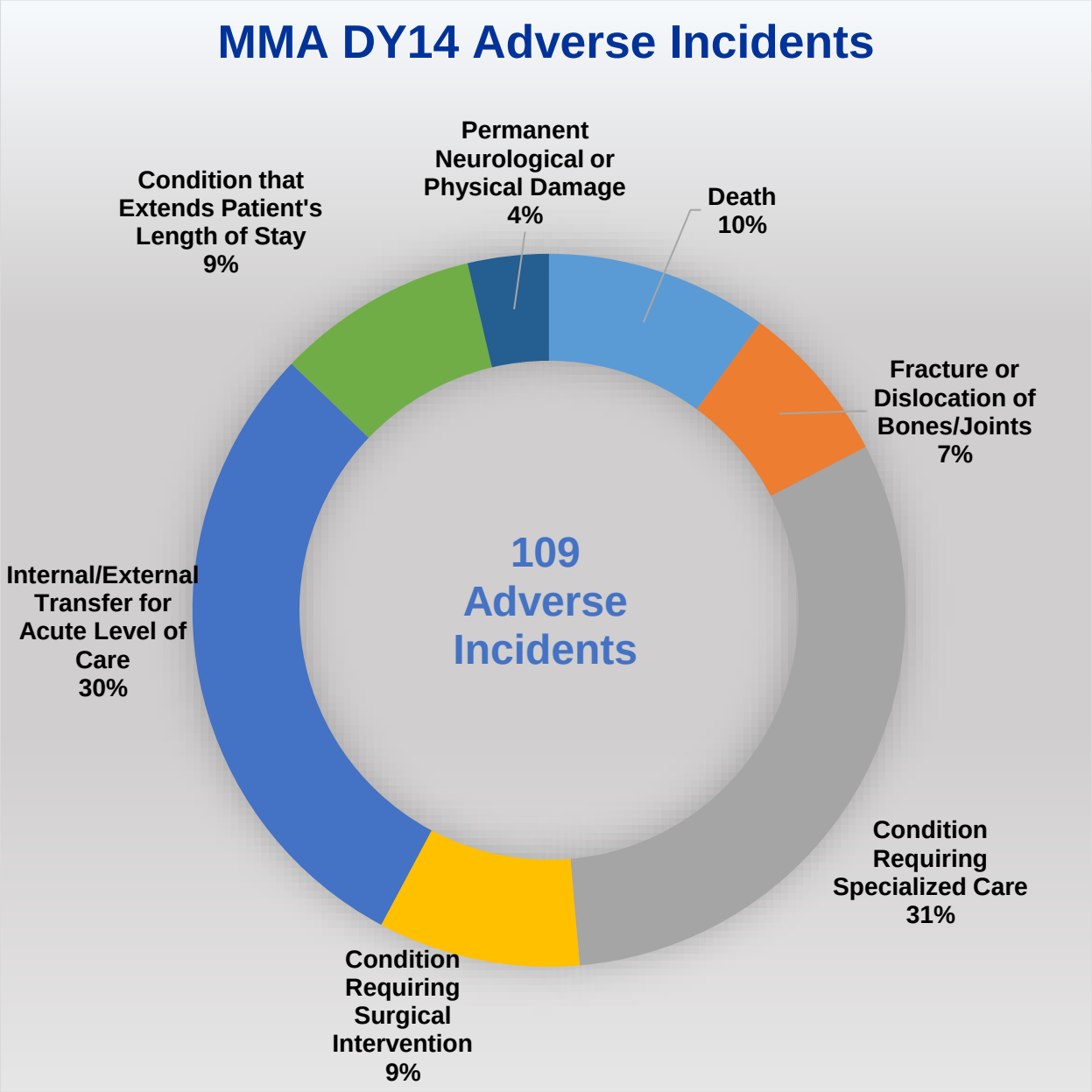




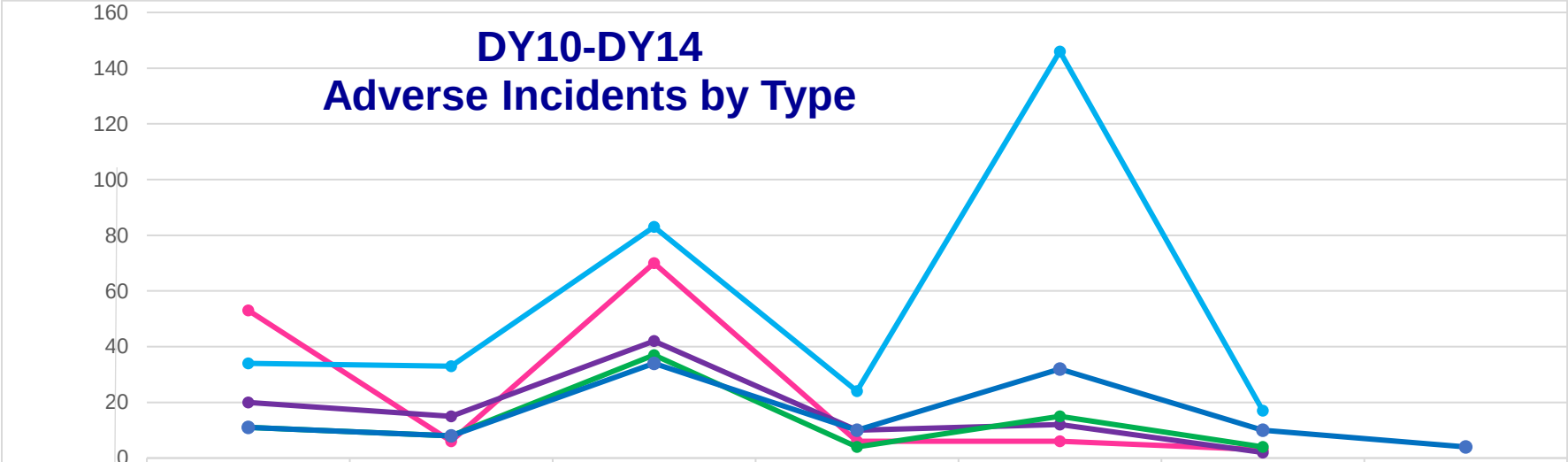
While the above chart illustrates an increase in fair hearing requests from DY13 to DY14, it is important to note that the Dental plans were not operational for the first quarter and most of the second quarter in DY13, which accounts for the increase.

Adverse Incident Reports

The Agency monitors adverse incidents and follows up with plans when it detects reporting anomalies or suspected trends in order to determine what the issues are and to obtain detailed information around those specific incidents. There were 109 adverse incidents reported during DY14; this is a 37.97% increase from those reported in DY13.

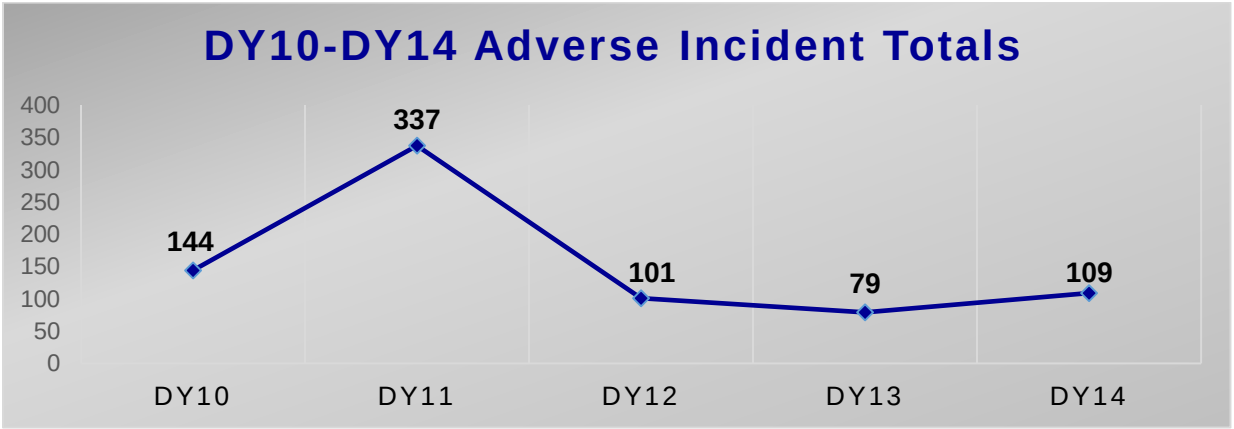


There were an additional 30 adverse incidents reported in DY14 when compared to DY13, and while there was fluctuation across most of the reporting categories, the reporting category with the most deviation was internal/external transfer for acute level of care, which increased by 17 occurrences. The following graphs detail historical adverse incident reporting, first by incident type followed by demonstration year totals, for further comparison.



	Enrollee Death	Fracture or Dislocation of Bones or Joints	Condition Requiring Definitive or Specialized Medical Attention Not Consistent with Pre-Existing Condition	Condition Requiring Surgical Intervention to Correct or Control	Condition Resulting in Transfer to Acute Care	Condition Extending Patient's Length of Stay	Permanent Neurological or Physical Damage
DY10	53	6	70	6	6	3	
DY11	34	33	83	24	146	17	
DY12	20	15	42	10	12	2	
DY13	11	8	37	4	15	4	
DY14	11	8	34	10	32	10	4

As illustrated above, there were increases during DY14 in three of the six categories reported on in both DY13 and DY14. In DY14, there was an additional adverse incident category the plans reported on; permanent neurological or physical damage.



Section III: Evaluation

Evaluation of the Demonstration

The demonstration evaluation is an ongoing process conducted continuously throughout the Demonstration's approval period. Under STC 107, the Agency was required to complete a revised evaluation design in December 2019 and March 2020 to address feedback and guidance received from CMS. The revised evaluation design includes a discussion of the goals, objectives, and specific testable hypotheses used to determine the demonstration's impact during the approval period.

Evaluation Design DY14

In Spring 2020, the Agency collaborated with the evaluation team at the University of Florida to develop an analytic method for utilizing credit data to analyze the effects of the retroactive eligibility waiver on new Medicaid enrollees' medical debt. In addition to credit bureau data, the evaluators proposed a modified difference-in-differences approach to identify and isolate potential causal effects.

Updates to the evaluation design included an explanation of the difference-in-differences methodology that the evaluation team will employ to address both the Behavioral Health and Supportive Housing Assistance pilot (Component 10) and the impact of the change to Florida's retroactive eligibility policy on new enrollee financial burden (Component 9). Additionally, there was a note included clarifying that since dental plans are only collecting CAHPS data for children, the evaluation will focus solely on child dental CAHPS results until such time that adult dental CAHPS data becomes available. CMS approved theses evaluation design revisions on April 27, 2020.

