Florida Medicaid
Managed Medical Assistance (MMA) Waiver

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

Annual Monitoring Report
(Part B)
July 1, 2020 – June 30, 2021
Demonstration Year 15

Agency for Health Care Administration

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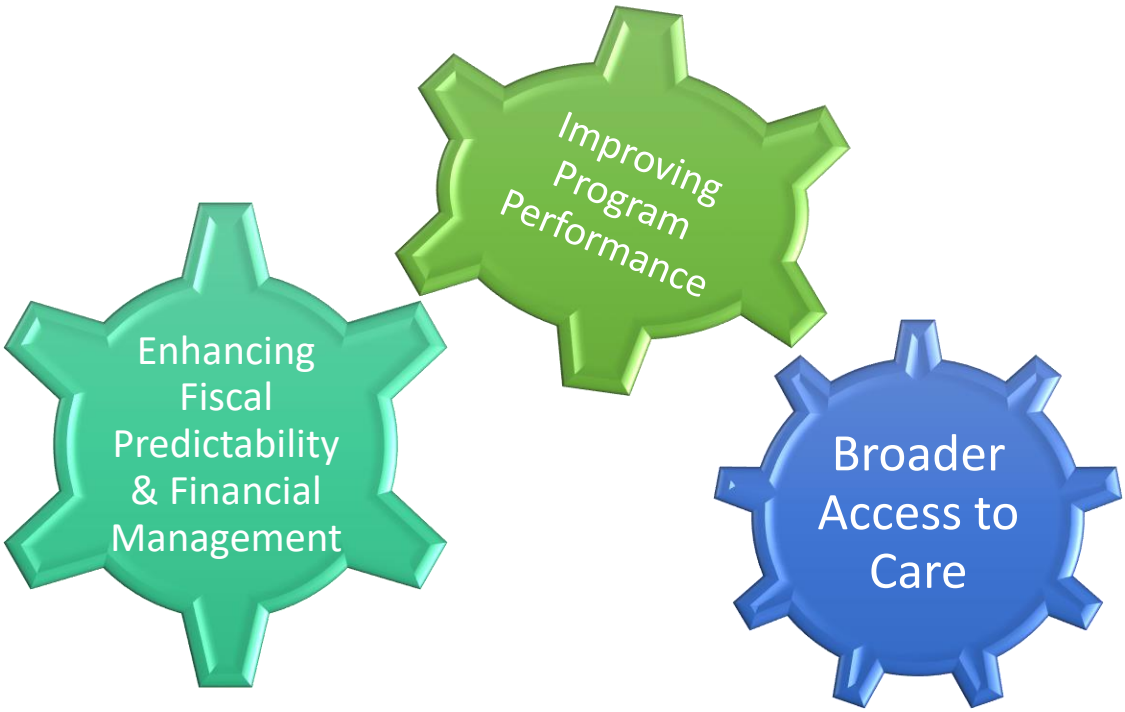
Executive Summary

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. Subsequent renewals were issued for August 2017 through June 2022, and the most recent renewal was a 10-year extension granted in January 2021. The 10-year extension granted in January 2021 expanded the waiver's approval period through June 30, 2030.

Per the Special Terms and Conditions (STC) of the MMA Waver, 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 15 (DY15) covering July 1, 2020, through June 30, 2021.

The Agency, in collaboration with CMS, is in the process of developing a new Monitoring Protocol and Report for the MMA Waiver. Until the Monitoring Protocol is complete and approved by CMS, the State was authorized to continue with the existing Annual Report template.

Additional detailed information regarding previous waiver activities and reports are 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). These flexibilities have continued through DY15. 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: extended recipient eligibility; increased time to request fair hearings; expanded provider enrollment parameters; expanded service coverage; and waived prior authorization requirements. The Agency's action in these areas began in DY14 and extended into DY15. The aforementioned strategies worked in concert to maintain the goals of the Medicaid program in the face of the PHE.

Health Care Plan Contract Procurement

The SMMC program began in 2013, with five-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 and were set to expire in 2023. However, 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 on the following page 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. Under the SMMC contracts, the Agency's focus is on 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:

- Preventative Services
- Behavioral Health Integration
- Maternal Outcomes

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.

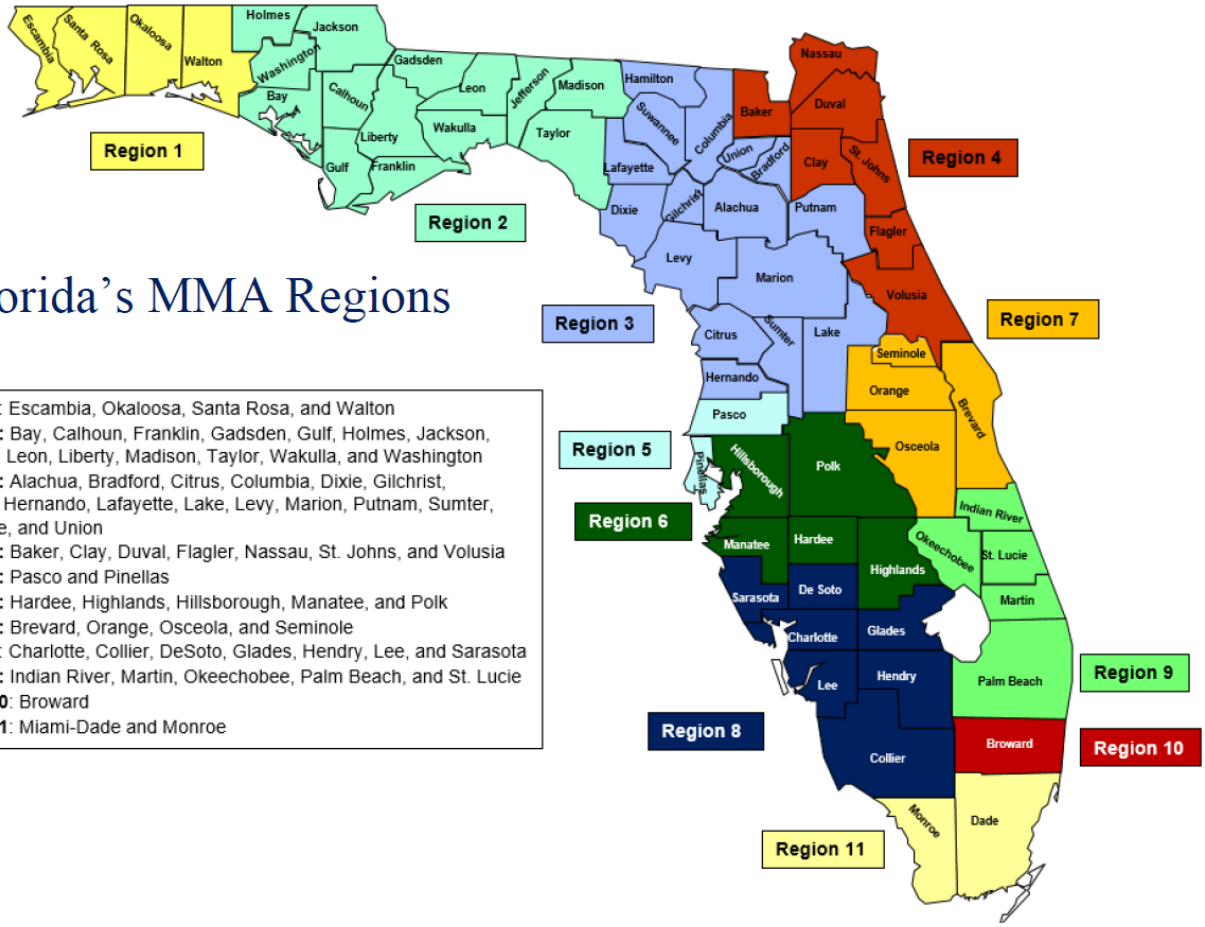
Each plan has a unique offering of expanded benefits, as the plans are not required to cover all of the expanded benefit services enumerated on the comprehensive list contained in **Attachment I**. However, there are some expanded benefits that are covered by all of the MMA plans, such as vaccines for adults. 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.

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

STATEWIDE MEDICAID MANAGED CARE (SMMC) HEALTH PLANS
(2018-2024)

REGION	AETNA BETTER HEALTH (COV)	COMMUNITY CARE PLAN (CCP)	FLORIDA COMMUNITY CARE (FCC)	HUMANA MEDICAL PLAN (HUM)	MOLINA HEALTHCARE (MOL)	AMERIHEALTH (PRS)	SIMPLY HEALTHCARE (SHP)	STAYWELL (STW)	SUNSHINE HEALTH (SUN)	UNITED-HEALTHCARE (URA)	VIVIDA HEALTH (BST)
1			FCC LTC+	HUM COMP			SHP MMA	STW COMP	SUN COMP		
2			FCC LTC+	HUM COMP			SHP MMA	STW COMP	SUN COMP		
3			FCC LTC+	HUM COMP				STW COMP	SUN COMP	URA COMP	
4			FCC LTC+	HUM COMP				STW COMP	SUN COMP	URA COMP	
5			FCC LTC+	HUM COMP			SHP COMP	STW COMP	SUN COMP		
6	COV COMP		FCC LTC+	HUM COMP			SHP COMP	STW COMP	SUN COMP	URA COMP	
7	COV COMP		FCC LTC+	HUM COMP			SHP COMP	STW COMP	SUN COMP		
8			FCC LTC+	HUM COMP	MOL COMP			STW COMP	SUN COMP		BST MMA
9			FCC LTC+	HUM COMP		PRS MMA	SHP MMA	STW COMP	SUN COMP		
10		CCP MMA	FCC LTC+	HUM COMP			SHP COMP		SUN COMP		
11	COV COMP		FCC LTC+	HUM COMP	MOL COMP	PRS MMA	SHP COMP	STW COMP	SUN COMP	URA COMP	

SMMC SPECIALTY PLANS (2018-2024)						SMMC DENTAL PLANS (2018-2024)		
REGION	CHILDREN'S MEDICAL SERVICES PLAN - CHILDREN WITH CHRONIC CONDITIONS	CLEAR HEALTH ALLIANCE HIV/AIDS	MOLINA HEALTHCARE 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	MOLINA HEALTHCARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
5	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MOLINA HEALTHCARE 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	MOLINA HEALTHCARE 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
11	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN

DY15 Contract Amendments

July 2020

This amendment adds special payment enhancements and rates for:

- Public Emergency Medical Transportation Uniform Increase Payment (New Exhibit I-G in Attachment I; and Attachment II, Section VIII.E.4.);
- MMA Hospital Inpatient and Outpatient Exemption Payments (New Exhibit I-K in Attachment I, and corresponding language in Attachment I, Section III. Method of Payment; and MMA Exhibit II-A, Section VIII.E.)
- COVID-19 Public Health Emergency Adult Day Care (ADC) Retainer Payments (LTC Exhibit II-B, Section VIII.E.)

Updated Rates Effective for Rate Year (RY) 19/20 for:

- Managed Care Plan Rates (Exhibit I-C to Attachment I);
- Kick Payments for Covered Obstetrical Delivery Services (Exhibit I-D to Attachment I);
- Faculty Plans of Florida Medical School Faculty Physician Groups Minimum Fee Schedule (Exhibit I-H to Attachment I); and
- Florida Cancer Hospital Rates (Exhibit I-I to Attachment I)

Administration and Management:

- Public health emergency added for inclusion in plans' Emergency Management Plans in Attachment II, Core, Section X.B.7.

October 2020

This amendment updates special payment enhancements and rates for:

- Public Emergency Medical Transportation Uniform Increase Payment (Exhibit I-G in Attachment I);
- MMA Hospital Inpatient and Outpatient Exemption Payments (Exhibit I-K in Attachment I)

Rates Effective for Rate Year (RY) 20/21 added to Attachment I for:

- Managed Care Plan Rates (Exhibit I-C);
- Kick Payments for Covered Obstetrical Delivery Services (Exhibit I-D);
- Faculty Plans of Florida Medical School Faculty Physician Groups Minimum Fee Schedule (Exhibit I-H); and
- Florida Cancer Hospital Rates (Exhibit I-I)

General (non-Rate) Amendment Highlights:

- Incorporation of SUPPORT Act requirements
- Pharmacy Lock-In and PDL implementation timeframes
- Implementation requirements of PDN Withhold
- Incorporation of applicable Policy Transmittals
- Advance notice (30-days) requirement for provider manual changes involving service authorization and claims payment
- Requirements for authorization of inpatient behavioral health services
- Addition of Liquidated Damages
- Summary of Reporting Requirements Table updates in alignment with Managed Care Report Guide
- Statutory citation corrections
- Care Coordinator requirements for children with special health care needs in need of residential treatment
- LTC Plan of Care submission requirements to enrollee PCP

Merger Amendments Executed During SFY 2020-2021:

- Effective February 1, 2021: Simply Healthcare Plans, Inc. purchased Lighthouse Health Plan Medicaid line of business
- Effective May 1, 2021: Simply Healthcare Plans, Inc. purchased Miami Children's Health Medicaid line of business

Merger Amendments for SFY2021-2022

- Effective September 1, 2021: Molina Healthcare of Florida, Inc. acquired Florida MHS, Inc. d/b/a Magellan Complete Care specialty plan
- Effective October 1, 2021: Sunshine and Wellcare d/b/a Staywell

Communication to the MMA Plans

During DY14, the Agency released 61 plan communications. This included 58 policy transmittals and 3 contract interpretations.

Examples of DY14 Policy Transmittal Topics include:

- COVID-19 State of Emergency: Vaccine Administration
- 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 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 DY15 reporting period, plans either sponsored, co-sponsored, or participated in 366 events. The number of events held by the MMA plans decreased during DY15 as the plans continue to accommodate the challenges presented by the PHE.

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	0	0	0	***0***
Florida Department of Health Children's Medical Services	50	0	0	***50***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	0	0	0	***0***
DentaQuest of Florida, Inc.	0	6	0	***6***
Florida Community Care, LLC	4	0	0	***4***
Humana Medical Plan, Inc.	0	0	0	***0***
Lighthouse Health Plan	0	0	0	***0***
Liberty Dental Plan of Florida, Inc.	0	36	0	***36***
Managed Care Plan of North America, Inc.	0	0	0	***0***
Florida MHS, Inc./Magellan Complete Care	5	0	0	***5***
Miami Children's Health Plan, Inc.	91	0	0	***91***
Molina Health Care of Florida, Inc.	14	2	2	***18***
South Florida Community Care Network, LLC/ Community Care Plan	0	6	0	***6***
Florida True Health Inc./Prestige Health Choice	0	0	3	***2***
Simply Healthcare Plans, Inc.	35	16	0	***51***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	76	0	0	***76***
Sunshine State Health Plan, Inc.	14	3	0	***17***
United Health Care of Florida, Inc.	2	1	0	***3***
Total	***291***	***70***	***5***	***366***

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 871 marketing materials in DY15.

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.