Summary of Evaluation Activities DY14 (SFY 2019-20)

- The Agency met with the evaluation team (University of Florida, Florida State University, and University of Alabama at Birmingham) monthly to discuss pertinent issues related to the MMA evaluation and status updates.
- The Agency provided DY12 (SFY17-18) data to the evaluators in June 2019.
- The evaluators submitted the draft and final DY12 evaluation reports for Components 1-7 during Spring 2020.
- The evaluation team administered a survey to hospital and nursing facility personnel regarding the retroactive eligibility policy change (Component 9) during Fall 2019.
- An amendment to the Agency's contract with the University of Florida (Amendment 5), to incorporate the legislative report on the waiver of retroactive eligibility, was executed on December 10, 2019.
- The Agency and the evaluators worked to acquire credit bureau data in January through March 2020, which will be essential in the evaluation of medical debt associated with the

retroactive eligibility policy change (Component 9 – Impact of the Waiver of Retroactive Eligibility).

- In Spring 2020, the Agency began working on Amendment 6 to the Agency's contract with the evaluation team.
  - This amendment incorporates Component 9 and 10 (Impact of the Behavioral Health and Supportive Housing Pilot) into the Contract Scope of Services.
- In Spring 2020, the Agency collaborated with the vendor in the design of a survey that will be used to address research questions 9G (Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?) and 9H (What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?).

DY12 Final Reports: Findings

The Demonstration Evaluation Report for DY12 was finalized in Spring 2020. Below is a summary of the results.

Project 1: Access, Use, Cost, and Quality of Care (Components 1, 2, 5, and 7)

- Overall plan performance on HEDIS measures related to access to care improved between CY 2015 and 2018.
  - 92% (22 measures) of the 24 accessibility measures showed improvement and 8% (2 measures) of the 24 measures showed no change between the pre-MMA and MMA periods.
- Results from the CAHPS surveys indicate that in 2018, approximately 76% of adult MMA enrollees rated their overall health plans as an 8, 9, or 10 on a scale of 1 to 10.
- In general, the contractual standard for wait times were met 85% of the time for urgent care, 95% of the time for routine care, and 97% of the time for well care.
- Average PMPM expenditures continue to be lower for all eligibility groups during the MMA period compared to the pre-MMA period.
- Of the 3,334,629 enrollees in DY12 who used any service, 76% utilized expanded benefits.
- Of the 259,644 new individual enrollees, 82% (213,914) were enrolled under Express Enrollment using auto-enrollment, where they were automatically assigned to an MMA plan.
- On average, new enrollees access services approximately 74 days after enrollment. However, the number of days varies by enrollment method. The average number of days for a new enrollee to access services under:
  - Express (auto) enrollment was 81 days, and
  - Voluntary choice enrollment was 43 days.

Project 2: Healthy Behaviors Programs (Component 3)

- In addition to the three medically approved mandatory programs (Smoking Cessation, Weight Loss, and Alcohol/Substance Abuse Recovery), there were a total of 15 different types of Healthy Behaviors programs offered across Florida's 16 MMA plans.
- Of the mandatory programs, the medically-directed weight loss program reported the highest number of current enrollees (1,026) in DY12, as well as the highest number of enrollees who completed the program (124).
- Out of all Healthy Behaviors programs, the well-child visits program had the highest number of enrollees who completed the program (36,126), followed by pregnancy/maternity programs (3,209).
- Among the mandatory programs, women were more likely than men to be currently enrolled in and have completed the programs.

Project 3: Low Income Pool (LIP) (Component 4)

- 172 hospitals received a total of approximately $745 million in LIP payments.
- Out of the 172 hospital providers that received LIP funding, 166 of those hospitals reported milestone data for individuals eligible for uncompensated charity care.
- Out of approximately 7.9 million total service encounters, the three services with the greatest number of encounters for uncompensated charity care patients across all tiers were:
    1. Emergency room visits with 2.4 million total encounters;
    2. Inpatient days with 1.9 million total encounters; and
    3. Outpatient visits with 1.6 million total encounters.

Project 4: Dual-Eligible Enrollees (Component 6)

- The January 2018 Florida Statewide Medicaid Enrollment Report indicated that 200,873 dual-eligibles were enrolled in the MMA program, a decline of 12.1% from one year earlier.
- Dual-eligible users are using fewer behavioral health services, and those services have lower costs per service compared to non-dual-eligible users.
- Dual-eligible users are using more transportation services, but those services have lower costs per service compared to non-dual-eligible users.

MMA Plan Monitoring

Plan Compliance

The Agency monitors the MMA plans' performance through a variety of mechanisms including plan reports and submissions, desk and on-site compliance reviews, and reviews of complaint and grievance data.

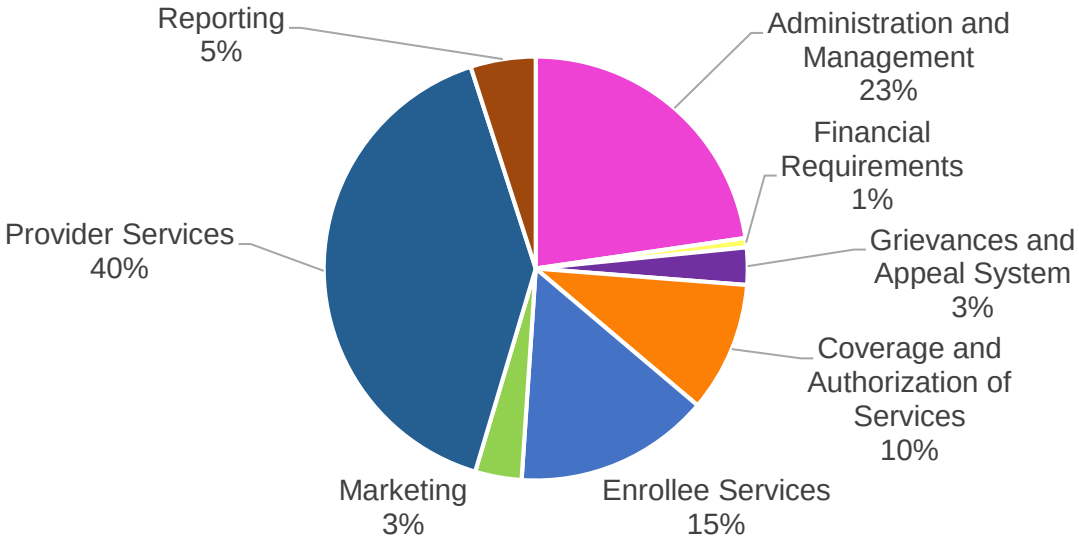
The Agency provides oversight in all aspects of MMA plan operations and may take the following compliance actions when a plan fails to meet the requirements specified in their contract (non-compliance):

- **Corrective Action Plan:** A plan submitted to the Agency, detailing how the managed care plan will remedy an area of non-compliance.
- **Liquidated Damages:** A monetary charge to the plan. Liquidated damages are not intended to be a penalty, but rather a reasonable estimate of the Agency's projected financial loss and damage resulting from the managed care plan's non-performance, including financial loss as a result of program delays.
- **Sanction:** Monetary or non-monetary action, including, but not limited to enrollment freezes or temporary Agency management of the managed care plan.

In DY14, the Agency took 141 final compliance actions, 10 less than in DY13. The most prevalent categories for MMA plan non-compliance, with number of occurrences exceeding 30, in DY14 were administration and management and provider services. The leading problematic subcategories within these compliance categories with occurrences greater than 20, include encounter data requirements with 29 occurrences, claims and provider payments with 22 occurrences, and network adequacy standards with 23 occurrences.

The following graph and table further detail the compliance actions taken during DY14.

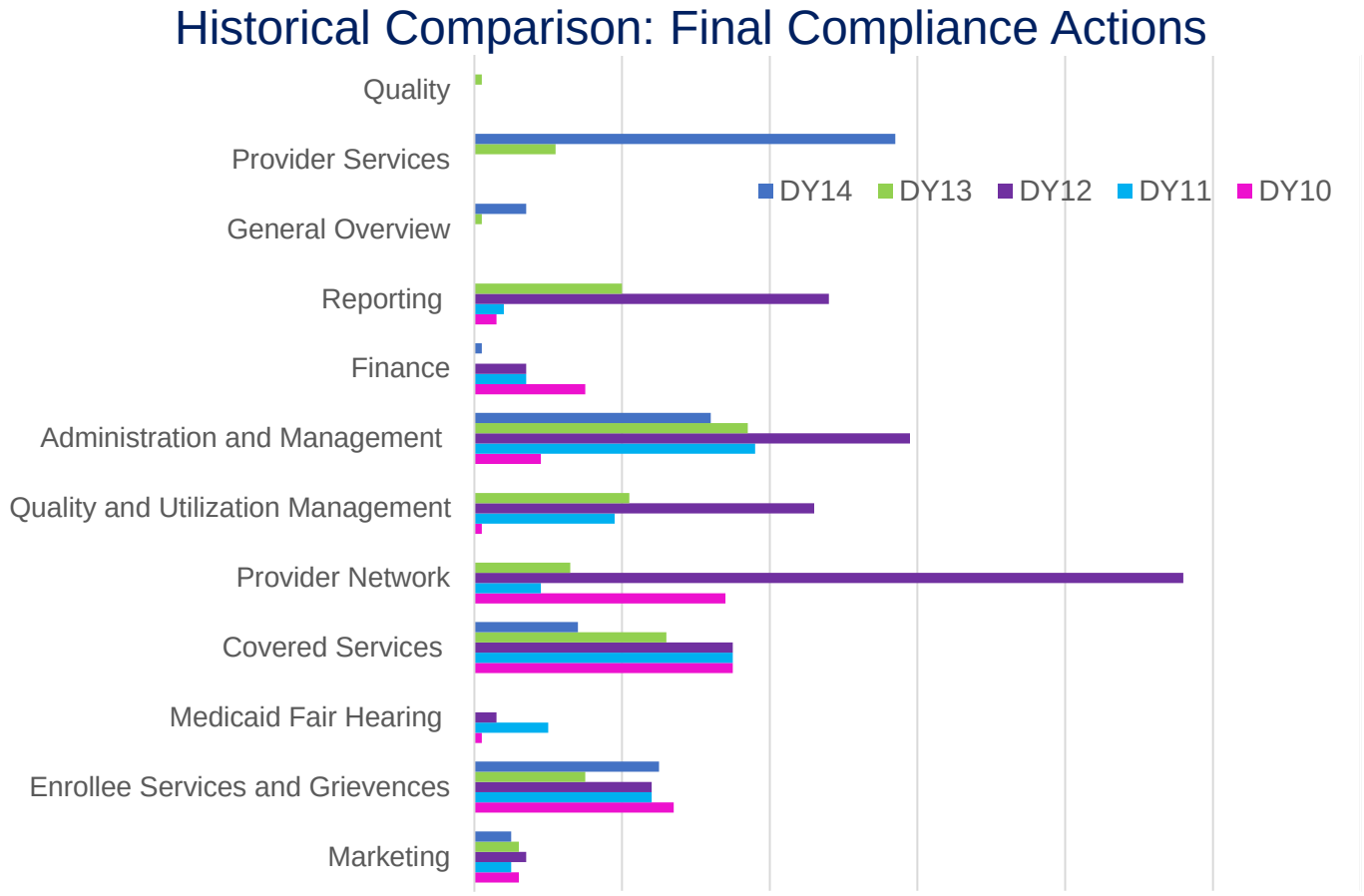
DY14 Final Compliance Actions



DY14 Itemized Final Compliance Actions

Category and Subcategories of Non-Compliance	Occurrences
Administration and Management	**32**
Encounter Data Requirements	29
Fraud and Abuse Prevention	2
Subcontracts	1
Coverage and Authorization of Services	**14**
Prescribed Drug Services	13
Ultimately and/or Inaccurate Reporting	1
Enrollee Services	**21**
Online Enrollee Materials	12
Provider Directory	9
Financial Requirements	**1**
Untimely and/or Inaccurate Reporting	1
Grievances and Appeal System	**4**
Enrollee Notice Requirements	3
Medicaid Fair Hearings	1
Marketing	**5**
Distributing Marketing Materials at Public/Education	1
Not Present at Scheduled Event	2
Untimely and/or Inaccurate Reporting	1
Use of Unapproved Marketing Material	1
Provider Services	**57**
Claims and Provider Payment	22
Network Adequacy Standards	23
Untimely and/or Inaccurate Reporting	12
Reporting	**7**
HIPAA Reporting	7
Total	***141***

As the following illustrates, during the four most recent demonstration years (DY11 – DY14), plan administration and management has been in the top three highest ranking non-compliance categories; however, while this was still true for DY14, the number of occurrences decreased from those in DY13 and were at the lowest reported level since DY10. Additionally, the total number of final compliance actions the Agency took in DY14 decreased from DY13 and was at the lowest level since DY10.



Area of Non-Compliance	DY10	DY11	DY12	DY13	DY14
Marketing	6	5	7	6	5
Enrollee Services and Grievances	27	24	24	15	25
Medicaid Fair Hearing	1	10	3		
Covered Services	35	35	35	26	14
Provider Network	34	9	96	13	23
Quality and Utilization Management	1	19	46	22	
Administration and Management	9	38	59	37	32
Finance	15	7	7		1
Reporting	3	4	48	20	7
General Overview				1	
Provider Services				11	34
Totals	**131**	**151**	**325**	**151**	**141**

Section IV: Financial Reporting Requirements and Budget Neutrality

Medical Loss Ratio (MLR)

The Agency evaluates the MMA Plans' MLR annually to determine compliance. In addition to the annual MLR evaluation, quarterly reports are provided to the Agency by the MMA plans for informational purposes as well as ongoing Agency monitoring. Specifically, quarterly reports are monitored for seasonal and inherent claim volatility, which may cause the MLR results to fluctuate somewhat from quarter to quarter; especially for smaller plans.

The Agency monitors the financial performance of MMA plans reporting an MLR at or above 95% and at or below 75%. Factors that may contribute to the reported MLR results are the inclusion of incurred but not reported claims in the MLR calculation due to three months of claim runout, as well as the inclusion of Expanded Benefits, which are offered at the plan's discretion over and above the Medicaid State Plan services. The financial data underlying the MLR results has been, and will continue to be, provided to the Agency's actuaries.

All but five of the MMA plans contracted with the Agency reported an MLR greater than or equal to the required 85% threshold. The MMA plans reporting below the 85% threshold include:

1. Bestcare Assurance D/B/A Vivida Health Plan of Florida
   - As of December 31, 2019, Vivida Health reported an MLR of 80.65%.
   - The total operating loss was -$1,483,566 and the operating margin was reported at - 6.02%.
   - The financial data underlying the MLR results has been provided to the Agency's actuaries and the Agency will continue to provide them data as it becomes available.
   - Bestcare Assurance D/B/A/ Vivida Health was awarded an SMMC 2018-2024 contract for one Medicaid region, and the contract was effective in January 2019.
2. Lighthouse Health Plan
   - As of December 31, 2019, Lighthouse Health Plan reported an MLR of 80%.
   - The total operating income was $699,826 and the operating margin was reported at 0.86%.
   - The financial data underlying the MLR results has been provided to the Agency's actuaries and the Agency will continue to provide them data as it becomes available.
   - Lighthouse Health Plan was awarded a SMMC contract for two regions for the 2018-2024 SMMC contract term, and the contract was effective in February 2019.

3. Children’s Medical Services Network
   - As of December 31, 2019, Children's Medical Services Health Plan reported an MLR at 80.37%.
   - The total operating income was $209,061,887 and the operating margin was reported at 16.16%.
   - The financial data underlying the MLR results has been provided to the Agency's actuaries and the Agency will continue to provide them data as it becomes available.
   - Children's Medical Services Health Plan was awarded a SMMC contract for 11 regions for the 2018-2024 SMMC contract term, and the contract was effective in February 2019.
4. Sunshine-Child Welfare Specialty Plan
   - As of December 31, 2019, Sunshine-Child Welfare Specialty Plan reported an MLR at 83.67%.
   - The total operating income was $24,928,908 and the operating margin was reported at 10.30%.
   - The financial data underlying the MLR results has been provided to the Agency's actuaries and the Agency will continue to provide them data as it becomes available.
   - Sunshine-Child Welfare Specialty plan is a subsidiary of Sunshine State Health Plan. Sunshine State Health Plan was awarded a SMMC contract for 11 regions for the 2018-2024 SMMC contract term, and the contract was effective in December 2018.
5. Liberty Dental of Florida, Inc.
   - As of December 31, 2019, Liberty Dental of Florida Inc. reported an MLR at 80.37%.
   - The total operating income was $5,934,156 and the operating margin was reported at 5.44%.
   - The financial data underlying the MLR results has been provided to the Agency's actuaries and the Agency will continue to provide them data as it becomes available.
   - Liberty Dental of Florida Inc. was awarded a SMMC contract for 11 regions during the 2018-2024 SMMC contract term, and the contract was effective in December 2018.

Each of the MMA Plans reported their annual Medical Loss Ratio (MLR) for calendar year (CY) 2019 during DY14. The CY2019 MLR results contained in the following table are unaudited, subject to Agency review, and MMA plan resubmissions of underlying MLR data.

Annual Medical Loss Ratio Evaluation Report (As reported by the MMA Plans for CY2019)							
Plan Type	**MMA Plan Name**	**Capitation Paid Less Fed/State Taxes/Fees**	**Total Expenses**	**Funds & Contributions**	**Capitation - Total Expenses**	**Medical Loss Ratio**	**Difference[1]**
Standard MMA Plans	Coventry Healthcare of Florida D/B/A/ Aetna Better Health of Florida	$306,269,824	$265,517,816	$0	$40,752,008	86.69%	1.69%
	Humana Medical Plan, Inc.	$1,559,422,720	$1,383,137,996	$0	$176,284,725	88.70%	3.70%
	Molina Healthcare of Florida, Inc.	$413,032,099	$376,597,022	$0	$36,435,076	91.18%	6.18%
	Prestige Health Choice	$317,638,451	$293,493,637	$0	$24,144,814	92.40%	7.40%
	Simply Healthcare Plans, Inc.	$1,640,936,972	$1,440,575,244	$0	$200,361,728	87.79%	2.79%
	Sunshine State Health Plan, Inc.	$1,680,551,503	$1,518,787,609	$0	$161,763,894	90.37%	5.37%
	United Healthcare of Florida, Inc.	$945,123,243	$830,570,971	$0	$114,552,273	87.88%	2.88%
	WellCare of Florida D/B/A/ StayWell Health Plan of Florida	$2,882,579,909	$2,683,335,945	$0	$199,243,964	93.09%	8.09%
Standard Plans < 50,000 Members	Bestcare Assurance D/B/A/ Vivida Health	$24,638,117	$19,869,851	$0	$4,768,266	80.65%	-4.35%
	Community Care Plan	$130,759,319	$118,177,016	$0	$12,582,303	90.38%	5.38%
	Lighthouse Health Plan	$81,516,652	$65,212,382	$0	$16,304,270	80.00%	-5.00%
	Miami Children's Health Plan, Inc.	$41,758,939	$36,799,568	$0	$4,959,370	88.12%	3.12%
	Florida Community Care, LLC	$22,409,071	$19,075,205	$0	$3,333,866	85.12%	0.12%
Specialty Plans	Clear Health Alliance-HIV/AIDs Specialty Plan	$287,901,989	$245,485,183	$0	$42,416,806	85.27%	0.27%
	Children's Medical Services Network	$1,256,419,757	$1,009,816,187	$0	$246,603,570	80.37%	-4.63%
	Magellan Complete Care	$211,736,418	$185,486,609	$0	$26,249,810	87.60%	2.60%
	Sunshine-Child Welfare Specialty Plan	$235,490,887	$197,026,798	$0	$38,464,089	83.67%	-1.33%
	StayWell-Serious Mental Illness Specialty Plan	$619,139,572	$535,426,992	$0	$83,712,580	86.48%	1.48%
Dental Plans	DentaQuest of Florida, Inc.	$160,437,523	$150,104,985	$0	$10,332,538	93.56%	8.56%
	Liberty Dental of Florida Inc.	$108,366,738	$87,097,359	$0	$21,269,379	80.37%	-4.63%
	Managed Care of North America, Inc.	$59,673,895	$55,947,982	$0	$3,725,913	93.76%	8.76%
	Grand Total	**$12,985,803,598**	**$11,517,542,358**	**$0**	**$1,468,261,240**	**88.69%**	**3.69%**

[1] The Difference column is the difference above or below 85.0%. [Medical Loss Ratio (column G) - 85%]

Encounter Data Activities

During DY14, the Agency continued to work with the plans to improve encounter acceptance rates. Regularly held online and in-person meetings provided a platform for both the Agency and the plans to provide feedback regarding the encounter process.

In January 2019, the Agency implemented the new Health Plan Portal. Primarily, this portal grants plans access to view encounter data contained within the Florida Medicaid Management Information System.

The Health Plan Portal includes Encounter Dashboards, which display encounter timeliness and accuracy compliance percentages and trends.

Encounter Accuracy Reports are disseminated to the plans weekly and include supplemental reports, which contain encounter submissions that were denied and the reason for the denial.

The dissemination of these reports has proved to be beneficial in communicating information to the MMA plans, and the easy to use platform has assisted the plans in determining where encounter submission improvements need to implemented.

Budget Neutrality

In Tables A through I, both the date of service and date of payment data are presented. Tables that provide data on a quarterly basis (Tables B & C) reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Tables B through I, in accordance with STC #77(d).

Per Member Per Month Cap

Table A shows the Per Member Per Month (PMPM) cap established in the MMA Waiver as specified in STC #93(b). These caps are compared to actual waiver expenditures using date of service tracking and reporting.