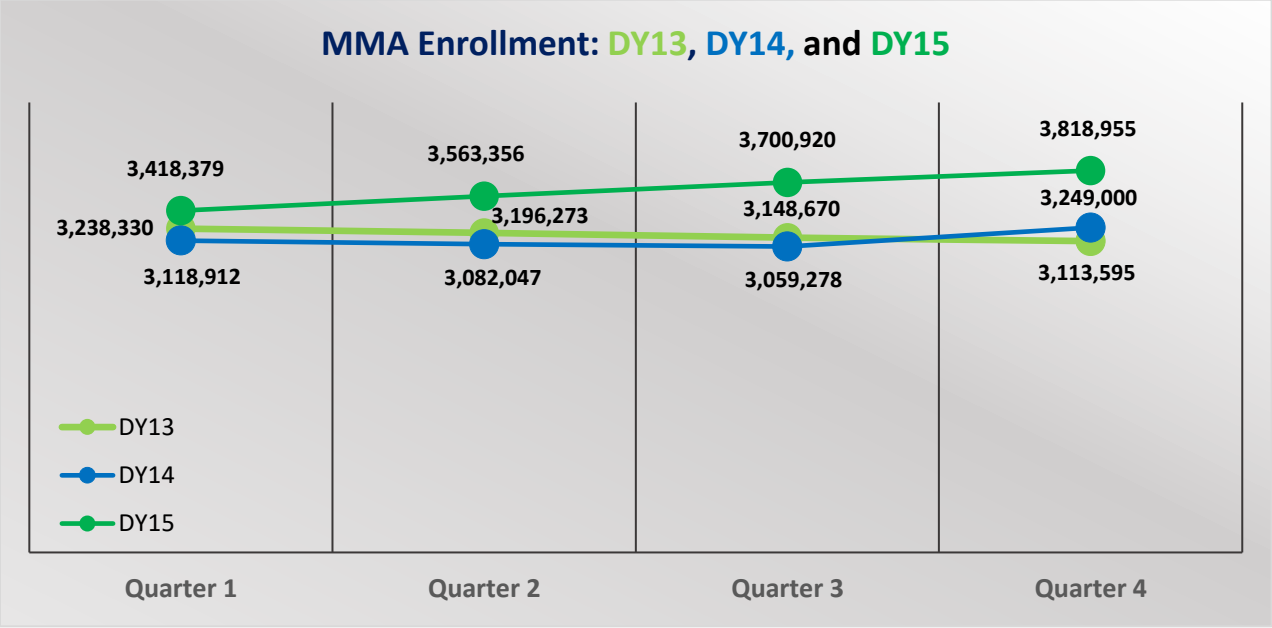
MMA Plan Materials Submitted to the Agency

SMMC Plan	Branding	Nominal Gifts	Scripts	Written	*Total*
Best Care Assurance, LLC/Vivida Health	0	0	63	6	***69***
Florida Department of Health Children's Medical Services	0	12	6	6	***24***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	0	1	67	4	***72***
DentaQuest of Florida, Inc.	0	1	0	1	***2***
Florida Community Care, LLC	0	1	0	3	***4***
Humana Medical Plan, Inc.	0	7	161	0	***168***
Lighthouse Health Plan	0	0	0	0	***0***
Liberty Dental Plan of Florida, Inc.	0	21	20	0	***41***
Managed Care Plan of North America, Inc.	0	0	0	1	***1***
Florida MHS, Inc./Magellan Complete Care	0	0	0	0	***0***
Miami Children's Health Plan, Inc.	3	1	68	0	***72***
Molina Health Care of Florida, Inc.	1	1	9	3	***14***
South Florida Community Care Network, LLC/ Community Care Plan	4	7	69	1	***81***
Florida True Health Inc./Prestige Health Choice	4	23	38	10	***75***
Simply Healthcare Plans, Inc.	6	3	23	3	***35***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	0	0	56	0	***56***
Sunshine State Health Plan, Inc.	11	7	88	4	***110***
United Health Care of Florida, Inc.	12	19	16	0	***47***
Total	***41***	***104***	***684***	***42***	***871***

1.3 Enrollment and Disenrollment

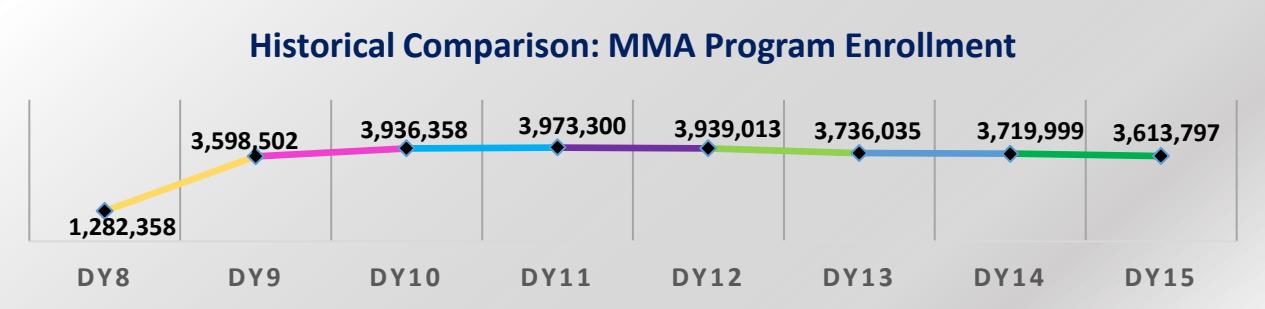
Managed Medical Assistance Enrollment

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 DY15 enrollment.



Enrollment steadily increased during each of the DY15 quarters, and as projected in the DY14 Annual Report, Medicaid enrollment was higher in DY15 than in years past. This is attributable to COVID-19 and the PHE, 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 also 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.



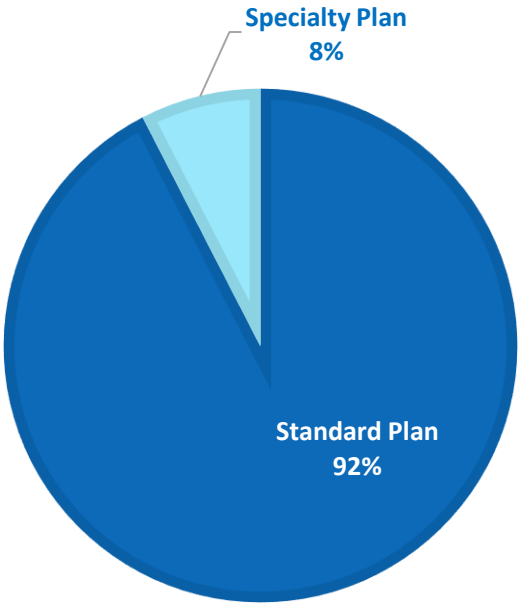
Specialty Plan Enrollment

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 8% of the total MMA program population. Specialty Plan enrollment increased one percentage point from DY14.

DY15
MMA Specialty Plan Enrollment

Enrollment Statistics:

Specialty Plan	273,932
Standard Plan	3,339,865
Total	3,613,797



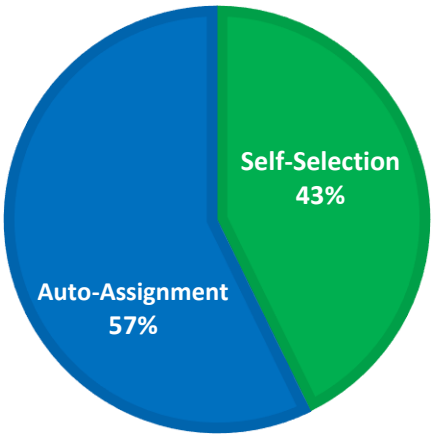
The complete MMA Enrollment Report is contained in **Attachment III.**

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 DY15 and the subsequent graph illustrates past demonstration year data.

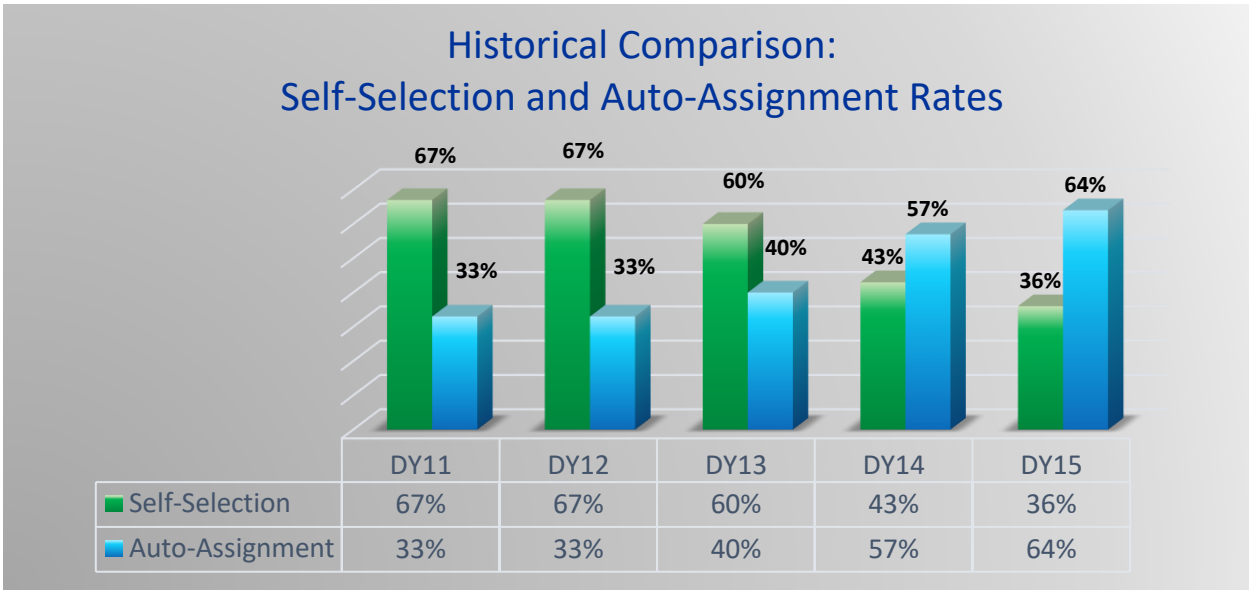


DY15
Self-Selection and Auto-Assignment

Auto-Assignment	425,871
Self-Selection	243,783
Total	**669,654**

Auto-assignments outnumbered self-selections in DY15. 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 and DY15 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 in DY14, and the reinstated group is not reflected in either of the enrollment choice categories.



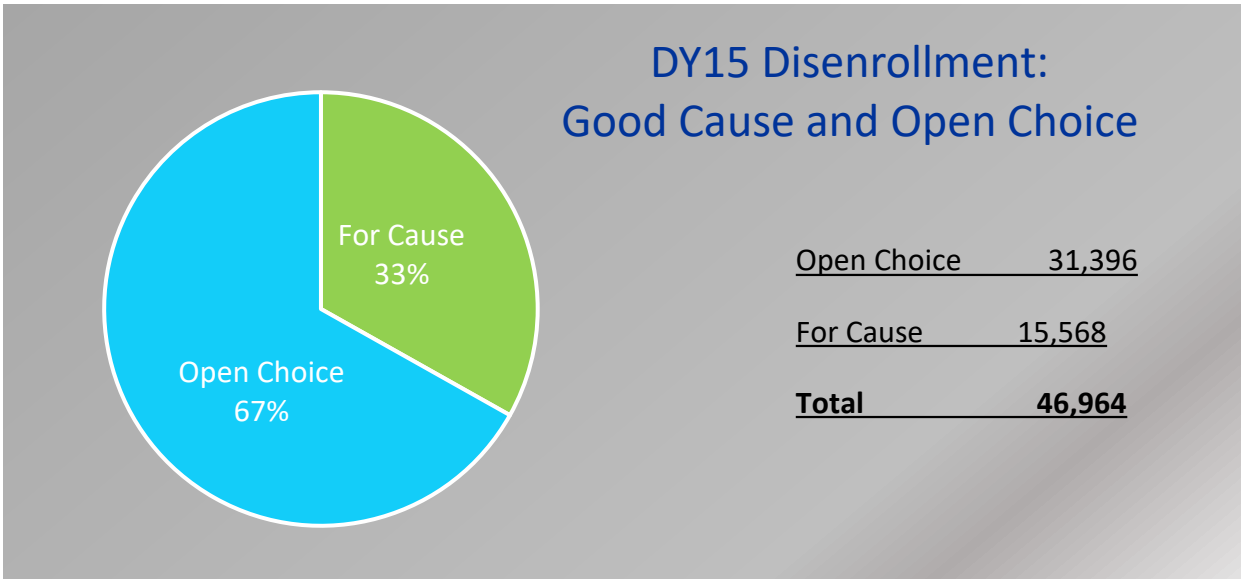
The increase in auto-assignments during DY14 and DY15 can also be attributed to the success of the Agency's MMA plan assignment algorithm, as most recipients are not utilizing the 120-day post enrollment period to change their MMA plan, which would categorize them as a self-selection choice. This indicates 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. For Cause Disenrollment
2. Open Choice Period Disenrollment

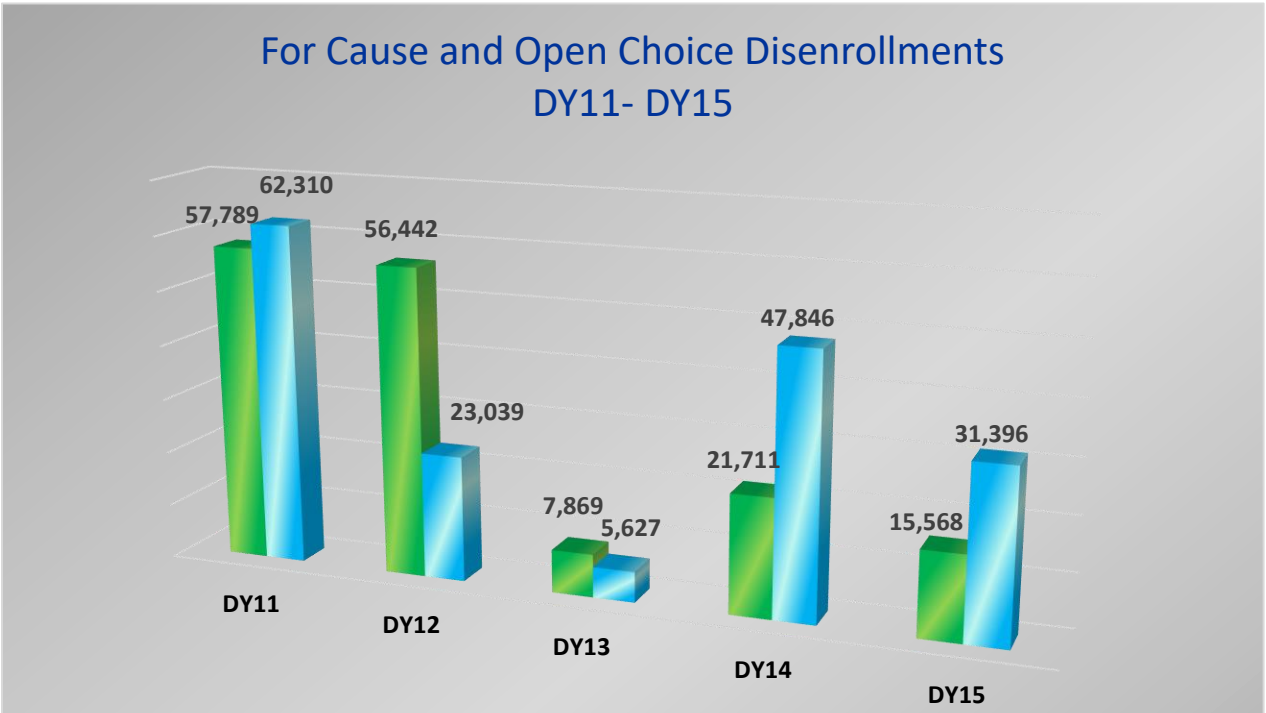
For cause disenrollment occurs when an enrollee disenrolls from their MMA plan either outside of the 120-day post enrollment window or outside of their open enrollment period. Beyond the initial 120-days, and outside of the annual open enrollment period, disenrollment from an MMA plan is only permitted when there is cause; for 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 DY15, open enrollment disenrollments accounted for approximately 67% of disenrollments.