TABLE A		
PMPM Targets		
WOW[2] PMPM	**MEG 1**	**MEG 2**
DY1	$948.79	$199.48
DY2	$1,024.69	$215.44
DY3	$1,106.67	$232.68
DY4	$1,195.20	$251.29
DY5	$1,290.82	$271.39
DY6	$1,356.65	$285.77
DY7	$1,425.84	$300.92
DY8	$1,498.56	$316.87
DY9	$786.70	$324.13
DY10	$830.22	$339.04
DY11	$876.81	$354.64
DY12	$1,027.49	$267.77
DY13	$1,068.59	$280.09
DY14	$1,111.33	$292.97
DY15	$1,155.78	$306.45
DY16	$1,202.01	$320.55

The quarter beginning October 2014 (Q34 - date of payment) is the first complete quarter under the MMA program. Historical data prior to this quarter is available upon request.

[2] Without Waiver

Medicaid Eligibility Groups (MEGs) 1, 2, 3, 4, 5, 6, and 7 Statistics

Tables B through I, contain the statistics for Medicaid Eligibility Groups (MEGs) 1, 2, 3, 4, 5, 6, and 7 for date of payment beginning through June 30, 2020. Member months (MM) provided in Tables B, C, and F for MEGs 1, 2, and 4 are actual eligibility counts as of the last day of each quarter. The expenditures provided are recorded on a cash basis for the month paid.

TABLE B
MEG 1 Statistics: SSI Related

DY/Quarter	Actual MEG 1	Member Months	Total Spend*	PMPM
DY09/Q34	Oct-Dec 2014	1,500,372	$1,213,976,973	$809.12
DY09/Q35	Jan-Mar 2015	1,462,357	$1,115,644,053	$762.91
DY09/Q36	Apr-Jun 2015	1,337,626	$992,006,791	$741.62
DY10/Q37	Jul-Sep 2015	1,596,204	$1,010,889,767	$633.31
DY10/Q38	Oct-Dec 2015	1,604,502	$1,212,999,244	$756.00
DY10/Q39	Jan-Mar 2016	1,616,079	$1,250,700,040	$773.91
DY10/Q40	Apr-Jun 2016	1,673,703	$1,265,779,740	$756.28
DY11/Q41	July-Sep 2016	1,663,286	$1,420,833,105	$854.23
DY11/Q42	Oct-Dec 2016	1,664,558	$1,464,711,347	$879.94
DY11/Q43	Jan-Mar 2017	1,652,117	$1,435,996,169	$869.19
DY11/Q44	Apr-Jun 2017	1,630,929	$1,452,522,842	$890.61
DY12/Q45	Jul-Sep 2017	1,611,019	$1,462,244,237	$907.65
DY12/Q46	Oct-Dec 2017	1,601,642	$1,414,383,190	$883.08
DY12/Q47	Jan-Mar 2018	1,596,747	$1,466,472,666	$918.41
DY12/Q48	Apr-Jun 2018	1,663,494	$1,361,916,067	$818.71
DY13/Q49	Jul-Sep 2018	1,578,034	$1,253,014,135	$794.03
DY13/Q50	Oct-Dec 2018	1,663,309	$1,353,658,533	$813.83
DY13/Q51	Jan-Mar 2019	1,629,631	$1,364,488,951	$837.30
DY13/Q52	Apr-Jun 2019	1.630,175	$1,560,341,403	$957.16
DY14/Q53	Jul-Sep 2019	1,632,152	$1,275,811,089	$781.67
DY14/Q54	Oct-Dec 2019	1,634,257	$1,376,285,643	$842.15
DY14/Q55	Jan-Mar 2020	1,430,521	$1,523,775,318	$1,065.19
DY14/Q56	Apr-Jun 2020	1,441,370	$2,124,447,934	$1,473.91
Managed Medical Assistance- MEG 1 Total[3]		**65,144,120**	**$61,551,316,940**	**$944.85**

* For Tables B and C, the quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 report submissions without the adjustment of rebates.

[3] MMA MEG1 Totals (from DY01 on)

TABLE C MEG 2 Statistics: Children and Families				
DY/Quarter	**Actual MEG 2**	**member months**	**Total Spend***	**PMPM**
DY09/Q34	Oct-Dec 2014	6,858,360	$1,924,853,997	$280.66
DY09/Q35	Jan-Mar 2015	7,294,147	$1,703,780,305	$233.58
DY09/Q36	Apr-Jun 2015	6,479,912	$1,456,451,988	$224.76
DY10/Q37	Jul-Sep 2015	7,370,555	$1,686,197,587	$228.77
DY10/Q38	Oct-Dec 2015	7,489,852	$2,007,715,826	$268.06
DY10/Q39	Jan-Mar 2016	7,547,248	$1,920,135,049	$254.42
DY10/Q40	Apr-Jun 2016	7,650,908	$1,942,508,693	$253.89
DY11/Q41	July-Sep 2016	7,701,261	$1,829,213,303	$237.52
DY11/Q42	Oct-Dec 2016	7,692,285	$2,246,810,827	$292.09
DY11/Q43	Jan-Mar 2017	7,718,856	$2,095,219,625	$271.44
DY11/Q44	Apr-Jun 2017	7,714,538	$2,141,555,345	$277.60
DY12/Q45	Jul-Sep 2017	7,238,915	$1,974,708,482	$272.79
DY12/Q46	Oct-Dec 2017	7,275,495	$2,044,956,976	$281.07
DY12/Q47	Jan-Mar 2018	7,287,879	$2,044,934,697	$280.59
DY12/Q48	Apr-Jun 2018	7,342,683	$2,076,495,884	$282.80
DY13/Q49	Jul-Sep 2018	7,132,311	$1,954,402,395	$274.02
DY13/Q50	Oct-Dec 2018	7,124,805	$2,324,687,285	$326.28
DY13/Q51	Jan-Mar 2019	7,057,761	$2,056,619,243	$291.40
DY13/Q52	Apr-Jun 2019	6,973,128	$2,291,349,779	$328.60
DY14/Q53	Jul-Sep 2019	6,850,680	$1,735,861,484	$253.39
DY14/Q54	Oct-Dec 2019	6,808,386	$1,889,161,825	$277.48
DY14/Q55	Jan-Mar 2020	6,563,335	$1,725,864,956	$262.96
DY14/Q56	Apr-Jun 2020	7,240,933	$2,130,026,180	$294.16
Managed Medical Assistance- MEG 2 Total[4]		**333,930,755**	**333,930,755**	**$73,705,182,782**

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 report submissions without the adjustment of rebates.

Cumulative Expenditures and Member Months

Tables D and E, on the following pages, provide cumulative expenditures and member months for the reporting period for each demonstration year. The combined PMPM is calculated by weighting MEGs 1 and 2 using the actual member months. In addition, the PMPM targets as provided in the STCs are also weighted using the actual member months.

[4] MMA MEG2 Total (from DY01 on)

Table D MEG1 and MEG2 Annual Statistics			
DY09– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY09 Total	5,326,173	$4,235,554,765	$795.23
WOW DY09 Total	5,326,173	$4,190,100,299	$786.70
Difference		$(45,454,466)	
% of WOW PMPM MEG 1			101.08%
DY09– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY09 Total	27,169,344	$6,171,352,881	$227.14
WOW DY09 Total	27,169,344	$8,806,399,471	$324.13
Difference		$2,635,046,589	
% of WOW PMPM MEG 2			70.08%
DY10– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY10 Total	6,490,488	$5,150,312,128	$793.52
WOW DY10 Total	6,490,488	$5,388,532,947	$830.22
Difference		$238,220,819	
% of WOW PMPM MEG 1			95.58%
DY10– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY10 Total	30,058,563	$7,556,557,156	$251.39
WOW DY10 Total	30,058,563	$10,191,055,200	$339.04
Difference		$2,634,498,044	
% of WOW PMPM MEG 2			74.15%
DY11– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY11 Total	6,610,890	$5,774,063,463	$873.42
WOW DY11 Total	6,610,890	$5,796,494,461	$876.81
Difference		$22,430,998	
% of WOW PMPM MEG 1			99.61%
DY11– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY11 Total	30,826,940	$8,312,799,101	$269.66
WOW DY11 Total	30,826,940	$10,932,466,002	$354.64
Difference		$2,619,666,900	
% of WOW PMPM MEG 2			76.04%
DY12– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY12 Total	6,472,902	$5,705,016,160	$882.49
WOW DY12 Total	6,472,902	$6,650,842,076	$1,027.49
Difference		$945,825,916	
% of WOW PMPM MEG 1			85.78%
DY12– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY12 Total	29,144,972	$8,128,970,358	$278.92
WOW DY12 Total	29,144,972	$7,804,149,152	$267.77
Difference		$(324,821,206)	
% of WOW PMPM MEG 2			104.16%
DY13– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY13 Total	6,501,149	$5,538,320,985	$790.61
WOW DY13 Total	6,501,149	$6,947,062,810	$1,068.59
Difference		$1,408,741,285	
% of WOW PMPM MEG 1			79.72%
DY13– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY13 Total	28,288,005	$8,627,058,702	$304.97
WOW DY13 Total	28,288,005	$7,923,187,320	$280.09
Difference		$(703,871,382)	
% of WOW PMPM MEG 2			108.88%
DY14– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY14 Total	6,138,300	$6,300,319,984	$1,026.39
WOW DY14 Total	6,138,300	$6,821,676,939	$1,111.33
Difference		$573,033,008	
% of WOW PMPM MEG 1			92.36%
DY14– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY14 Total	27,463,334	$7,614,735,206	$272.40
WOW DY14 Total	27,463,334	$8,045,932,962	$292.97
Difference		$815,066,372	
% of WOW PMPM MEG 2			92.98%

Table D:

- For DY9, MEG 1 has a PMPM of $795.23 (Table D), compared to WOW of $786.70 (Table A), which is 101.08% of the target PMPM for MEG 1. MEG 2 has a PMPM of $227.14 (Table D), compared to WOW of $324.13 (Table A), which is 70.08% of the target PMPM for MEG 2.
- For DY10, MEG 1 has a PMPM of $793.52 (Table D), compared to WOW of $830.22 (Table A), which is 95.58% of the target PMPM for MEG 1. MEG 2 has a PMPM of $251.39 (Table D), compared to WOW of $339.04 (Table A), which is 74.15% of the target PMPM for MEG 2.
- For DY11, MEG 1 has a PMPM of $873.42 (Table D), compared to WOW of $876.81 (Table A), which is 99.61% of the target PMPM for MEG 1. MEG 2 has a PMPM of $269.66 (Table D), compared to WOW of $354.64 (Table A), which is 76.04% of the target PMPM for MEG 2.
- For DY12, MEG 1 has a PMPM of $881.37 (Table D), compared to WOW of $1,027.49 (Table A), which is 85.78% of the target PMPM for MEG 1. MEG 2 has a PMPM of $278.92 (Table D), compared to WOW of $267.77 (Table A), which is 104.16% of the target PMPM for MEG 2.
- For DY13, MEG 1 has a PMPM of $851.90 (Table D), compared to WOW of $1,068.59 (Table A), which is 79.72% of the target PMPM for MEG 1. MEG 2 has a PMPM of $304.97 (Table D), compared to WOW of $280.09 (Table A), which is 108.88% of the target PMPM for MEG 2.
- For DY14, MEG 1 has a PMPM of $1,026.39 (Table D), compared to WOW of $1,111.33 (Table A), which is 92.36% of the target PMPM for MEG 1. MEG 2 has a PMPM of $272.40 (Table D), compared to WOW of $292.97 (Table A), which is 92.98% of the target PMPM for MEG 2.

Table E Managed Medical Assistance Cumulative Statistics			
DY 09	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	32,495,57	$10,406,907,646	$320.26
WOW	32,495,57	$12,996,499,70	$399.95
Difference		$(2,589,592,124)	
% Of WOW			80.07%
DY 10	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	36,549,051	$12,706,869,284	$347.67
WOW	36,549,051	$15,579,588,147	$426.27
Difference		$(2,872,718,863)	
% Of WOW			81.56%
DY 11	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	37,437,830	$14,086,862,564	$376.27
WOW	37,437,830	$16,728,960,463	$446.85
Difference		$(2,642,097,898)	
% Of WOW			84.21%
DY 12	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	35,617,874	$13,833,986,518	$388.40
WOW	35,617,874	$14,454,991,228	$405.84
Difference		$(621,004,710)	
% Of WOW			95.70%
DY 13	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	34,789,154	$14,165,379,687	$407.18
WOW	34,789,154	$14,870,250,130	$427.44
Difference		$(704,870,443)	
% Of WOW			95.26%
DY 14	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	33,601,634	$13,781,234,429	$410.14
WOW	33,601,634	$14,867,609,901	$442.47
Difference		$(1,388,099,380)	

Table E:

- For DY9, the weighted target PMPM for the reporting period using the actual member months and the MEG specific targets in the STCs (Table E) is $399.95. The actual PMPM weighted for the reporting period using the actual member months and the MEG specific actual PMPM as provided in Table E is $320.26. Comparing the calculated weighted averages, the actual PMPM is 80.07% of the target PMPM.
- For DY10, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $426.27. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table E is $347.67. Comparing the calculated weighted averages, the actual PMPM is 81.56% of the target PMPM.
- For DY11, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $446.85. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table E is $376.27. Comparing the calculated weighted averages, the actual PMPM is 84.21% of the target PMPM.
- For DY12, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $405.84. The actual PMPM weighted for the reporting period using the actual member months and the MMA

specific actual PMPM as provided in Table G is $388.40. Comparing the calculated weighted averages, the actual PMPM is 95.70% of the target PMPM.

- For DY13, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $427.44. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table G is $407.18. Comparing the calculated weighted averages, the actual PMPM is 95.26% of the target PMPM.
- For DY14, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $442.47. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table G is $410.14. Comparing the calculated weighted averages, the actual PMPM is 92.69% of the target PMPM.

Hypothetical & Supplemental Budget Neutrality Test

Table F shows the Hypothetical & Supplemental Budget Neutrality Test for **MEDS-AD (MEG 4)** established in the MMA Waiver as specified in STC #95. Expenditures cap cost for each DY is calculated by multiplying actual MEDS-AD member months to DY/PMPM and compared to actual waiver expenditures using date of service tracking and reporting.

TABLE F MEG 4 MEDS AD				
MEDS AD	**DY12**	**DY13**	**DY14**	**TOTAL**
PMPM	$1,004.22	$1,004.22	$1,004.22	
Actual MM	595,021	899,412	645,501	
Cap Cost	$597,531,989	$903,207,519	$649,229,234	$2,149,968,741
Total spend	$360,056,121	$674,592,451	$621,909,979	$1,656,558,551
Hypothetical Variance	$237,475,868	$228,615,068	$27,319,255	$493,410,190

DY14 Costs for the AIDS, Healthy Start, and the Program for All-Inclusive Care for Children Programs

The AIDS Program (MEG 5), The Healthy Start Program (MEG 6), and the **Program for All-Inclusive Care for Children (PACC) (MEG 7)** are authorized as Cost Not Otherwise Matchable (CNOM) services under the 1115 MMA Waiver. Table G identifies the DY14 costs for these three programs. For budget neutrality purposes, these CNOM costs are deducted from the savings resulting from the difference between the With Waiver costs and the With-Out Waiver costs identified for DY14 in Table E on the previous page.

Table G WW/WOW Difference Less CNOM Costs				
DY14 Difference July 2019 - June 2020:				$1,388,099,380
CNOM Costs July 2019 – June 2020:				
	MEG 5 AIDS			$13,301,782
	MEG 6 Healthy Start			$39,771,608
	MEG 7 PACC			$136,216
DY14 Net Difference:				$1,334,889,774

Low Income Pool Statistics

Table H MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
DY09/Q34	$690,421,416
DY09/Q35	$556,474,290
DY09/Q36	$830,244,034
DY10/Q37	$0
DY10/Q38	$303,368,192
DY10/Q39	$437,678,858
DY10/Q40	$257,014,028
DY11/Q41	$0
DY11/Q42	$0
DY11/Q43	$390,048,771
DY11/Q44	$187,263,611
DY12/Q45	$0
DY12/Q46	$0
DY12/Q47	$135,591,685
DY12/Q48	$729,468,270
DY13/Q49	$ 16,240,436
DY13/Q50	$0
DY13/Q51	$466,328,947
DY13/Q52	$136,874,270
DY14/Q53	$54,413,099
DY14/Q54	$44,808,626
DY14/Q55	$559,512,502
DY14/Q56	$400,095,004
Total Paid[5]	**$14,374,516,783**

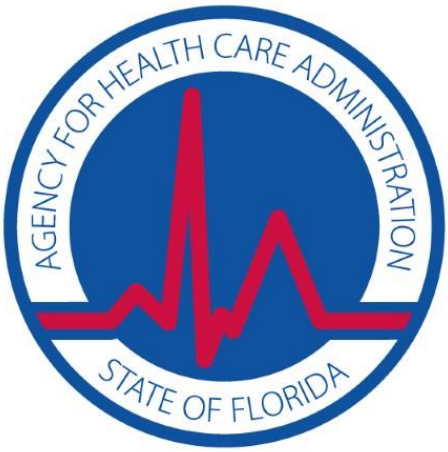
[5] MMA MEG3 Total (from DY01 on)

Low-Income Pool DY14 Expenditures

Expenditures for DY14 for **MEG 3**, Low Income Pool (LIP), were $1,258,829,231 (83.46%) of $1,508,385,773.

Table I MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY09	$2,077,139,740	$2,167,718,341	95.82%
DY10	$998,061,078	$1,000,000,000	99.81%
DY11	$577,312,382	$607,825,452	94.98%
DY12	$865,059,955	$1,508,385,773	57.35%
DY13	$619,443,653	$1,508,385,773	41.07%
DY14	$1,258,829,231	$1,508,385,773	83.46%

* STC #63 a. The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773.



Attachments

Attachment I	Statewide Medicaid Managed Care Expanded Benefits
Attachment II	MMA Plan Communications
Attachment III	MMA Enrollment Report
Attachment IV	Healthy Behaviors Program Enrollment Statistics
Attachment V	HEDIS Performance Measures

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Attachment I

Statewide Medicaid Managed Care Expanded Benefits

General Expanded Benefits *Available for children and/or adults*	**Adult Expanded Benefits (cont.)**
Cellular Services (minutes and/or data)	Computerized Cognitive Behavioral Therapy
Circumcision (newborns only)	Durable Medical Equipment/Supplies
CVS Discount Program (20% discount off certain items)	Equine Therapy
Doula Services (birth coach who helps pregnant women)	Group Therapy (Behavioral Health)
Home Delivered Meals	Hearing Services
Housing Assistance (rent, utilities, and/or grocery assistance)	Home Health Nursing/Aide Services
Meal Stipend (available for long distance medical appointment day-trips)	Homemaker Services (e.g., hypoallergenic carpet cleanings)
Over-the-Counter Benefit	Home Visit by a Social Worker
Swimming Lessons (children only)	Individual/Family Therapy
Transportation Services to Non-Medical Appointments/Activities	Massage Therapy
Adult Expanded Benefits *These services are only available for adults because they are already covered for children on Medicaid when medically necessary*	Medication Assisted Treatment Services
Acupuncture Services	Mental Health Targeted Case Management
Art Therapy	Nutritional Counseling
Behavioral Health Assessment/Evaluation Services	Occupational Therapy
Behavioral Health Day Services/Day Treatment	Outpatient Hospital Services
Behavioral Health Intensive Outpatient Treatment	Pet Therapy
Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)	Physical Therapy
Behavioral Health Psychosocial Rehabilitation	Prenatal Services
Behavioral Health Screening Services	Primary Care Services
Chiropractic Services	Respiratory Therapy

Adult Expanded Benefits (cont.)	Child Welfare Specialty Plan Services *These services are only available for enrollees in a specialty plan*
Speech Therapy	Care Grant
Substance Abuse Treatment or Detoxification Services (Outpatient)	Life Skills Development
Therapeutic Behavioral On-Site Services	Transition Assistance – Youth Aging Out of Foster Care
Vaccine – Influenza	**HIV/AIDS Specialty Plan Services** *These services are only available for enrollees in a specialty plan* Transition Assistance
Vaccine – Pneumonia	Home and Community-Based Services
Vaccine – Shingles	Vaccine - Hepatitis B
Vaccine – TdaP	Vaccine - Human Papilloma Virus
Vision Services	Vaccine – Meningococcal
Waived Copayments	
Long-Term Care Services *These services are only available for LTC enrollees*	
Assisted Living Facility/Adult Family Care Home - Bed Hold Days	
Individual Therapy Sessions for Caregivers	
Nursing Facility to Community Setting Transition Assistance	

MMA Dental Plan Expanded Benefits

In addition, all dental plans offer these expanded dental benefits if recipients are 21 or older with prior approval from the dental plan:

- ✓ Additional dental exams
- ✓ Additional dental X-rays
- ✓ Additional extractions
- ✓ Dental Screenings
- ✓ Fillings (silver and white)
- ✓ Fluoride
- ✓ Oral Health Instructions
- ✓ Sealants
- ✓ Teeth Cleanings (basic and deep)