Consistent with DY14, the DY15 disenrollment rate for open choice was greater than the for cause disenrollment rate. DY15 open choice disenrollments decreased slightly from those in DY14 (69%). DY15 had a slight increase with for cause disenrollments over DY14. This is consistent for the last two demonstration years. The total disenrollment numbers for DY15 represent a decrease when compared to DY14, DY12 and DY11.

During DY13, the Agency was transitioning to a new MMA health plan contract; thus, for 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 and DY15 represent a decrease when compared to DY11 and DY12.



	DY11	DY12	DY13	DY14	DY15
Open Choice	57,789	56,442	7,869	21,711	15,568
For Cause	62,310	23,039	5,627	47,846	31,396

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.

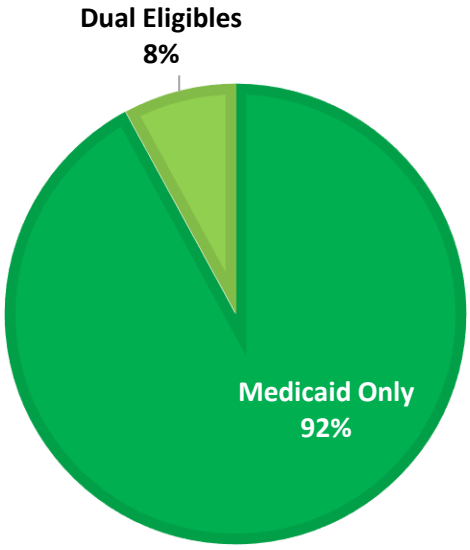
The number of dually eligible recipients enrolled in MMA plans during DY15 was 286,792, which represents 8% of total MMA program enrollment. This enrollment figure is slightly

higher than in DY14 when the dually eligible enrollment was 228,014, representing 6% of the total DY14 MMA program enrollment.

Dual Eligibility Enrollment DY15

Eligibility Statistics:

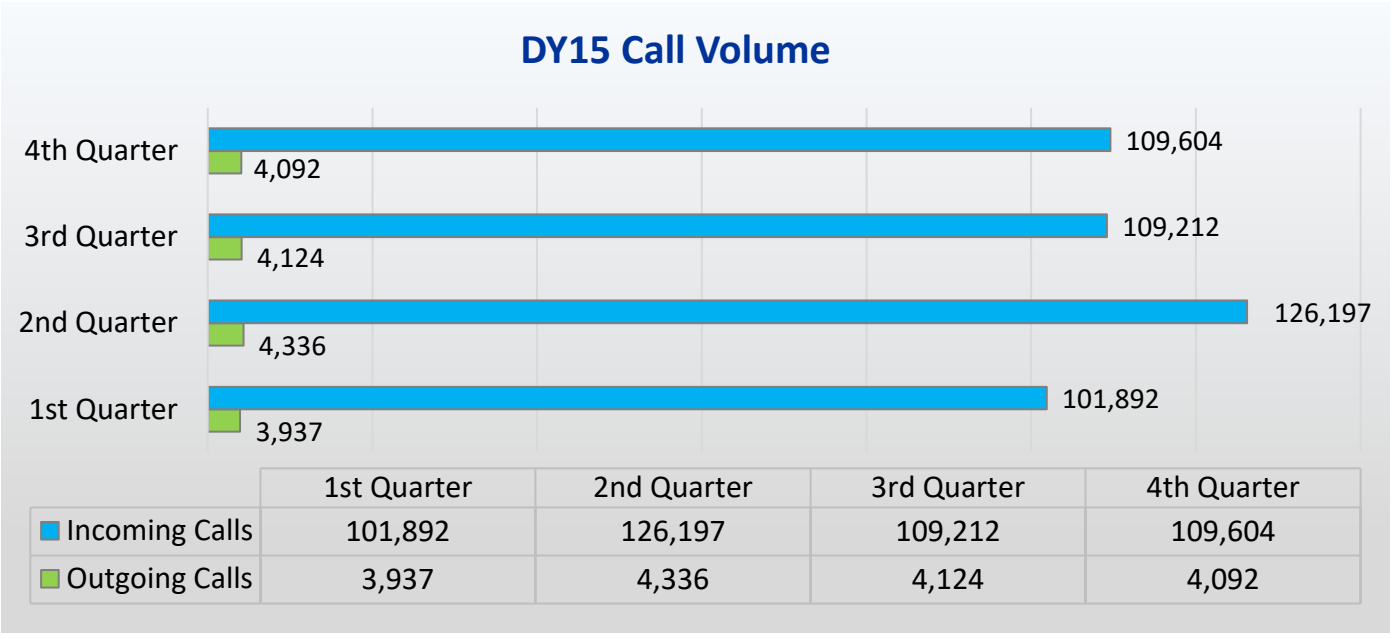
Medicaid Only	3,327,005
Dual Eligibles	286,792
Total	3,613,797



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	101,892	126,197	109,212	109,604
Outgoing Calls	3,937	4,336	4,124	4,092

Incoming calls represented approximately 96% of all call volume during DY15. As illustrated above, incoming call volume was higher during the first and second quarters of DY15 due to Open Enrollment and outgoing calls remained consistent throughout all four quarters.

DY15 call center trends continued to deviate from past demonstration year call volumes by continuing on the downward trend for incoming calls and the upward trend for outgoing calls. These trends began in DY14. However, these call volume trends could be attributable to the PHE and thus be followed by a return to normalcy at the conclusion of the PHE and the return to normal operating procedures.

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 – DY15 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
DY15	101,892	126,197	109,212	109,604

DY12 – DY15 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
DY15	3,937	4,336	4,124	4,092

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.

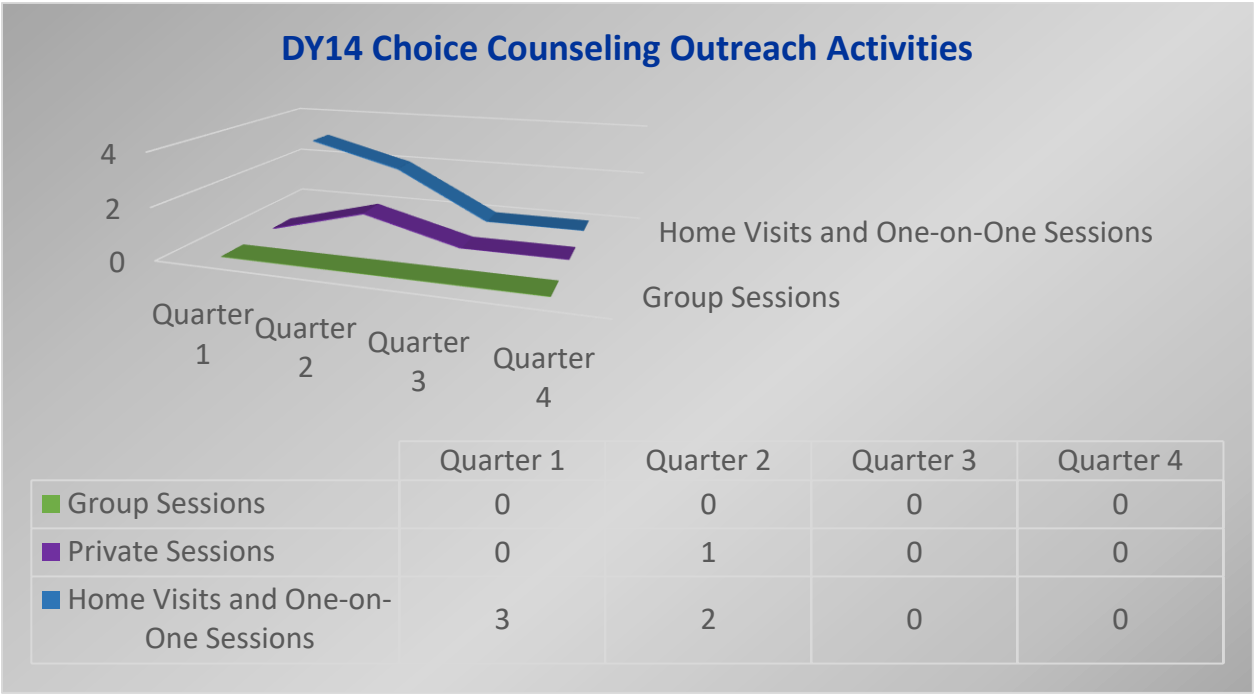
In DY12, the call volume increases were due to consolidation of the 1915(c) Project AIDS Care Waiver, Adults with Cystic Fibrosis Waiver, and Traumatic Brain and Spinal Cord Injury Waiver into the SMMC program. During the second and third quarters, a large percentage of MMA recipients were permitted 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 and DY15'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 graph, 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. During DY15, choice counseling outreach activities were suspended due to the COVID-19 PHE.



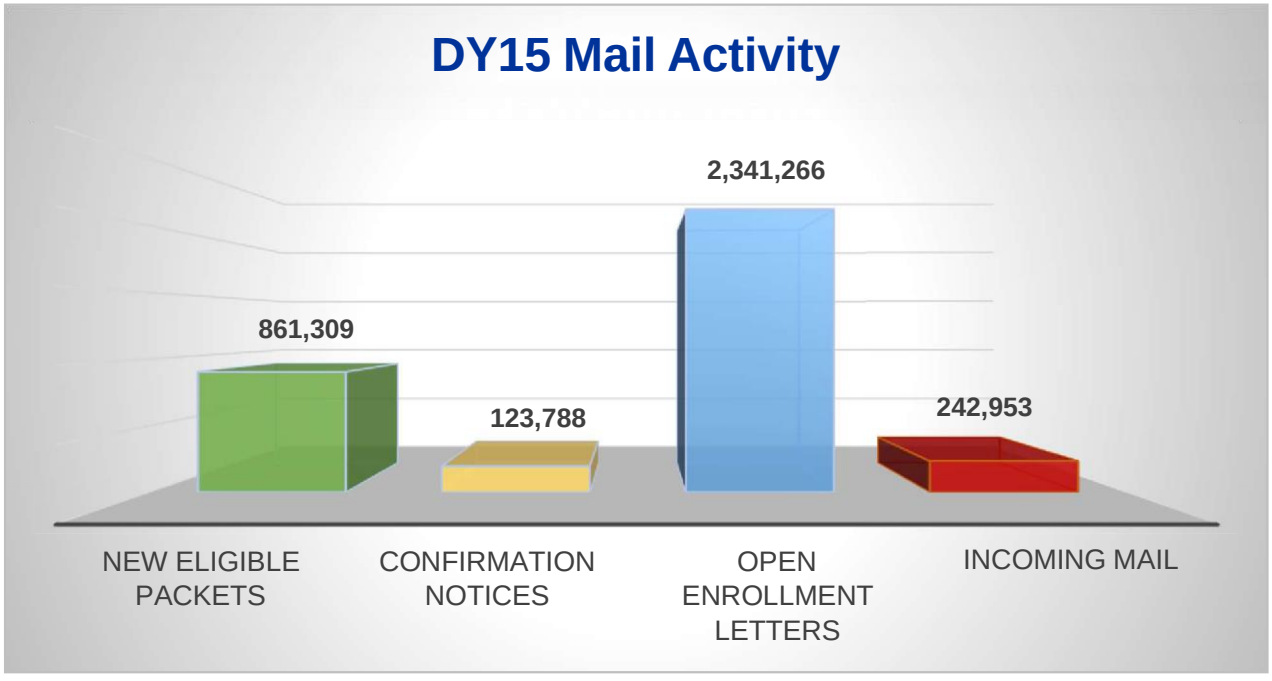
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Group Sessions	0	0	0	0
Private Sessions	0	1	0	0
Home Visits and One-on-One Sessions	3	2	0	0

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.

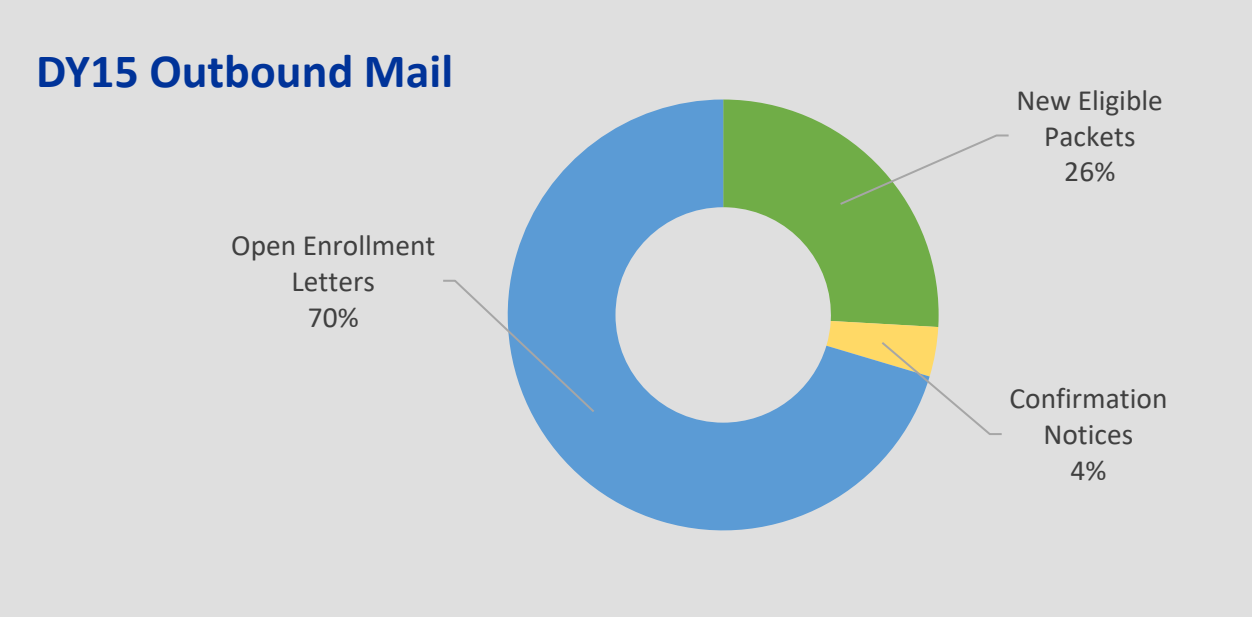
The decrease in recipients accessing these services is expected as the MMA program matures, and recipients become more comfortable and familiar with the program, including how to access assistance from the choice counseling vendor. Due to the suspension of choice counseling activities in DY15, the realization of this anticipated trend remains to be seen and more analysis will be conducted once normal activities resume.

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 DY15 mailing activity is as follows:



During DY15, the choice counseling vendor mailed 2,341,266 pieces to Medicaid recipients. This is an 877,226-piece reduction in outbound mail from DY14. Open Enrollment letters accounted for 70% of the total outgoing mail.



1.5 Demonstration Programs

1.5.1 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

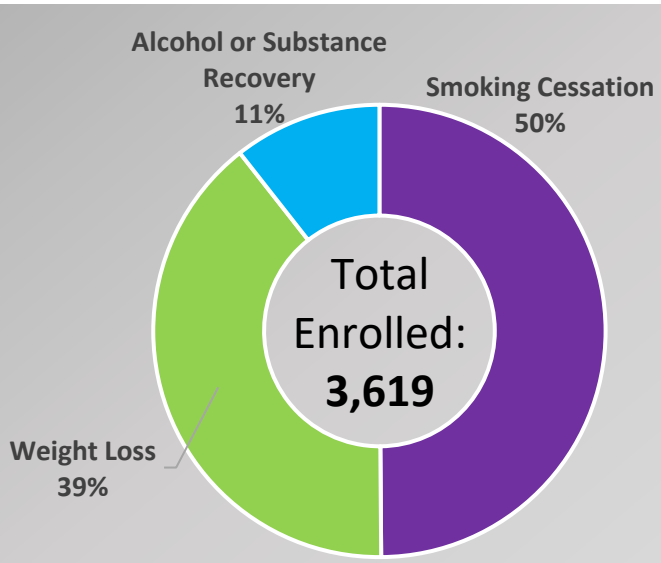
In addition to the required programs, the Agency encourages health plans to offer other healthy behaviors programs, and several plans offer additional programs such as managing diabetes, well child visits, and prenatal care, all of which are in line with the Agency's goals and areas of interest for the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

Itemized DY15 participation and completion data for the required Healthy Behaviors programs is in **Attachment III**.

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 DY15.

DY15 Healthy Behaviors Program Enrollment

Smoking Cessation	1,805
Weight Loss	1,431
Substance or Alcohol Abuse	383



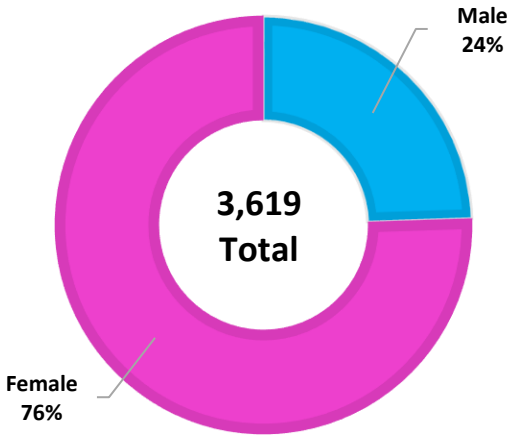
For the third consecutive demonstration year, the Medically Approved Smoking Cessation Program had the highest enrollment of all three of the Healthy Behaviors programs, followed by the Medically Directed Weight Loss Program. The Alcohol or Substance Recovery program continued to have the lowest overall enrollment in DY15.

The overall enrollment in the required Healthy Behaviors programs increased considerably in DY15 form DY14: Medically Approved Smoking Cessation programs increased by 10%, Medically Directed Weight Loss programs increased by 31%, and the Alcohol or Substance Abuse programs increased by 49%.

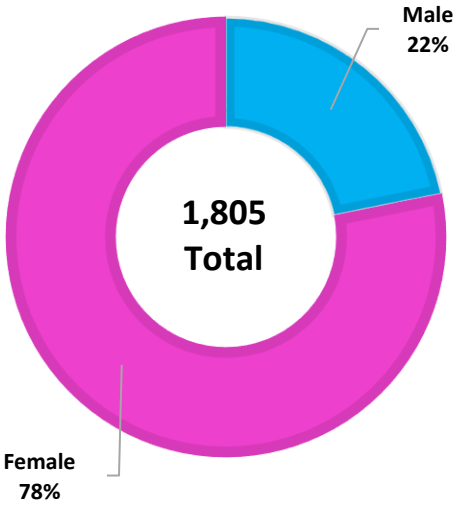
Healthy Behavior Program Participation: Gender

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 DY15 as illustrated below.

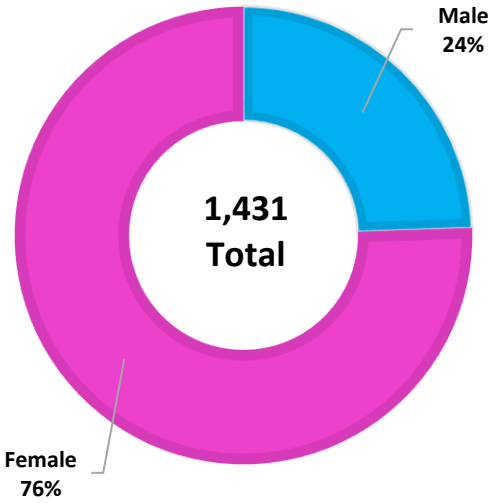
All Program Participation: Gender



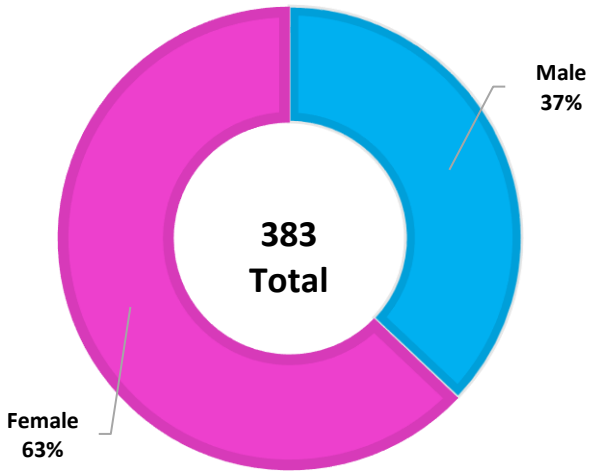
Smoking Cessation



Weight Loss



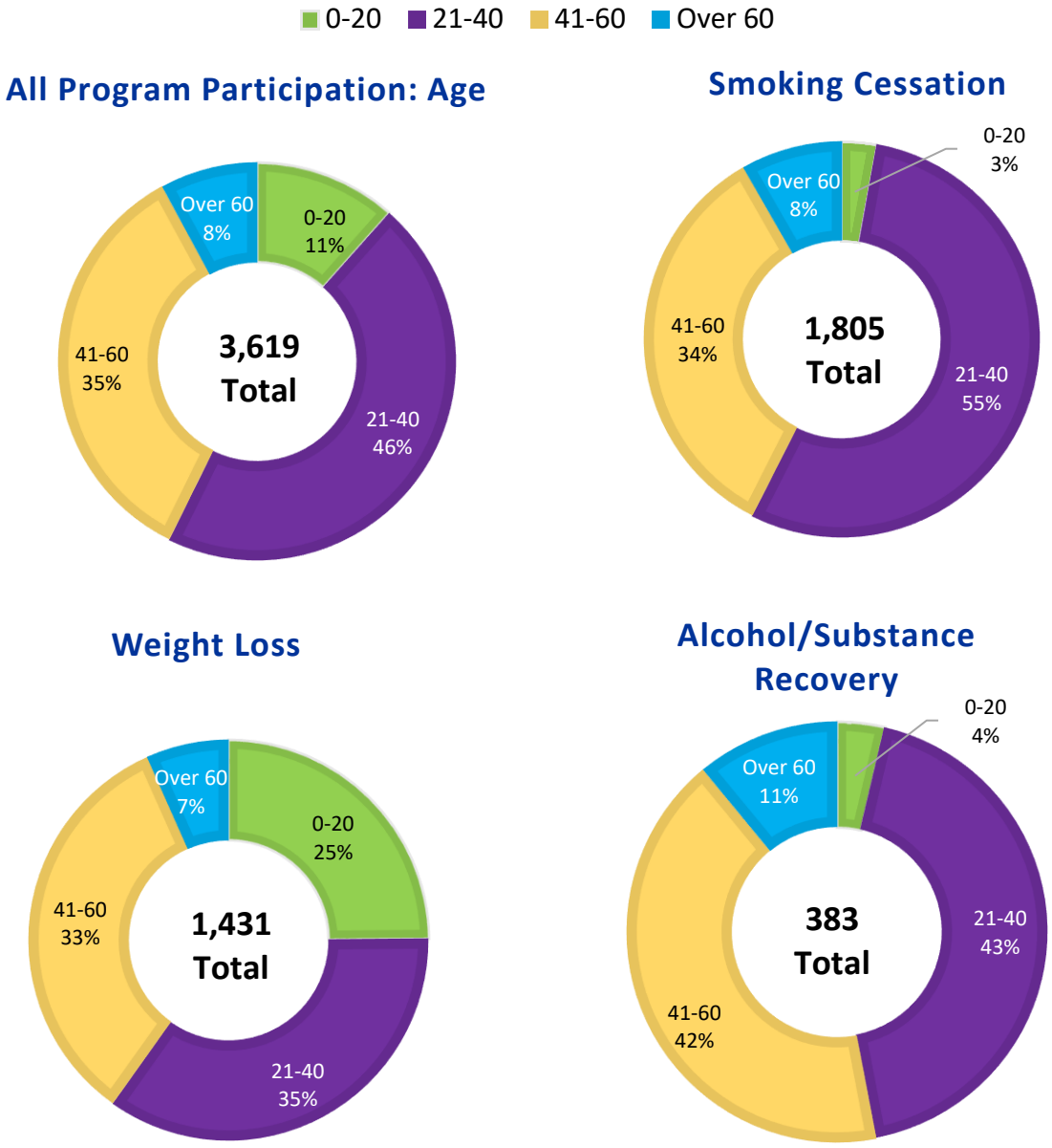
Alcohol/Substance Recovery



Healthy Behavior Program Participation: Age

The demographic breakdown by age for the required Healthy Behaviors programs in DY15 was very similar to DY14. The 21-40 age bracket remains the age group with the highest enrollment rate, and the over 60 age bracket remains the group with the lowest enrollment rate.

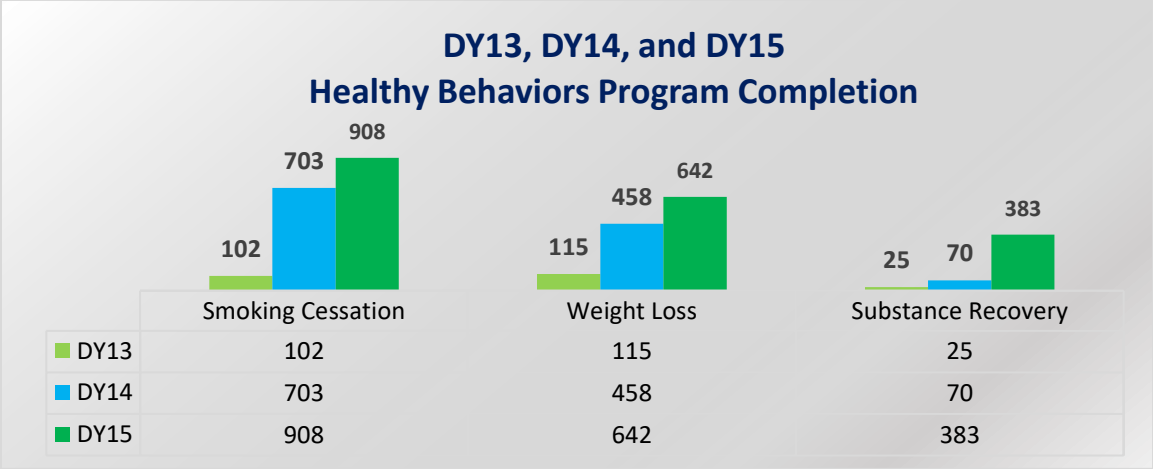
Notable changes in the age distribution from the previous demonstration year was that the overall participation for enrollees ages 21-40 in the Medically Directed Weight Loss programs increased by 8 percentage points, while the overall participation for the same enrollee age bracket in the Alcohol or Substance Abuse programs, decreased by 8 percentage points.



DY15 Healthy Behavior Program Participation and Completion

Healthy Behaviors Programs	Program Enrollment	Program Completion	Percentage Completed
Medically Approved Smoking Cessation	1,805	908	50%
Medically Directed Weight Loss	1,431	642	45%
Medically Approved Alcohol or Substance Abuse Recovery	383	161	42%
Healthy Behaviors Program Total	**3,619**	**1,711**	**41%**

The Healthy Behaviors program completion rate increased for all the required programs from DY14 to DY15. Notably, the completion rate for the Medically Approved Smoking Cessation program increased by 7-percentage points and the completion rate for the Medically Approved Alcohol or Substance Abuse Recovery programs increased by 15-percentage points. The overall completion rate among the three programs was 41%, which is unchanged from the completion rate reported for the previous demonstration year (DY14). The graph below illustrates Healthy Behaviors program completion for DY13, DY14, and DY15.



1.5.2 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 15 Update

During DY15, the Agency submitted the following Final Reports on the LIP program to CMS:

- SFY 2019-20 LIP Payments and FY 2019 Charity Care Report
- SFY 2019-20 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 DY15, there were 88 IGT providers that contributed IGTs in the amount of $339,089,740.

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

- In DY15, $1,064,980,340 was paid out to eligible providers.
- In DY14, $1,004,416,132 was paid out to eligible providers.
- In DY13, $857,693,316 was paid out to eligible providers.

1.5.3 Prepaid Dental Health Program

Operational Update

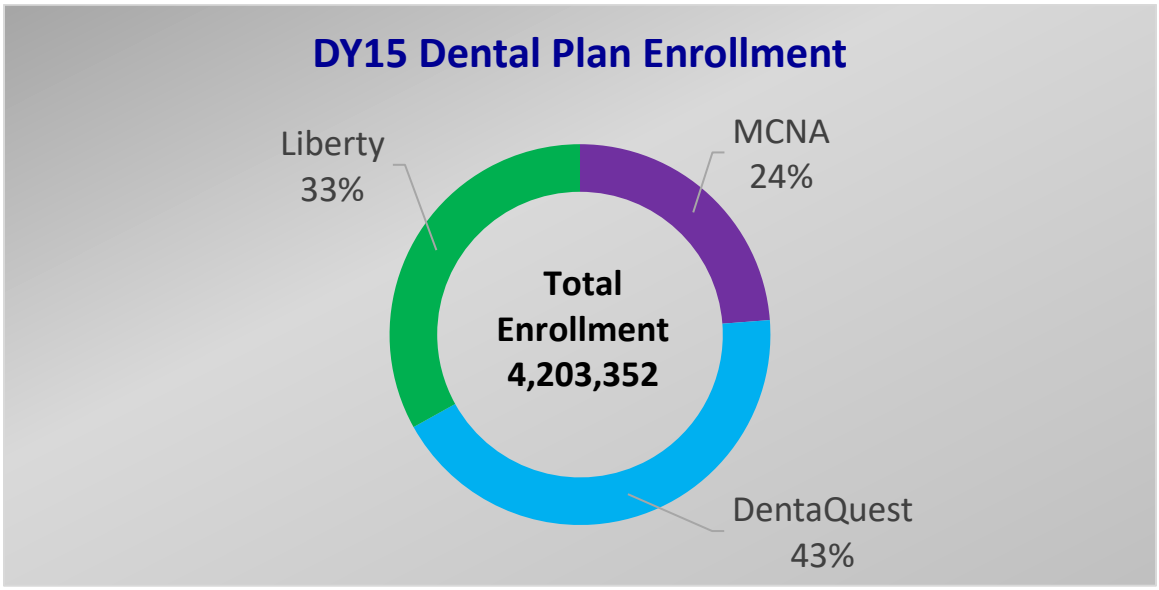
Following CMS' approval, the Agency completed the implementation of the Prepaid Dental Health Program during DY12. There are three prepaid dental health plans contracted with the

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.