Attachment II

DY14 Agency Communications to the MMA Plans

Ad Hoc Request for Private Duty Nursing Data • Policy Transmittal: 2020-38 [144KB PDF] • Attachment: Ad Hoc PDN Template 06.24.2020 [45KB MS Excel]	PT 2020-38	06/26/2020
Ad Hoc Request for Pharmacy Transaction Fee Information • Policy Transmittal: 2020-37 [140KB PDF] • Attachment 1: Milliman: Additional Data Request [165KB PDF] • Attachment 2: Milliman: Exhibit A Additional Data Request [19KB MS Excel]	PT 2020-37	06/25/2020
Critical Incident Reporting and Adverse and Critical Incident Summary Reporting • Policy Transmittal: 2020-36 [144KB PDF] • Attachment 1: SMMC Report Guide Chapter 15: Critical Incident Report – Individual [112KB PDF] • Attachment 2: SMMC Report Guide Chapter 7: Adverse and Critical Incident Summary Report [82KB PDF] • AIRS User GUIDE for Health Plans [3.20MB MS Word] • The AIRS Individual Critical Incident Demonstration video may be viewed on the Agency's YouTube channel under the "Medicaid Quality" playlist at https://www.youtube.com/watch?v=_0qv0uPUBHw&feature=youtu.be	PT 2020-36	06/18/2020
COVID-19 State of Emergency: Prior Authorization Reinstatement • Policy Transmittal: 2020-35 [144KB PDF]	PT 2020-35	06/12/2020
COVID-19 State of Emergency: Well-Child Visits Provided via Telemedicine • Policy Transmittal: 2020-34 [115KB PDF]	PT 2020-34	05/29/2020

Revised Templates for July 1, 2020 Reporting of Performance Measures and Well Child Visit (CMS-416) and FL 80% Screening Report • Policy Transmittal: 2020-33 [139KB PDF] • Attachment 1: Performance Measures Report Template SMMC-FI [600KB MS Excel] • Attachment 2: Well Child Visit Report Template 03312020 [280KB MS Excel]	PT 2020-33	05/14/2020
Fraud, Abuse, Waste, and Disclosure Reporting Requirements • Policy Transmittal: 2020-32 [90KB PDF] • Attachment: Instructions for Submission of the Supplemental Referral [146KB PDF]	PT 2020-32	05/08/2020
COVID-19 State of Emergency: Behavioral Health Requirements • Policy Transmittal: 2020-31 [138KB PDF]	PT 2020-31	05/05/2020
COVID-19 State of Emergency: Public Health Emergency: Adult Day Care Retainer Payments • Policy Transmittal: 2020-30 [98KB PDF] • Attachment 1: Adult Day Care Retainer Payment Form [25KB MS Word] • Attachment 2: Managed Care Plan Acknowledgment and Notification Template [15KB MS Word]	PT 2020-30	05/01/2020
COVID-19 State of Emergency: Reporting Requirements • Policy Transmittal: 2020-29 [157KB PDF] • Attachment: Report Summary 4.30.2020rev [26KB MS Excel]	PT 2020-29	04/30/2020
Reprocessing State Fiscal Year (SFY) 2019-20 Diagnosis Related Group (DRG) Rates • Policy Transmittal: 2020-28 [96KB PDF]	PT 2020-28	04/29/2020
Achieved Savings Rebate (ASR) Financial Reporting • Policy Transmittal: 2020-27 [137KB PDF] • Attachment 1: ASR Financial Report Template 04272020 [2.34MB MS Excel] • Attachment 2: ASR Dental Financial Report Template 04272020 [777KB MS Excel]	PT 2020-27	04/28/2020

COVID-19 State-of-Emergency: COVID-19 Laboratory Testing • Policy Transmittal: 2020-26 [146KB PDF]	PT 2020-26	04/27/2020
COVID-19 State-of-Emergency: Behavioral Health Telemedicine/Telehealth Requirements • Policy Transmittal: 2020-25 [176KB PDF]	PT 2020-25	04/21/2020
COVID-19 State of Emergency: Prior Authorization and Claims Payment Requirements • Policy Transmittal: 2020-24 [196KB PDF]	PT 2020-24	04/21/2020
COVID-19 State-of-Emergency: Coverage of Non-Emergency Ambulance • Policy Transmittal: 2020-23 [87KB PDF]	PT 2020-23	04/17/2020
Performance Measure Reporting, Recipient Surveys, Provider Satisfaction Survey Reporting • Policy Transmittal: 2020-22 [196KB PDF] • Attachment [56KB MS Excel]	PT 2020-22	04/17/2020
Achieved Savings Rebate (ASR) Financial Reporting • Policy Transmittal: 2020-21 [142KB PDF] • Attachment 1: ASR Financial Report SMMC 033020 [2.33MB MS Excel] • Attachment 2: ASR Dental Financial Report SMMC 033020 [777KB MS Excel]	PT 2020-21	04/04/2020
COVID-19 State of Emergency: Telemedicine Services • Policy Transmittal: 2020-20 [168KB PDF]	PT 2020-20	04/03/2020
Ad Hoc Request for Pharmacy Claims Data • Policy Transmittal: 2020-19 [141KB PDF] • Attachment: Milliman Data Request for PBM Pricing [81KB PDF]	PT 2020-19	04/01/2020

COVID-19 State of Emergency: Coverage of Services and Other Provisions • Policy Transmittal: 2020-18 [144KB PDF]	PT 2020-18	03/25/2020
COVID-19 State of Emergency: Non-Urgent and Non-Emergent Services (Transportation) • Policy Transmittal: 2020-17 [138KB PDF]	PT 2020-17	03/22/2020
COVID-19 State of Emergency: Temporary Expansion of Long-Term Care Provider Qualifications • Policy Transmittal: 2020-16 [155KB PDF]	PT 2020-16	03/20/2020
COVID-19 State of Emergency: Coverage of Services • Policy Transmittal: 2020-15 [156KB PDF] • Attachment 1: DEM Order NO. 20-006 [206KB PDF] • Attachment 2: DOH No. 20-002 [162KB PDF]	PT 2020-15	03/18/2020
COVID-19 State of Emergency: Medicaid Coverage of Laboratory Testing, Guidance for NEMT Brokers and Providers, and Managed Care Plan Provider Credentialing • Policy Transmittal: 2020-14 [149KB PDF] • Attachment: Guidance for NEMT Brokers and Providers on COVID-19 [112KB PDF]	PT 2020-14	03/14/2020
Statewide Essential Providers • Policy Transmittal: 2020-13 [89KB PDF]	PT 2020-13	03/12/2020
Guidance on the COVID-19 State of Emergency • Policy Transmittal: 2020-12 [151KB PDF] • Attachment: COVID-19 Public Health Emergency Order No. 20-002 [207KB PDF]	PT 2020-12	03/12/2020

Ad Hoc Request for Monthly Electronic Visit Verification (EVV) Reports • Policy Transmittal: 2020-11 [252KB PDF] • Attachment: EVV Vendor Status Report Template 02/28/2020 [43KB MS Excel] (Some Header Descriptions Revised, Template Updated 3/10/2020)	PT 2020-11	02/28/2020
Ad Hoc Request for Private Duty Nursing (PDN) Policies and Procedures • Policy Transmittal: 2020-10 [267KB PDF]	PT 2020-10	02/24/2020
Case Management File Audit Report and Operational Guidelines • Policy Transmittal: 2020-09 [148KB PDF] • Attachment 1: Case Management File Audit Report Template [27KB MS Excel] • Attachment 2: Case Management File Audit Report Operational Guidelines [36KB MS Excel]	PT 2020-09	02/21/2020
Ad Hoc Request for Documentation of Subcontractor Insolvency Account • Policy Transmittal: 2020-08 [254KB MS Word]	PT 2020-08	02/11/2020
Provider Satisfaction Survey • Policy Transmittal: 2020-07 [264KB PDF] • Attachment 1: MMA Provider Satisfaction Survey Tool [89KB MS Word] • Attachment 2: LTC Provider Satisfaction Survey Tool [90KB MS Word] • Attachment 3: Dental Provider Satisfaction Survey Tool [89KB MS Word]	PT 2020-07	02/07/2020
Non-Emergency Transportation Timeliness Report • Policy Transmittal: 2020-06 [149KB PDF] • Non-Emergency Transportation Timeliness Report Template [629KB MS Excel] (Drop Down Values Extended, Template Updated 3/11/2020) • SMMC Managed Care Report Guide Chapter 35 Redline version [806KB PDF]	PT 2020-06	02/03/2020

Electronic Visit Verification (EVV) Compliance Requirements • Policy Transmittal: 2020-05 [260KB PDF]	PT 2020-05	01/31/2020
Ad Hoc Request for Pharmacy Claims Data • Policy Transmittal: 2020-04 [252KB PDF] • Attachment 1: Milliman: Data Request for Independent Analysis of PBM Pricing Practices in SMMC Program [209KB PDF] • Attachment 2: Milliman: Exhibit A Claims Data Request [17KB MS Excel]	PT 2020-04	01/30/2020
Community Behavioral Health Services • Policy Transmittal: 2020-03 [154KB PDF]	PT 2020-03	01/30/2020
MMA Performance Measures for July 1, 2020 Reporting • Policy Transmittal: 2020-02 [253KB PDF]	PT 2020-02	01/27/2020
Achieved Savings Rebate (ASR) Financial Reporting • Policy Transmittal: 2020-01 [138KB PDF] • Attachment 1: ASR Report Template [2.36MB MS Excel] (Formula Corrections, Template Updated 2/10/2020) • Attachment 2: ASR Dental Report Template [769KB MS Excel]	PT 2020-01	01/17/2020
Home and Community-Based (HCB) Settings Requirements • Policy Transmittal: 2019-25 [263KB PDF] • Attachment: HCB Setting Progress Report Template [28KB MS Excel]	PT 2019-25	12/10/2019
Transportation Network Companies (TNCs) • Contract Interpretation: 2019-08 [359KB PDF] • Attachment 1: TNC Request Form [26KB MS Word]	CI 2019-08	12/06/2019

Appointment Wait Times Report • Policy Transmittal: 2019-24 [148KB PDF] • Attachment 1: Report Guide, Chapter 9 (Track Changes Version) [153KB PDF] • Attachment 2: Report Template [52KB MS Excel]	PT 2019-24	12/05/2019
Electronic Visit Verification (EVV) Implementation Parameters • Policy Transmittal: 2019-23 [183KB PDF]	PT 2019-23	11/26/2019
LTC Training Plan and Training Materials • Policy Transmittal: 2019-22 [250KB PDF]	PT 2019-22	11/25/2019
Requirements for Personal Care and Adult Companion Care Services • Contract Interpretation: 2019-07 [251KB PDF]	CI 2019-07	10/29/2019
Achieved Savings Rebate (ASR) Reporting • Policy Transmittal: 2019-21 [249KB PDF] • Attachment 1: ASR Financial Template 10/8/2019 [2.27MB MS Excel] • Attachment 2: ASR Dental Financial Template 10/8/2019 [764KB MS Excel] • Attachment 3: CMS Informational Bulletin 05/15/2019 [114KB PDF]	PT 2019-21	10/08/2019
MMA Physician Incentive Program (MPIP) Requirements • Policy Transmittal: 2019-20 [259KB PDF]	PT 2019-20	10/03/2019
Electronic Visit Verification System • Contract Interpretation: 2019-06 [255KB PDF]	CI 2019-06	9/18/2019

Medical Foster Care Services Reporting • Policy Transmittal: 2019-19 [148KB PDF] • Attachment: Medical Foster Care Services Report Template [344KB MS Excel]	PT 2019-19	9/16/2019
Administration of the Prescribed Drug Program in SMMC • Policy Transmittal: 2019-18 [252KB PDF] • Attachment: Pharmacy Benefit Manager Information Request [11KB MS Excel]	PT 2019-18	9/10/2019
Behavioral Health and Medical Neglect Child Staffings • Policy Transmittal: 2019-17 [255KB PDF] • Attachment 1: Child Staffing Attendance Report Template Instructions [25KB PDF] • Attachment 2: Child Staffing Attendance Report Template [38KB MS Excel]	PT 2019-17	08/23/2019
Submission of Dispute Requests • Policy Transmittal: 2019-16 [107KB PDF]	PT 2019-16	08/07/2019
Revised Requirements for Health Performance Measures & Provider and Enrollee Satisfaction Surveys (LTC) • Policy Transmittal: 2019-15 [182KB PDF] • Attachment: LTC Performance Measures Technical Specifications Manual [25KB PDF]	PT 2019-15	08/02/2019
Reinstatement of Services Authorization Performance Outcome Report • Policy Transmittal: 2019-14 [151KB PDF] • Attachment: Services Authorization Performance Outcome Report Template [93KB MS Excel]	PT 2019-14	07/26/2019

Attachment III

Managed Medical Assistance Enrollment Report

There are two categories of Florida Medicaid recipients who are enrolled in an MMA plan: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the MMA enrollment reports, based on the enrollee's eligibility for Medicare. The MMA enrollment reports are a complete look at the entire enrollment for the MMA Waiver for the reporting period. Table 1 provides a description of each column in the MMA enrollment reports that are located on the following pages in Tables 2 and 3.

Table 1
MMA Enrollment by Plan and Type Report Descriptions

Column Name	Column Description
Plan Name	The name of the MMA plan
Plan Type	The plan's type (Standard or Specialty)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled - No Medicare	The number of SSI recipients enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients enrolled with the plan and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients with the plan; TANF and SSI combined
Market Share for MMA	The percentage of the Managed Medical Assistance population compared to the entire enrollment for the year being reported
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year

Table 2 lists the total number of TANF and SSI individuals enrolled, and the corresponding market share, for the reporting period and prior year. Table 3 lists enrollment by region and plan type, and the total number of TANF and SSI individuals enrolled and the corresponding market share, for the reporting period and prior year.

Table 2 MMA Enrollment by Plan and Type[6] (July 1, 2019 – June 30, 2020)									
Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous year	Percent Change from Previous Year
			Medicaid Only	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	STANDARD	-	-	-	-	0	0.00%	34,126	-100.00%
Better Health	STANDARD	-	-	-	-	0	0.00%	9,766	-100.00%
Coventry Health Care Of Florida	STANDARD	111,239	9,537	53	8,488	129,317	3.48%	106,454	21.48%
Florida Community Care	STANDARD	3	663	2	10,051	10,719	0.29%	5,789	85.16%
Humana Medical Plan	STANDARD	472,661	54,646	223	51,678	579,208	15.57%	525,610	10.20%
Lighthouse Health Plan	STANDARD	36,417	2,779	5	974	40,175	1.08%	31,677	26.83%
Miami Children's Health Plan	STANDARD	25,059	1,791	31	1,165	28,046	0.75%	16,355	71.48%
Molina Healthcare Of Florida	STANDARD	99,349	10,317	62	7,353	117,081	3.15%	159,801	-26.73%
Prestige Health Choice	STANDARD	90,045	6,695	42	2,947	99,729	2.68%	143,752	-30.62%
South Florida Community Care Network	STANDARD	44,817	3,769	34	1,841	50,461	1.36%	49,799	1.33%
Simply Healthcare	STANDARD	464,057	50,700	335	29,117	544,209	14.63%	524,647	3.73%
Staywell Health Plan	STANDARD	803,910	84,371	131	32,666	921,078	24.76%	929,209	-0.88%
Sunshine State Health Plan	STANDARD	513,283	44,620	159	57,015	615,077	16.53%	641,984	-4.19%
United Healthcare Of Florida	STANDARD	250,594	28,079	67	23,035	301,775	8.11%	309,646	-2.54%
Vivida Health	STANDARD	14,435	1,027	1	539	16,002	0.43%	9,783	63.57%
Standard Plans Total		2,925,869	298,994	1,145	226,869	3,452,877	92.82%	3,498,398	-1.30%
Positive Health Plan	SPECIALTY	-	-	-	-	0	0.00%	215	-100.00%
Magellan Complete Care	SPECIALTY	14,206	8,098	6	3,027	25,337	0.68%	41,066	-38.30%
Freedom Health	SPECIALTY	-	-	-	-	0	0.00%	30	-100.00%
Clear Health Alliance	SPECIALTY	3,135	5,791	5	3,500	12,431	0.33%	11,952	4.01%
Wellcare of Florida/Staywell	SPECIALTY	69,894	34,002	49	14,784	118,729	3.19%	84,442	40.60%
Sunshine State Health Plan	SPECIALTY	37,156	1,870	-	3	39,029	1.05%	36,766	6.16%
Children's Medical Services Network	SPECIALTY	42,478	28,917	-	201	71,596	1.92%	63,166	13.35%
Specialty Plans Total		166,869	78,678	60	21,515	267,122	7.18%	237,637	12.41%
MMA TOTAL		3,092,738	377,672	1,205	248,384	3,719,999	100%	3,736,035	-0.43%

[1] During the year, an enrollee is counted only once in the plan of earliest enrollment. Please refer to http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml for actual monthly enrollment totals.

Table 3
MMA Enrollment by Region and Type
(July 1, 2019 – June 30, 2020)

Region	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Region	Enrolled in previous year	Percent Change from previous year
			No Medicare	Medicare Part B	Medicare Parts A and B				
01	Standard & Specialty	107,509	13,332	7	8,076	128,924	3.47%	130,756	-1.40%
02	Standard & Specialty	108,943	15,877	13	9,188	134,021	3.60%	137,575	-2.58%
03	Standard & Specialty	268,015	37,076	27	20,453	325,571	8.75%	326,432	-0.26%
04	Standard & Specialty	331,494	38,225	24	20,928	390,671	10.50%	390,978	-0.08%
05	Standard & Specialty	181,338	25,380	31	20,265	227,014	6.10%	228,881	-0.82%
06	Standard & Specialty	447,789	53,391	85	28,443	529,708	14.24%	526,880	0.54%
07	Standard & Specialty	424,136	51,188	147	24,216	499,687	13.43%	505,215	-1.09%
08	Standard & Specialty	214,766	20,873	28	17,119	252,786	6.80%	252,294	0.20%
09	Standard & Specialty	280,102	27,253	119	21,485	328,959	8.84%	329,684	-0.22%
10	Standard & Specialty	267,229	29,743	200	21,184	318,356	8.56%	317,711	0.20%
11	Standard & Specialty	461,417	65,334	524	57,027	584,302	15.71%	589,629	-0.90%
MMA TOTAL		3,092,738	377,672	1,205	248,384	3,719,999	100.00%	3,736,035	-0.43%
01	STANDARD	101,962	10,795	7	7,383	120,147	3.48%	122,970	-2.30%
02	STANDARD	100,484	11,870	11	8,228	120,593	3.49%	125,390	-3.83%
03	STANDARD	248,824	28,395	21	18,308	295,548	8.56%	302,203	-2.20%
04	STANDARD	311,987	30,997	23	19,130	362,137	10.49%	366,132	-1.09%
05	STANDARD	169,522	19,953	29	18,591	208,095	6.03%	211,270	-1.50%
06	STANDARD	424,119	42,484	81	26,173	492,857	14.27%	493,876	-0.21%
07	STANDARD	401,646	40,035	137	21,942	463,760	13.43%	472,901	-1.93%
08	STANDARD	202,739	16,013	22	15,603	234,377	6.79%	236,818	-1.03%
09	STANDARD	266,776	21,574	116	19,862	308,328	8.93%	309,978	-0.53%
10	STANDARD	254,883	23,228	196	19,464	297,771	8.62%	298,410	-0.21%
11	STANDARD	442,927	53,650	502	52,185	549,264	15.91%	558,450	-1.64%
STANDARD TOTAL		2,925,869	298,994	1,145	226,869	3,452,877	100.00%	3,498,398	-1.30%

01	SPECIALTY	5,547	2,537	-	693	8,777	3.29%	7,786	12.73%
02	SPECIALTY	8,459	4,007	2	960	13,428	5.03%	12,185	10.20%
03	SPECIALTY	19,191	8,681	6	2,145	30,023	11.24%	24,229	23.91%
04	SPECIALTY	19,507	7,228	1	1,798	28,534	10.68%	24,846	14.84%
05	SPECIALTY	11,816	5,427	2	1,674	18,919	7.08%	17,611	7.43%
06	SPECIALTY	23,670	10,907	4	2,270	36,851	13.80%	33,004	11.66%
07	SPECIALTY	22,490	11,153	10	2,274	35,927	13.45%	32,314	11.18%
08	SPECIALTY	12,027	4,860	6	1,516	18,409	6.89%	15,476	18.95%
09	SPECIALTY	13,326	5,679	3	1,623	20,631	7.72%	19,706	4.69%
10	SPECIALTY	12,346	6,515	4	1,720	20,585	7.71%	19,301	6.65%
11	SPECIALTY	18,490	11,684	22	4,842	35,038	13.12%	31,179	12.38%
SPECIALTY TOTAL		166,869	78,678	60	21,515	267,122	100.00%	237,637	12.41%

Effective December 1, 2018 The Prepaid Dental Health Program (PDHP) is providing Florida State Plan Medicaid dental to all Florida Medicaid recipients in accordance with STC #56.

Table 4 lists the total number of individuals enrolled, and the corresponding market share, for the initial reporting period.

TABLE 4
SMMC DENTAL ENROLLMENT BY PLAN
(JULY 1, 2019 – JUNE 30, 2020

Plan Name	Total Number Enrolled	Market Share for PDHP by Plan	Enrolled in previous year	Percent Change from Previous Year
Managed Care of North America (MCNA)	**854,207**	21.78%	648,676	**31.68%**
DentaQuest of Florida	**1,773,930**	45.23%	1,715,292	**3.42%**
Liberty Dental Plan of Florida	**1,293,839**	32.99%	1,153,809	**12.14%**
TOTAL	**3,921,976**	**100.00%**	**3,517,777**	**11.49%**

Attachment IV

Healthy Behaviors Program Enrollment Statistics

Table A provides a summary of enrollees participating in Healthy Behaviors Programs during DY14, and **Table B** provides a summary of enrollees who completed a Healthy Behaviors Program during the DY14.