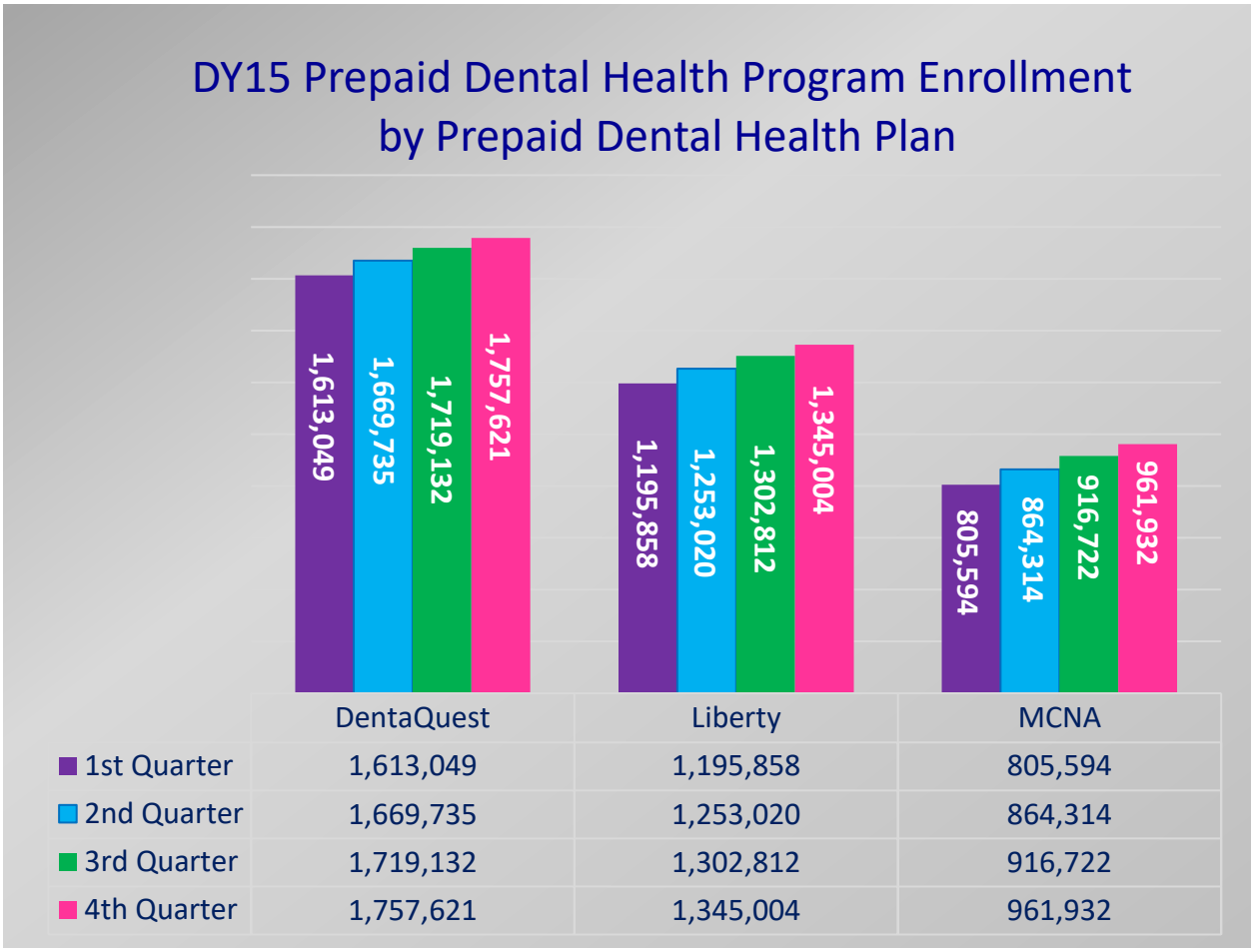
Prepaid Dental Health Plan Enrollment

There were 4,203,352 Florida Medicaid recipients enrolled in the Prepaid Dental Health Program in DY15. The chart and table below illustrate the program enrollment by Dental plan, which is also contained in **Attachment II**.

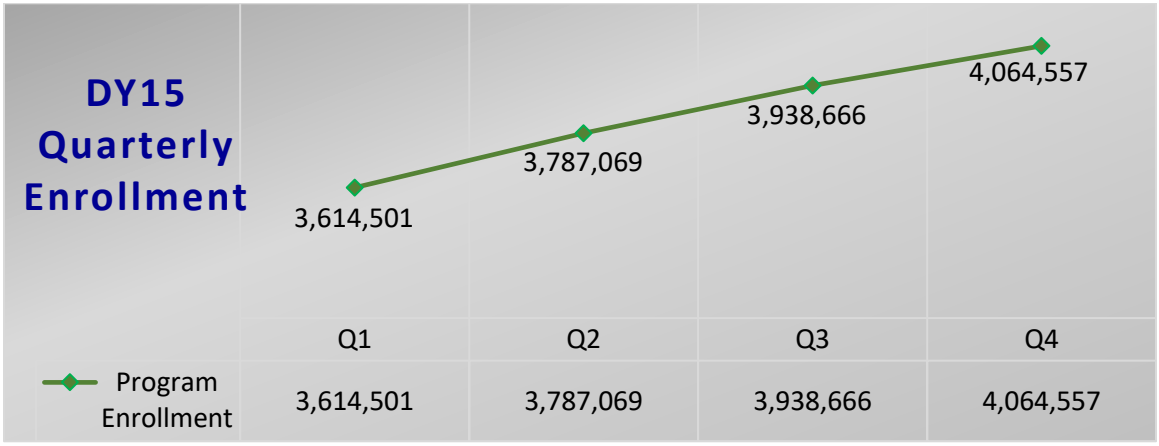


DY15 Prepaid Dental Health Plan Enrollment	
Plan Name	**Enrollment**
Liberty	1,390,094
DentaQuest	1,813,563
MCNA	999,695
Total	**4,203,352**

The graphs below detail DY15 enrollment, first by plan and quarter followed by the total quarterly enrollment, for the Prepaid Dental Health Program. As the graphs illustrate, enrollment increased across all the prepaid dental health plans during each of the quarters in DY15.



	DentaQuest	Liberty	MCNA
1st Quarter	1,613,049	1,195,858	805,594
2nd Quarter	1,669,735	1,253,020	864,314
3rd Quarter	1,719,132	1,302,812	916,722
4th Quarter	1,757,621	1,345,004	961,932



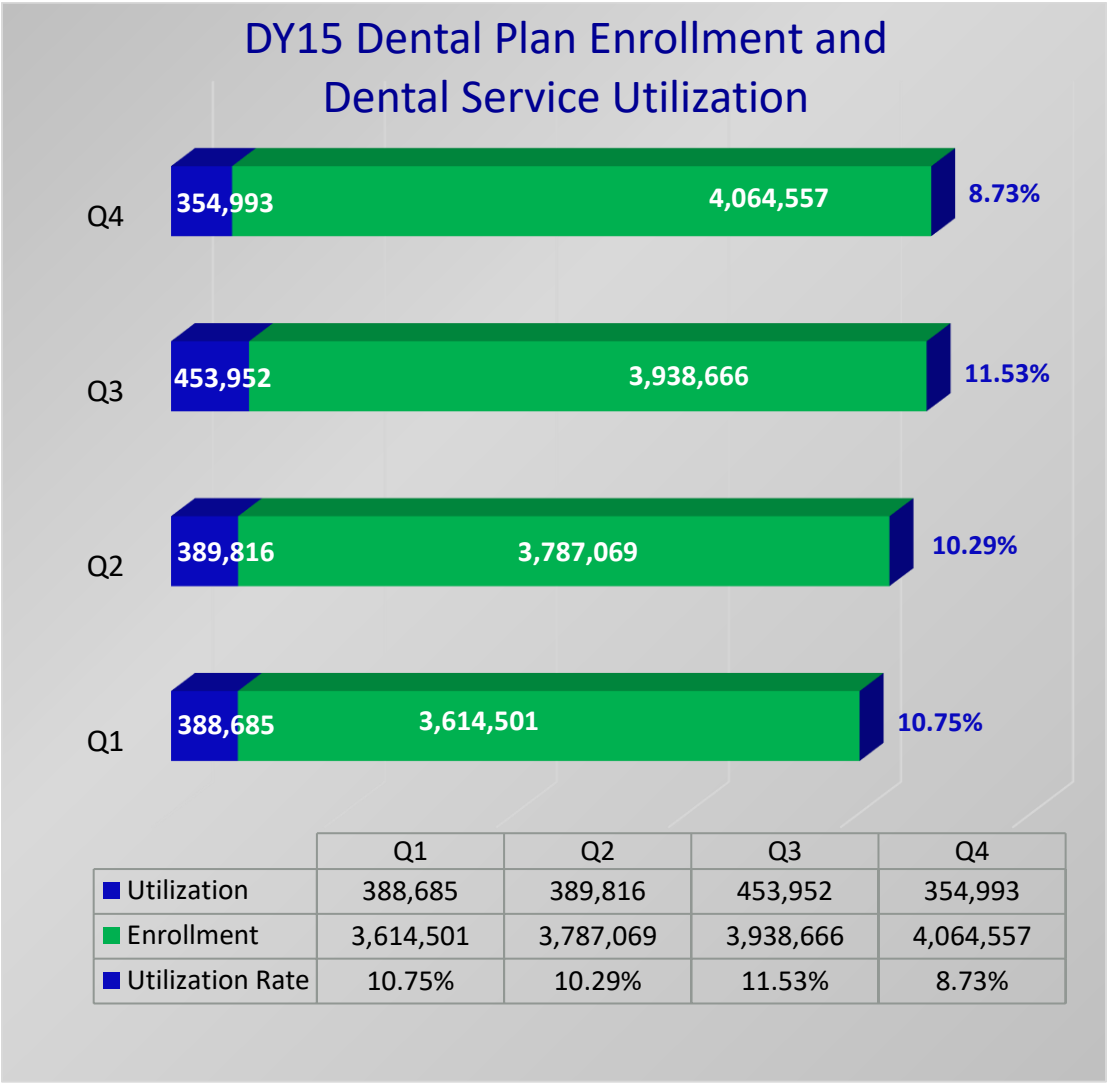
	Q1	Q2	Q3	Q4
Program Enrollment	3,614,501	3,787,069	3,938,666	4,064,557

Utilization

Similar to the variations experienced in the Prepaid Dental Health Program's enrollment, instances of service utilization steadily increased throughout the first three quarters of DY15, as the graph below demonstrates. However, the utilization rate decreased during the second quarter even though instances of service utilization increased. The number and rate of service

utilizations did not experience the same increase during the fourth quarter as the overall program enrollment did.

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	388,685	389,816	453,952	354,993
Enrollment	3,614,501	3,787,069	3,938,666	4,064,557
Utilization Rate	10.75%	10.29%	11.53%	8.73%

1.5.4 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 in a timely manner, 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, 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.

1.5.5 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. Molina
2. Staywell
3. Aetna
4. Simply

Molina Healthcare of Florida, Inc. acquired Florida MHS, Inc. d/b/a Magellan Complete Care specialty plan. This merger was effective September 1, 2021. Due to this merger, Molina is now the participating MMA plan in the Behavioral Health and Supportive Housing Assistance program.

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.

DY15 Program Activities

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.

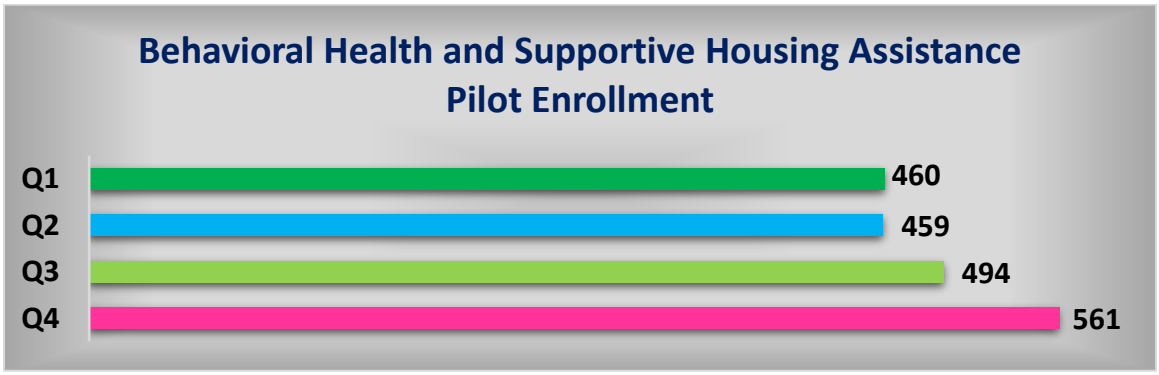
The MMA plans are continuing to enroll members and provide pilot services. As the pilot continues in the midst of COVID-19, the Agency and MMA plans are developing best practices for case management, service delivery, and implementation strategies.

The Agency continues to meet with the MMA plans regularly to monitor how the pilot is progressing and to refine the program as necessary. For instance, a new monitoring report was implemented in order to capture a more holistic view of the enrollees' health and the care they receive. This report is submitted to the Agency on a monthly basis.

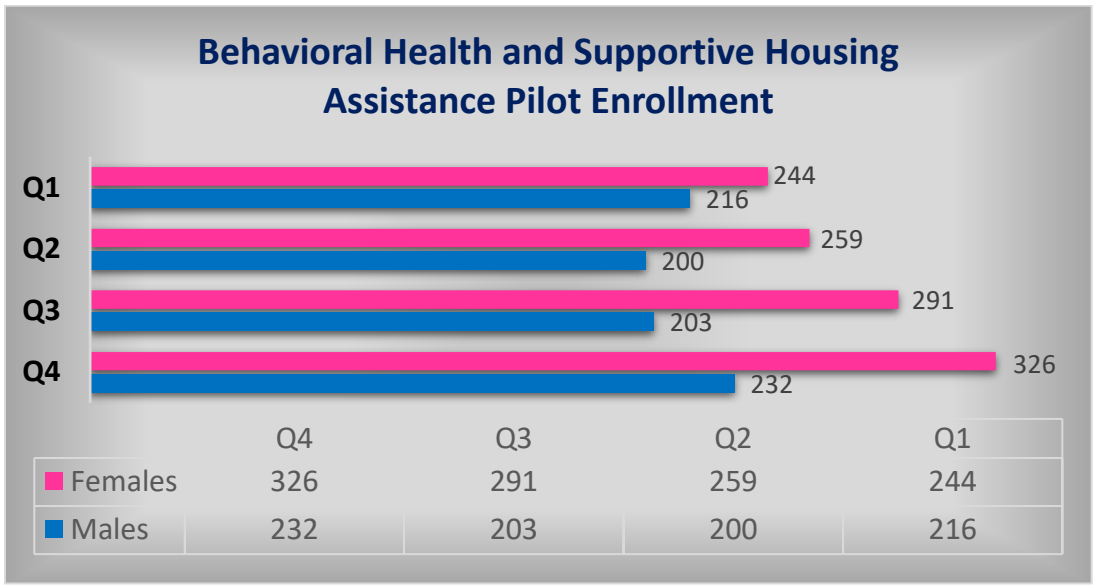
In March 2021, the MMA plans organized and held a stakeholder meeting with the intent to educate stakeholders and recruit providers.