Table A:
DY14 Healthy Behaviors Program Enrollment Statistics

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Aetna							
Medically Approved Smoking Cessation Program	22	11	11	0	2	11	9
Medically Directed Weight Loss Program	61	13	48	7	15	32	7
Medically Approved Alcohol or Substance Abuse Recovery Program	2	1	1	1	0	1	0
Children's Medical Services							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	7	5	2	7	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Community Care Plan							
Medically Approved Smoking Cessation Program	10	3	7	0	6	4	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	21	6	15	1	10	8	2

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Florida Community Care							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Humana Medical Plan							
Medically Approved Smoking Cessation Program	119	41	78	1	39	67	12
Medically Directed Weight Loss Program	96	19	77	1	30	49	16
Medically Approved Alcohol or Substance Abuse Recovery Program	83	31	52	0	44	33	6
Lighthouse Health Plan							
Medically Approved Smoking Cessation Program	2	0	2	0	2	0	0
Medically Directed Weight Loss Program	32	3	29	2	21	9	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Magellan Complete Care							
Medically Approved Smoking Cessation Program	8	3	5	0	3	5	0
Medically Directed Weight Loss Program	33	2	31	3	16	12	2
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Miami Children's Health Plan							
Medically Approved Smoking Cessation Program	3	2	4	0	0	4	2
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	4	4	4	2	3	3	0
Molina							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	13	7	6	0	4	8	1
Prestige Health Choice							
Medically Approved Smoking Cessation Program	6	1	5	0	0	3	3
Medically Directed Weight Loss Program	7	0	7	2	3	2	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Simply							
Medically Approved Smoking Cessation Program	12	6	6	0	0	6	6
Medically Directed Weight Loss Program	8	2	6	2	2	2	2
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Staywell							
Medically Approved Smoking Cessation Program	1268	207	1061	44	831	319	74
Medically Directed Weight Loss Program	297	79	218	101	123	61	12
Medically Approved Alcohol or Substance Abuse Recovery Program	54	13	41	3	26	22	3
Sunshine Health							
Medically Approved Smoking Cessation Program	51	26	25	1	6	33	11
Medically Directed Weight Loss Program	384	113	271	197	44	103	40
Medically Approved Alcohol or Substance Abuse Recovery Program	13	8	5	0	5	7	1
United Healthcare							
Medically Approved Smoking Cessation Program	130	39	91	1	34	71	24
Medically Directed Weight Loss Program	163	51	112	6	41	78	38
Medically Approved Alcohol or Substance Abuse Recovery Program	58	16	42	0	36	19	3
Vivida Health							
Medically Approved Smoking Cessation Program	4	1	3	0	0	3	1
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	4	3	1	1	1	2	0

Table B: DY14 Health Behaviors Program Completion Statistics							
Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Aetna							
Medically Approved Smoking Cessation Program	2	2	0	0	0	2	0
Medically Directed Weight Loss Program	4	2	2	0	2	2	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Children's Medical Services							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	7	5	2	7	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Community Care Plan							
Medically Approved Smoking Cessation Program	1	0	1	0	0	1	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	9	3	6	0	5	2	2
Florida Community Care							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Humana Medical Plan							
Medically Approved Smoking Cessation Program	9	1	8	0	3	4	2
Medically Directed Weight Loss Program	31	3	28	1	5	22	3
Medically Approved Alcohol or Substance Abuse Recovery Program	13	7	6	0	4	8	1
Lighthouse Health Plan							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	8	1	7	0	6	2	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Magellan Complete Care							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	2	0	2	0	0	2	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Miami Children's Health Plan							
Medically Approved Smoking Cessation Program	1	0	1	0	0	1	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	2	0	2	1	0	1	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Molina							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Prestige Health Choice							
Medically Approved Smoking Cessation Program	2	1	1	0	0	2	0
Medically Directed Weight Loss Program	1	0	1	0	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Simply							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Staywell							
Medically Approved Smoking Cessation Program	638	79	559	10	423	171	34
Medically Directed Weight Loss Program	196	44	152	85	66	38	7
Medically Approved Alcohol or Substance Abuse Recovery Program	38	8	30	2	24	9	3

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Sunshine Health							
Medically Approved Smoking Cessation Program	16	9	7	0	1	10	5
Medically Directed Weight Loss Program	143	36	107	49	16	58	20
Medically Approved Alcohol or Substance Abuse Recovery Program	3	1	2	0	1	1	1
United Healthcare							
Medically Approved Smoking Cessation Program	34	15	19	0	7	18	9
Medically Directed Weight Loss Program	66	21	45	2	10	34	20
Medically Approved Alcohol or Substance Abuse Recovery Program	5	3	2	0	1	4	0
Vivida Health							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Attachment V

HEDIS Performance Measures

Calendar Years (CY) 2018 and 2019 Florida Medicaid Managed Care Performance Measures					
	CY 2018		**CY 2019**		
Measure	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[1]**	**CY 2019 Weighted Mean**	**CY 2019 Comparison to National Mean[2]**	**CY 2019 Compared to CY 2018 Weighted Mean**
Adolescent Well-Care Visits	60%	Higher	63%	Higher	Higher
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years	70%	Lower	70%	Lower	Same
Adults' Access to Preventive/Ambulatory Health Services - 45-64 years	86%	Higher	86%	Higher	Same
Adults' Access to Preventive/Ambulatory Health Services - 65+ years	90%	Higher	87%	At the mean	Lower
Adults' Access to Preventive/Ambulatory Health Services - Total	77%	Lower	77%	Lower	Same
Adult BMI Assessment	89%	Higher	93%	Higher	Higher
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62%	Higher	60%	At the mean	Lower
Antidepressant Medication Management - Acute Phase	53%	Lower	55%	Higher	Higher
Antidepressant Medication Management - Continuation Phase	37%	Lower	40%	Higher	Higher
Asthma Medication Ratio- Total	72%	Higher	75%	Higher	Higher
Breast Cancer Screening	60%	Higher	61%	Higher	Higher
Cervical Cancer Screening	60%	Higher	58%	Lower	Lower
Controlling High Blood Pressure	64%	Higher	66%	Higher	Higher
Childhood Immunization Status - Combination 2	78%	Higher	79%	Higher	Higher
Childhood Immunization Status - Combination 3	73%	Higher	74%	Higher	Higher

Measure	CY 2018		CY 2019		
	CY 2018 Weighted Mean	CY 2018 Comparison to National Mean[1]	CY 2019 Weighted Mean	CY 2019 Comparison to National Mean[2]	CY 2019 Compared to CY 2018 Weighted Mean
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95%	At the mean	95%	At the mean	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	89%	Higher	89%	Higher	Same
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	89%	Lower	90%	At the mean	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	86%	Lower	87%	Lower	Higher
Chlamydia Screening in Women - 16-20 years	64%	Higher	63%	Higher	Lower
Chlamydia Screening in Women - 21-24 years	71%	Higher	69%	Higher	Lower
Chlamydia Screening in Women - Total	65%	Higher	64%	Higher	Lower
Comprehensive Diabetes Care - HbA1c Testing	86%	Lower	87%	Lower	Higher
Comprehensive Diabetes Care - HbA1c Poor Control (INVERSE)	42%	Lower (Better)	42%	Higher (Worse)	Same
Comprehensive Diabetes Care - HbA1c Good Control	48%	Lower	49%	At the mean	Higher
Comprehensive Diabetes Care - Eye Exam	56%	Lower	56%	Lower	Same
Comprehensive Diabetes Care - Nephropathy	92%	Higher	92%	Higher	Same
Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years	12%	Lower	13%	Lower	Higher
Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years	5%	Lower	7%	Lower	Higher
Engagement of Alcohol and Other Drug Dependence Treatment - Total	7%	Lower	7%	Lower	Same

	CY 2018		CY 2019		
Measure	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[1]**	**CY 2019 Weighted Mean**	**CY 2019 Comparison to National Mean[2]**	**CY 2019 Compared to CY 2018 Weighted Mean**
Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase	41%	Lower	46%	Higher	Higher
Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	55%	Lower	57%	Higher	Higher
Follow-up after Hospitalization for Mental Illness – 7 Day, Total	30%	Lower	28%	Lower	Lower
Follow-up after Hospitalization for Mental Illness – 30 Day, Total	50%	Lower	48%	Lower	Lower
Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Day, Total	6%	Lower	6%	Lower	Same
Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day, Total	8%	Lower	9%	Lower	Higher
Follow-up after Emergency Department Visit for Mental Illness – 7 Day, Total	29%	Lower	27%	Lower	Lower
Follow-up after Emergency Department Visit for Mental Illness – 30 Day, Total	45%	Lower	43%	Lower	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years	42%	Lower	46%	Higher	Higher
Initiation of Alcohol and Other Drug Dependence Treatment - 18+ years	42%	Lower	44%	Higher	Higher
Initiation of Alcohol and Other Drug Dependence Treatment - Total	41%	Lower	44%	Higher	Higher
Immunizations for Adolescents - Combination 1	74%	Lower	76%	Lower	Higher
Lead Screening in Children	71%	Higher	75%	Higher	Higher

	CY 2018		CY 2019		
Measure	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[1]**	**CY 2019 Weighted Mean**	**CY 2019 Comparison to National Mean[2]**	**CY 2019 Compared to CY 2018 Weighted Mean**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	40%	Higher	38%	Higher	Lower
Timeliness of Prenatal Care[3]	83%	Higher	92%	Higher	Higher
Postpartum Care[3]	63%	Lower	75%	Higher	Higher
Use of First- Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	62%	Higher	61%	Higher	Lower
Weight Assessment and Counseling for Children/ Adolescents – BMI Percentile	88%	Higher	89%	Higher	Higher
Well-Child Visits in the First 15 Months of Life - 0 Visits (INVERSE)	2%	At the mean	2%	Lower (Better)	Same
Well-Child Visits in the First 15 Months of Life - 6+ Visits	70%	Higher	73%	Higher	Higher
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78%	Higher	80%	Higher	Higher

[1]National Mean as published by NCQA, Medicaid product line. The National Mean that is compared to is the National Mean for 2018 reporting, which is calculated using CY 2017 service data.

[2]National Mean as published by NCQA, Medicaid product line. The National Mean that is compared to is the National Mean for 2019 reporting, which is calculated using CY 2018 service data.

[3]This measure's specifications changed significantly for calendar year 2019 service reporting so comparisons to the prior year's weighted mean and national Medicaid mean should be made with caution. *Timeliness of Prenatal Care* changed from requiring that the prenatal care visit occur while the member was enrolled in the plan to allowing a prenatal care visit to count for the measure even if that visit occurred prior to the member's enrollment in the plan. The *Postpartum Care* measure previously required that the postpartum visit occur between 21 and 56 days after delivery – this timeframe changed to between 7 and 84 days after delivery for calendar year 2019 (HEDIS 2020).

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Mission Statement
Better Healthcare for All Floridians.