Enrollment

As illustrated in the graph below, enrollment in the Behavioral Health and the Supportive Housing Assistance pilot increased throughout DY15 with exception being quarter two. During the second quarter there was one less participate than there was in the first quarter.



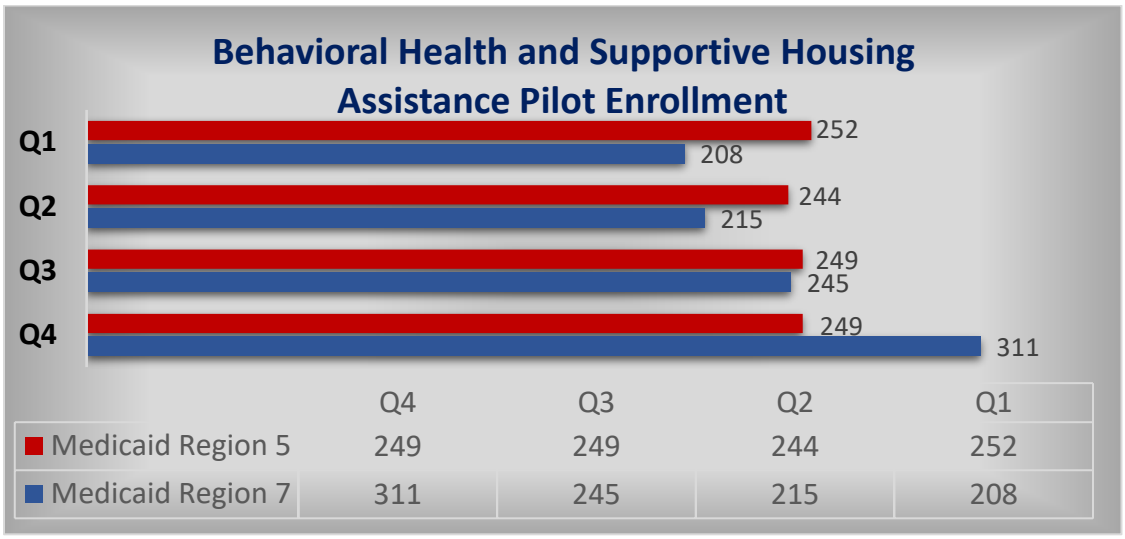
Unlike in DY14, when male enrollment totals outnumbered female enrollment totals, in DY15 female participants outnumbered male participants; see the graph on the following page for details.



The average age of participants enrolled in the Behavioral Health and Supportive Housing Assistance program was 46; enrollment by age group is detailed in the table below.

Participant Count by Age Group	Q1	Q2	Q3	Q4
Age 21-40	157	158	171	193
Age 41-60	242	241	262	300
Over 60	61	60	61	65

As illustrated below, enrollment in the Behavioral Health and Supportive Housing Assistance Program was greater throughout DY15 in Medicaid Region 5 except for during the forth quarter when enrollment was higher in Medicaid Region 7.



DY15 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 number and percentage of participants that meet the criteria for the measure.

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. In the following table, 'Rate across Plans" is the total Service Utilization Rate or total number of participants across plans that met the criteria for a measure.

DY15: Q1 – Q4 Housing Assistance Waiver Pilot Quarterly Performance Measure Summary				
Measures	**Q1 (July – September 2020)**	**Q2 (October – December 2020)**	**Q3 (January – March 2021)**	**Q4 (April – June 2021)**
	Rate Across Plans	**Rate Across Plans**	**Rate Across Plans**	**Rate Across Plans**
Percent of Participants with a Comprehensive Health Risk Assessment	80%	83%	79%	85%
Percent of participants that received at least one core housing assistance service during each month of quarter	27%	27%	33%	44%
Percent of participants whose housing condition was upgraded	12%	9%	12%	12%
Percent of participants who had stable permanent housing	35%	37%	40%	42%
Percent of participants with an OUD dx who received medication and bx therapy	12%*	34%	33%	25%
Percent of participants with SUD dx who report no drug use	56%	63%	59%	40%
Percent of participants with an SMI dx who are compliant with medication management requirements	79%	81%	79%	82%
Percent of pilot participants who achieved permanent housing*	6%	6%	5%	5%

*The program participant must be in the tenant on lease for a term of at least one year.

First Quarter

During the first quarter of DY15:

- 80% of pilot participants had a Comprehensive Health Risk Assessment.
- 27% had received at least one core housing assistance service. This is an increase of eight percentage points over the previous quarter.
- 35% of participants had stable permanent housing.
- 12% of participants had their housing condition improve and 6% achieved permanent housing during the quarter/month.

Across the plans, of the pilot participants in the first quarter who had substance use disorder diagnoses, 12% had received medication and/or behavioral therapy services during the quarter and 56% reported no drug use during the quarter.

Of the participants with serious mental illness (SMI) diagnoses, plans reported that 79% were compliant with medication management requirements during the quarter.

The following measures look at participants during the first quarter who were also enrolled in the prior quarter and whether the participant had a change in the metric from the previous quarter to the first quarter.

DY15 Q1 Performance Measures	
Measure	**Rate across Plans**
Percent of participants whose days of homelessness were reduced during the quarter	18%
Percent of participants with reduced emergency department (ED) visits during the quarter	50%
Percent of participants with reduced hospital admissions or readmissions during the quarter	65%

Across the plans, 18% of participants meeting the definition of homelessness reduced their days of homelessness during the first quarter.

Of participants who had ED visits during the fourth quarter of DY14, 50% had reduced ED visits during the first quarter of DY15.

Of participants who had hospital admissions or readmissions during the prior quarter, 65% had reduced hospital admissions or readmissions during the first quarter.

Second Quarter

During the second quarter:

- 83% of pilot participants had a Comprehensive Health Risk Assessment. This is an increase of three percentage points over the previous quarter.
- 27% had received at least one core housing assistance service.
- 37% of participants had stable permanent housing. This is an increase of two percentage points over the previous quarter.
- 9% of participants had their housing condition improve and 6% achieved permanent housing during the quarter/month.

Across the plans, of the pilot participants in the second quarter who had opioid use disorder diagnoses, 34% had received medication and/or behavioral therapy services during the quarter.

Of those with substance use disorder diagnoses, 63% reported no drug use during the quarter.

Of the participants with serious mental illness (SMI) diagnoses, plans reported that 81% were compliant with medication management requirements during the quarter.

The following measures look at participants during the second quarter who were also enrolled in the prior quarter and whether the participant had a change in the metric from the previous quarter to the first quarter.

DY15 Q2 Performance Measures	
Measure	**Rate across Plans**
Percent of participants whose days of homelessness were reduced during the quarter	10%
Percent of participants with reduced emergency department (ED) visits during the quarter	54%
Percent of participants with reduced hospital admissions or readmissions during the quarter	65%

Across the plans, 10% of participants meeting the definition of homelessness reduced their days of homelessness during the second quarter. Of participants who had ED visits during the first quarter, 54% had reduced ED visits during the second quarter. Of participants who had hospital admissions or readmissions during the prior quarter, 65% had reduced hospital admissions or readmissions during the second quarter.

Third Quarter

During the third quarter of DY15:

- 79% of pilot participants had a Comprehensive Health Risk Assessment. This is a decrease of four percentage points compared to the previous quarter.
- 33% had received at least one core housing assistance service. This is an increase of six percentage points over the previous quarter.
- 40% of participants had stable permanent housing. This is an increase of three percentage points over the previous quarter.
- 12% of participants had their housing condition improve and 5% achieved permanent housing during the quarter.

Across the plans, of the pilot participants in the third quarter who had opioid use disorder diagnoses, 33% had received medication and/or behavioral therapy services during the quarter.

Of those with substance use disorder diagnoses, 59% reported no drug use during the quarter.

Of the participants with serious mental illness (SMI) diagnoses, plans reported that 79% were compliant with medication management requirements during the quarter.

The following measures look at participants during the third quarter who were also enrolled in the prior quarter and whether the participant had a change in the metric from the previous quarter to the third quarter.

DY15 Q3 Performance Measures	
Measure	**Rate across Plans**
Percent of participants whose days of homelessness were reduced during the quarter	29%
Percent of participants with reduced emergency department (ED) visits during the quarter	64%
Percent of participants with reduced hospital admissions or readmissions during the quarter	65%

Across the plans, 29% of participants meeting the definition of homelessness reduced their days of homelessness during the third quarter by upgrading their housing condition during the quarter. Of participants who had ED visits during the second quarter, 64% had reduced ED visits during the third quarter. Of participants who had hospital admissions or readmissions during the second quarter, 65% had reduced hospital admissions or readmissions during the third quarter.

Fourth Quarter

During the fourth quarter of DY15:

- 85% of pilot participants had a Comprehensive Health Risk Assessment. This is an increase of six percentage points compared to the previous quarter.
- 44% had received at least one core housing assistance service during each month of the quarter. This is an increase of eleven percentage points over the previous quarter.
- 42% of participants had stable permanent housing. This is an increase of two percentage points over the previous quarter.
- 12% of participants had their housing condition improve and 5% achieved permanent housing during the quarter.

Across the plans, of the pilot participants in the fourth quarter who had opioid use disorder diagnoses, 25 percent had received medication and/or behavioral therapy services during the quarter. Of those with substance use disorder diagnoses, 40% reported no drug use during the quarter. Of the participants with serious mental illness (SMI) diagnoses, plans reported that 82% were compliant with medication management requirements during the quarter.

The following measures look at participants during the fourth quarter who were also enrolled in the prior quarter and whether the participant had a change in the metric from the previous quarter to the fourth quarter.

DY15 Q4 Performance Measures	
Measure	**Rate across Plans**
Percent of participants whose days of homelessness were reduced during the quarter	47%
Percent of participants with reduced emergency department (ED) visits during the quarter	64%
Percent of participants with reduced hospital admissions or readmissions during the quarter	57%

Across the plans, 47% of participants meeting the definition of homelessness reduced their days of homelessness during the fourth quarter by upgrading their housing condition during the quarter. Of participants who had ED visits during the third quarter, 64% had reduced ED visits during the fourth quarter. Of participants who had hospital admissions or readmissions during the third quarter, 57% had reduced hospital admissions or readmissions during the fourth quarter.

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.

Through calendar year 2019 performance measure reporting, the Agency required plans to report the HEDIS measures at the statewide level. Beginning with calendar year 2020 reporting, the Agency is requiring plans to report regional rates as well. The Agency provided plans with a new file layout to enable more streamlined reporting of the additional data and has worked to automate the process. The comparisons of the calendar year 2020 data to the calendar year 2019 data are underway and will be included in the next report to CMS.

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 2019

◉ 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	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Children's Medical Services *	★★★★★	★★★★☆	N/A	N/A	★★☆☆☆	★★★★★
Clear Health Alliance *	★★★☆☆	N/A	N/A	★★★★☆	★★★☆☆	★★☆☆☆
Community Care Plan	★★★★★	★★★★☆	N/A	★★★★☆	★★★★★	★★★☆☆
Florida Community Care ‡	N/A	N/A	N/A	N/A	N/A	★☆☆☆☆
Humana Medical Plan, Inc.	★★★★★	★★★☆☆	N/A	★★★★☆	★★★★★	★★★★☆
Lighthouse Health Plan, LLC ‡	★★★★★	★★☆☆☆	N/A	★☆☆☆☆	★★☆☆☆	★☆☆☆☆
Magellan Complete Care *	★☆☆☆☆	N/A	N/A	★★☆☆☆	★★☆☆☆	★☆☆☆☆
Miami Children's Health Plan, LLC ‡	★★★★☆	★★★☆☆	N/A	★☆☆☆☆	★☆☆☆☆	★☆☆☆☆
Molina Healthcare of Florida, Inc.	★★★★★	★★★★☆	N/A	★★★★☆	★★★★★	★★★★★
Prestige Health Choice	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Simply Healthcare Plans, Inc. *	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Staywell Health Plan	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Staywell Health Plan of Florida - SMI * ‡	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Sunshine Health Child Welfare Specialty Plan *	★★★★★	★★★★☆	N/A	N/A	N/A	★★★★★
Sunshine State Health Plan, Inc. *	★★★★★	★★★☆☆	N/A	★★★★☆	★★★★☆	★★★★☆
United Healthcare of Florida, Inc.	★★★★★	★★★★☆	N/A	★★★★☆	★★★★☆	★★★★☆
Vivida Health ‡	★★★★☆	★★☆☆☆	N/A	N/A	★★★★☆	★☆☆☆☆

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

* Use caution when viewing the star ratings for these plans. These plans only serve people with certain diagnoses or conditions. The star ratings compare these plans to plans that may be serving healthier people.

If a plan was unable to report valid rates for less than half of the performance measures in a particular report card category, no group average will be calculated and "N/A" will be displayed.

‡ For measures reported using the hybrid methodology only, plans were allowed to report their audited HEDIS 2019 hybrid rate if it is better than their HEDIS 2020 hybrid rate. New Medicaid plans reported HEDIS 2020 hybrid rates as this was their first year of operations on which they could report. Due to some plans reporting on calendar year 2018 and other plans reporting on calendar year 2019 data, comparisons between plans should be made with caution.

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey developed and maintained by the Agency for Healthcare Research and Quality and consists of a series of patient surveys rating health care experiences. The Agency requires MMA plans to conduct and report on the Medicaid Health Plan CAHPS Survey annually. The statewide averages to select survey items and composites as well as plan-specific rates are posted online 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 in previous years. The 2021 survey was conducted in the spring and asked MMA plan members about their experiences during the previous six months, which was during the COVID-19 pandemic. While some ratings stayed the same, two improved, and some declined. The following tables present highlights from the survey results for 2021 along with the 2016-2020 results for comparison.

Adult Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019	2020	2021
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%	75%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	80%	83%	81%	82%	81%	80%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	82%	84%	82%	83%	83%	80%
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%	89%
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%	76%

Child Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019	2020	2021
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%	86%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	83%	83%	84%	**	84%	85%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	89%	89%	89%	89%	90%	88%
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%	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%	88%

**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) 2019-20 to CMS in the Spring of 2021. The COVID-19 pandemic, which spanned half of the reporting period, significantly decreased the number of individuals receiving non-emergency healthcare services, including dental, and Medicaid also experience this trend.

- 33.2% of eligible children aged 1 through 20 years, enrolled for 90 continuous days, received a preventive dental service, as calculated using the Child Core Set PDENT measure.
- 40.7% of eligible children aged 1 through 20 years accessed some form of oral health care through Florida Medicaid.

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 December 14, 2020. The CQS is available on the Agency's website:

https://ahca.myflorida.com/medicaid/policy_and_quality/quality/docs/Comprehensive_Quality_Strategy_Report.pdf

CQS Update:

The 2020 submission of the CQS focuses on specific priorities and program goals identified by Florida Medicaid and the quality initiatives in place to achieve them. The Agency's established goals seek to build upon the success of the SMMC program 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.
- Reducing potentially preventable dental-related hospital events and improve access to preventive dental services.

External Quality Review

The Agency contracts with the Health Services Advisory Group (HSAG) as its External Quality Review Organization (EQRO) vendor. During DY15, HSAG submitted the following annual reports to the Agency:

- 2019-2020 Annual Technical Report
- 2020-2021 Performance Improvement Projects Annual Summary Report
  - Report findings include:
    - Sixty-three percent (19/30) of PIPs received an overall Met validation status.
    - Thirty percent (9/30) of PIPS received an overall Partially Met validation status.
    - Fifty percent of dental plan PIPs received an overall Met validation status.
    - Thirty-three percent of dental plan PIPs received Partially Met validation status.
- 2020-2021 Performance Measure Validation Findings Report
  - Report findings include:
    - The MMA plans performed at or above the 50th percentile for 26 of 47 (approximately 55 percent) measure rates appropriate for comparison to benchmarks.
    - 10 of 12 plans within the Pediatric Care domain (approximately 83 percent) rates exceeded the 50th percentile.
    - There were six measures from the Pediatric Care and Living With Illness domains that met or exceeded the 75th percentile.

- In the Women's Care domain, eight of 14 statewide average rates (approximately 57 percent) that could be compared to the prior year's rates demonstrated significant increases from RY 2019 to RY 2020.

Post Award Forum

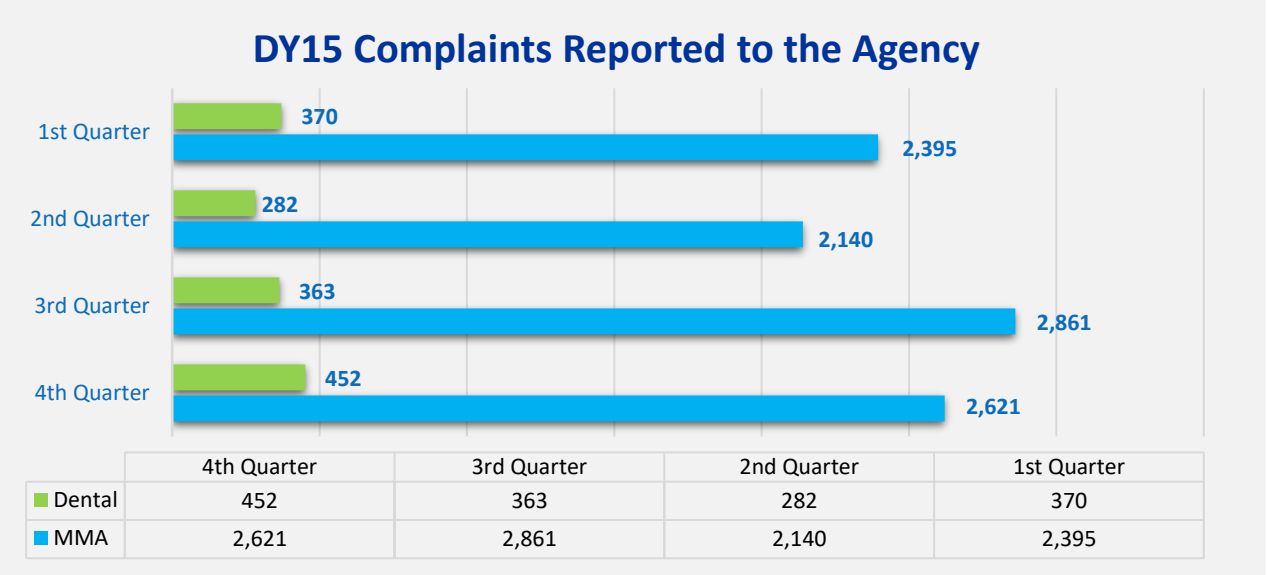
The annual post award public forum was conducted on January 25, 2021 during the Medical Care Advisory Committee meeting. The meeting was publicly noticed in the Florida Administrative Register. The Agency presented an overview of the MMA program, including information regarding amendments and key evaluation 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.



	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter
Dental	452	363	282	370
MMA	2,621	2,861	2,140	2,395

DY15 Complaints Received by the Agency per 1,000 Enrollees

DY15	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Dental Enrollment	3,583,322	3,760,027	3,908,367	4,034,907
Dental Complaints	370	282	363	452
DY15 Dental Complaints per 1000 Enrollees	**.10**	**.07**	**.09**	**.11**
MMA Enrollment	3,389,302	3,540,437	3,677,298	3,792,564
MMA Complaints	2,395	2,140	2,861	2,621
DY15 MMA Complaints per 1000 Enrollees	**.71**	**.60**	**.78**	**.69**

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 - DY15

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
DY15 Dental	**.10**	**.07**	**.09**	**.11**
DY14 Dental	.15	.11	.09	.06
DY13 Dental	Not Applicable*	Not Applicable*	.01	.12
DY15 MMA	**.71**	**.60**	**.78**	**.69**
DY14 MMA	1.15	.83	.94	.70
DY13 MMA	.83	.80	1.22	.82
DY12 MMA	.95	1.01	1.33	1.11

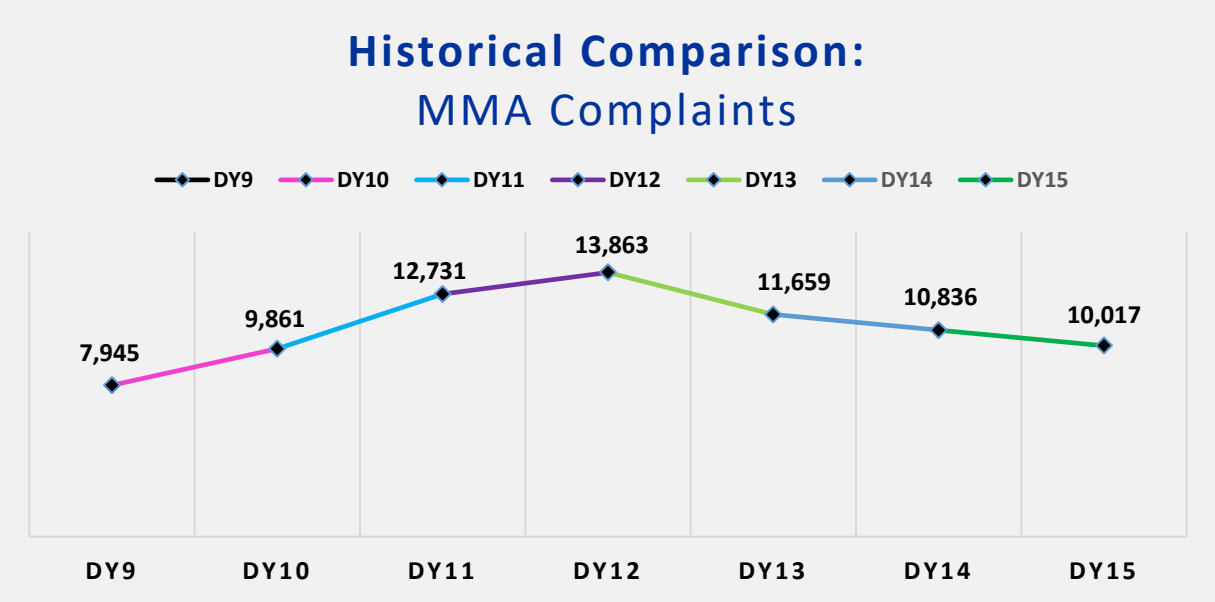
* Dental Plan enrollment began in December of 2018, which was the last month in the second quarter.

The dental program's complaint rate was lower in each of the DY15 quarters than it was in DY14 except for the third quarter when the complaint rate was the same. This is especially notable, as the program enrollment in DY15 was higher than in DY14 while the number of complaints filed were lower in DY15 than in DY14.

Additionally, the complaint rate for the MMA program in DY15 decreased from DY14's rate during each of the quarters, while the enrollment in the MMA program was greater throughout

DY15. It is also notable that the complaint rate for the MMA program in DY15 was the lowest rate since prior to DY12.

The number of complaints has continued to decrease since DY12, as the graph below illustrates, and DY15 represents the lowest complaint figure experienced since DY10.



Complaints, Grievances, and Appeals Reported to the MMA Plans

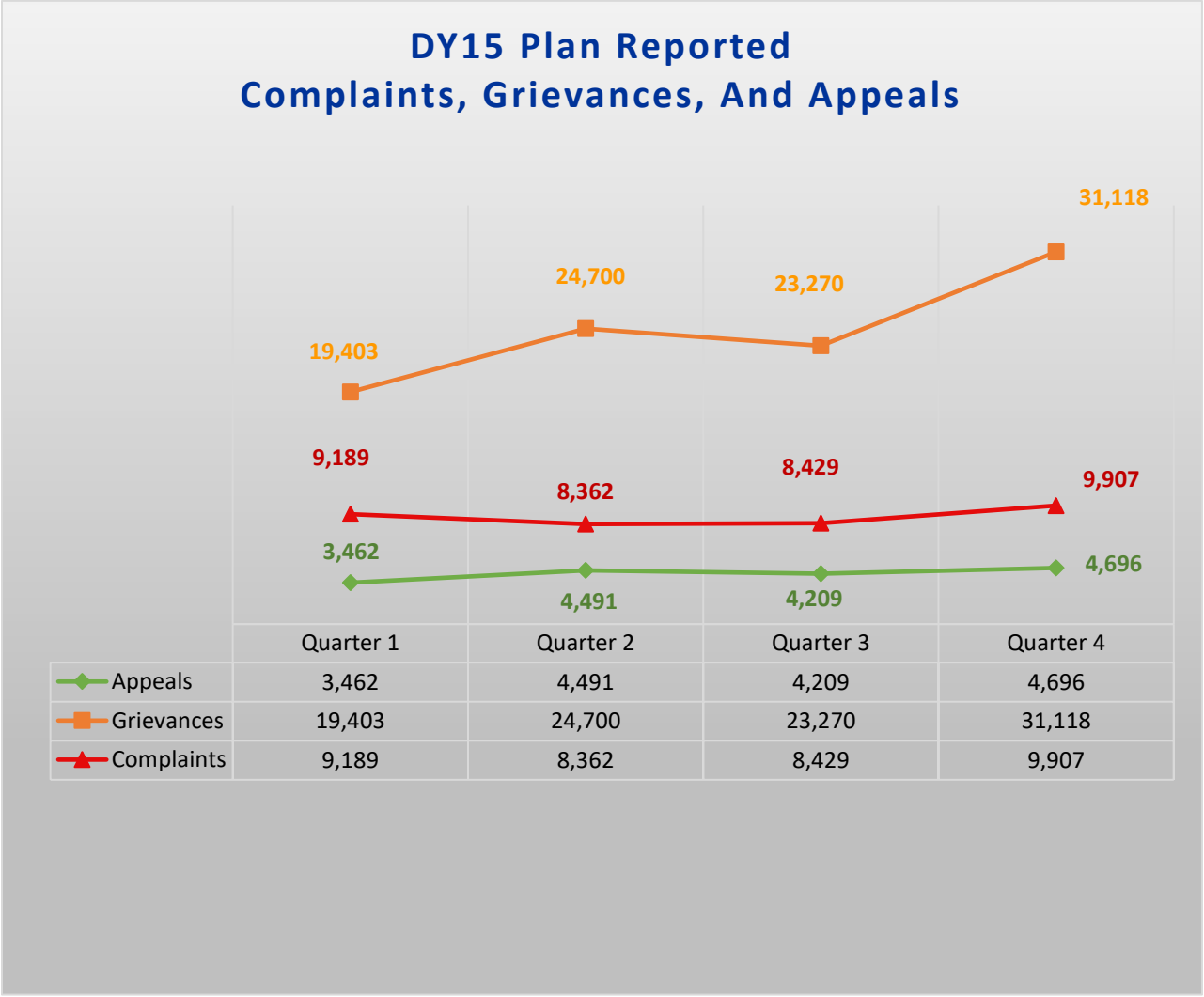
The MMA plans are required to report to the Agency all complaints, grievances, and appeals they receive monthly. If a complaint is not addressed by the MMA plan within one business day, it becomes a grievance. Complaints, grievances, and appeals are defined in the MMA contracts as well as in the Code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

DY15 Complaints, Grievances, and Appeals

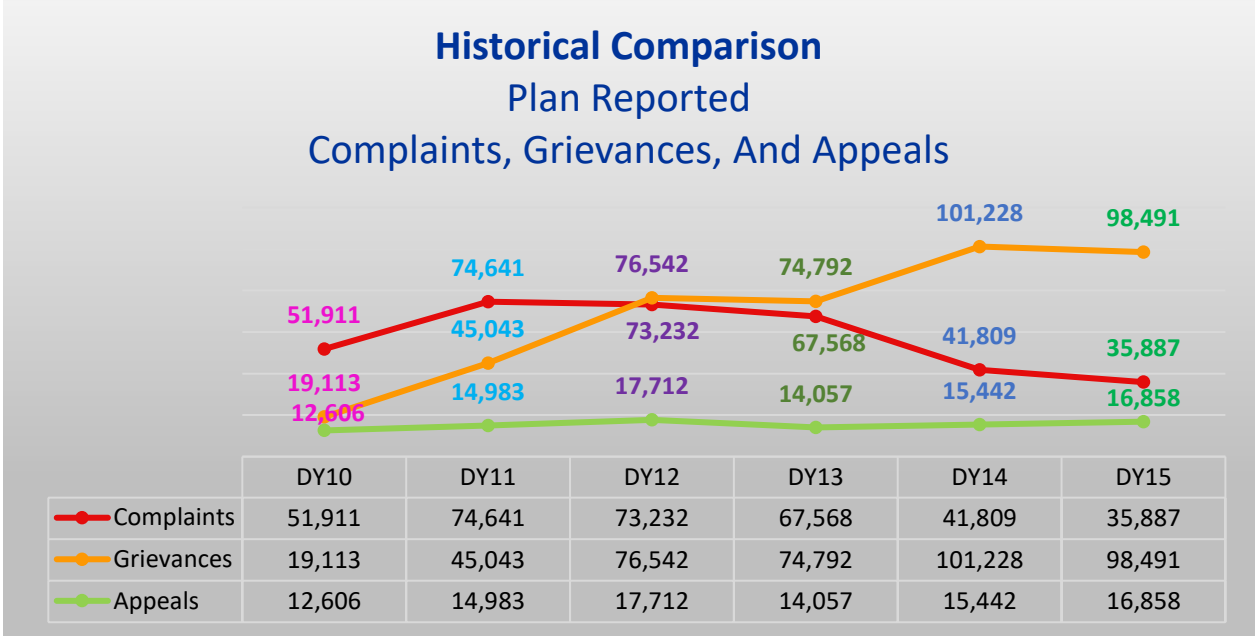
Complaints filed with the MMA plans increased during the first and fourth quarters. Grievances and appeals filed with the plans followed the same trend of alternating between increases and decreases throughout the demonstration year. The graph below details the complaints, grievances, and appeals filed with the MMA plans during DY15.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Appeals	3,462	4,491	4,209	4,696
Grievances	19,403	24,700	23,270	31,118
Complaints	9,189	8,362	8,429	9,907

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 and appeals, if not resolved, carryover and continue to be reported until they are resolved.

The number of complaints reported to the MMA plans continued to decrease in DY15 and set a record low for the MMA program. MMA plan reported grievances decreased in DY15 while the number of appeals increased. See the chart below for details.



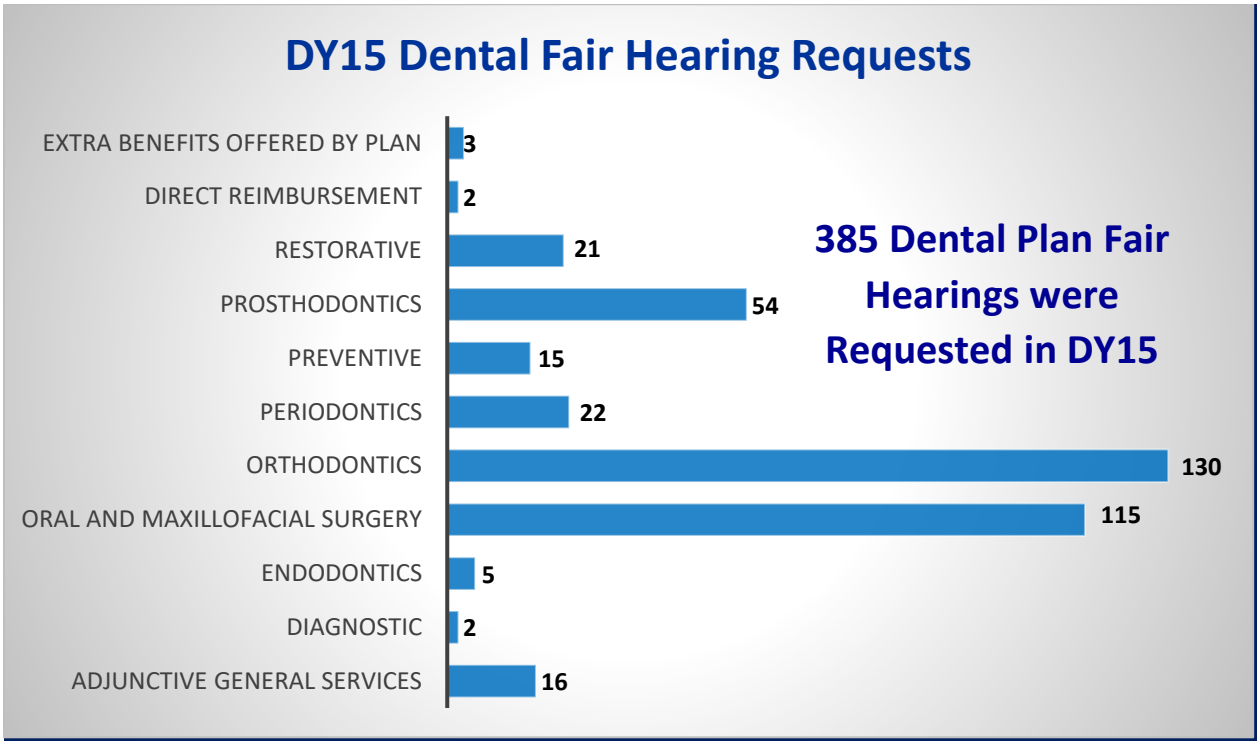
	DY10	DY11	DY12	DY13	DY14	DY15
Complaints	51,911	74,641	73,232	67,568	41,809	35,887
Grievances	19,113	45,043	76,542	74,792	101,228	98,491
Appeals	12,606	14,983	17,712	14,057	15,442	16,858

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 DY15, there were a total of 1,927 fair hearings requested, 1,542 for the MMA plans and 385 for the dental plans. The total number of fair hearings requested for both the MMA health and dental plans increased in DY15. The requested fair hearings for both the MMA health and dental plans are broken out on the following pages.

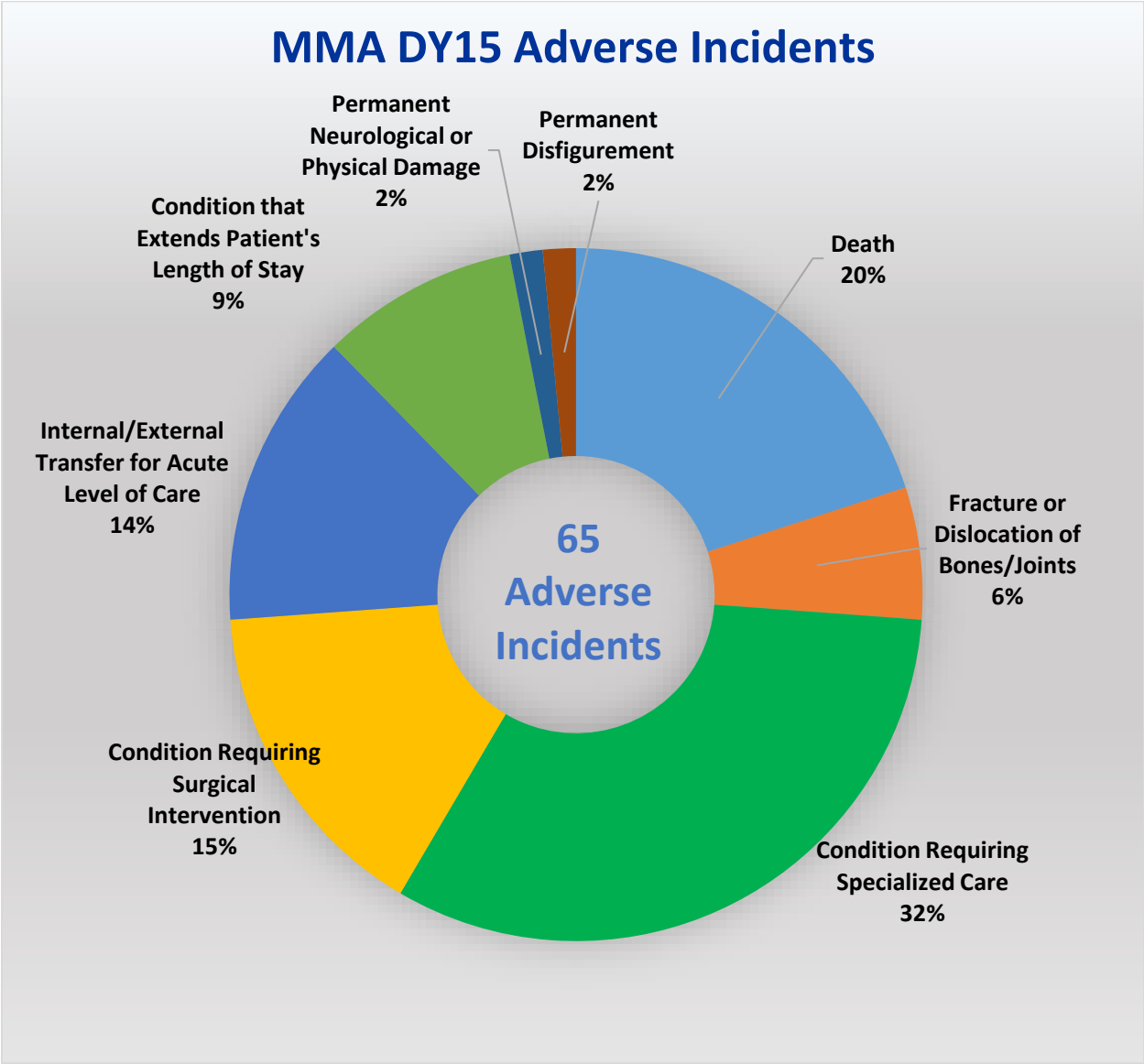
DY15 MMA Health and Dental Fair Hearings		
Service	**Requested**	**Conducted**
Adult Companion	225	117
Adult Day Care	6	1
Adult Day Care (Adult Day Health Care)	12	5
Ambulatory Surgical Treatment Center	1	1
Attendant Care	10	5
Behavioral/Mental Health Services - Inpatient	11	4
Case Management	1	0
Chiropractic	2	0
Dental	1	0
Dental - Adjunctive General Services	16	11
Dental - Diagnostic	2	1
Dental - Endodontics	5	3
Dental - Oral & Maxillofacial Surgery	115	74
Dental - Orthodontics	130	64
Dental - Periodontics	22	17
Dental - Preventive	15	9
Dental - Prosthodontics	54	40
Dental - Restorative	21	9
Direct Reimbursement	9	2
Emergency	1	0
Extra Benefits Offered by Plan	7	4
Home Accessibility Adaptation	18	8
Home Delivered Meals	73	41
Home Health	29	5
Homemaker	237	125
Hospital - Inpatient	29	4
Hospital - Outpatient	3	3
Imaging/MRI/X-Ray	25	9
Intermittent And Skilled Nursing	7	3
Laboratory	5	1
Medical Equipment & Supplies	199	100
Medical Equipment, Prosthesis, & Orthoses	4	1
Nursing Facility Care	4	2
Occupational Therapy	6	1
Pain Management	5	4
Personal Care	434	221
Personal Emergency Response System	5	3
Physical Therapy	6	1
Physician - Primary Care	4	0
Physician - Specialty Care	29	12
Prescription Drugs	71	26
Respiratory Equipment and Supplies	1	0
Respite Care	56	30
Speech Therapy	2	1
Substance Abuse Treatment	1	1
Transplant Services	1	1
Transportation - Emergency	1	0
Transportation - Non-Emergency	2	0
Transportation - Non-Emergency (Routine)	3	0
Transportation - Non-Emergency Ambulance	1	1
Total	**1,927**	**971**



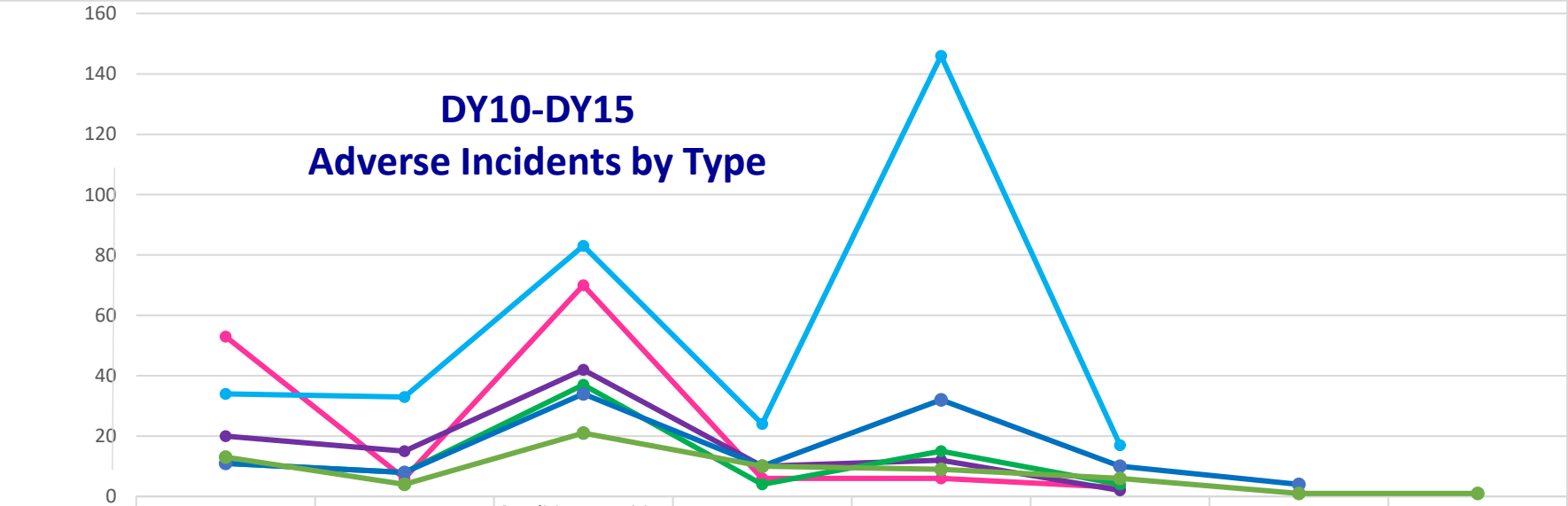
DY15 Dental Fair Hearing Requests				
SERVICE DESCRIPTION	DentaQuest	Liberty	MCNA	Total
Adjunctive General Services	16	0	0	16
Diagnostic	1	1	0	2
Endodontics	2	3	0	5
Oral and Maxillofacial Surgery	103	9	3	115
Orthodontics	102	17	11	130
Periodontics	17	3	2	22
Preventive	11	4	0	15
Prosthodontics	40	12	2	54
Restorative	17	2	2	21
Direct Reimbursement	1	0	1	2
Extra Benefits Offered by Plan	3	0	0	3
Total	313	51	21	385

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 65 adverse incidents reported in DY15. This is the lowest number of adverse incidents since prior to DY10 as the graph on the top of page 56 demonstrates.

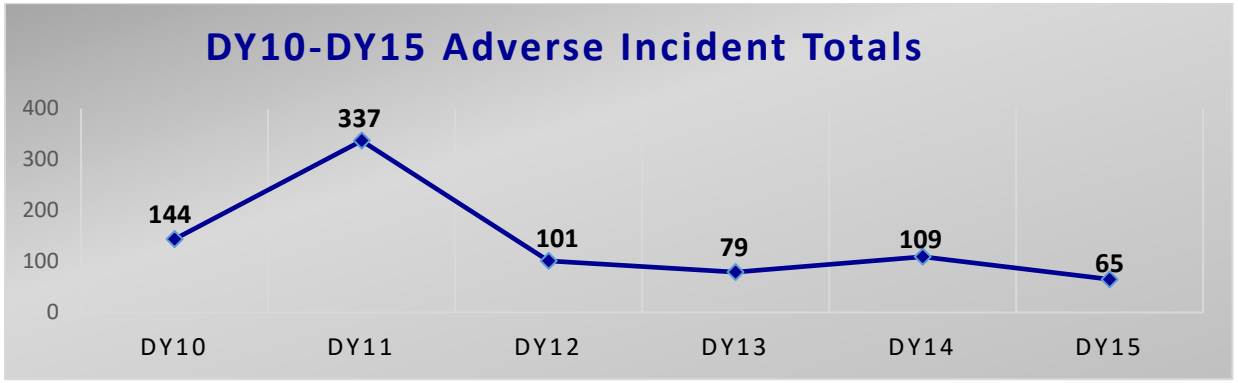


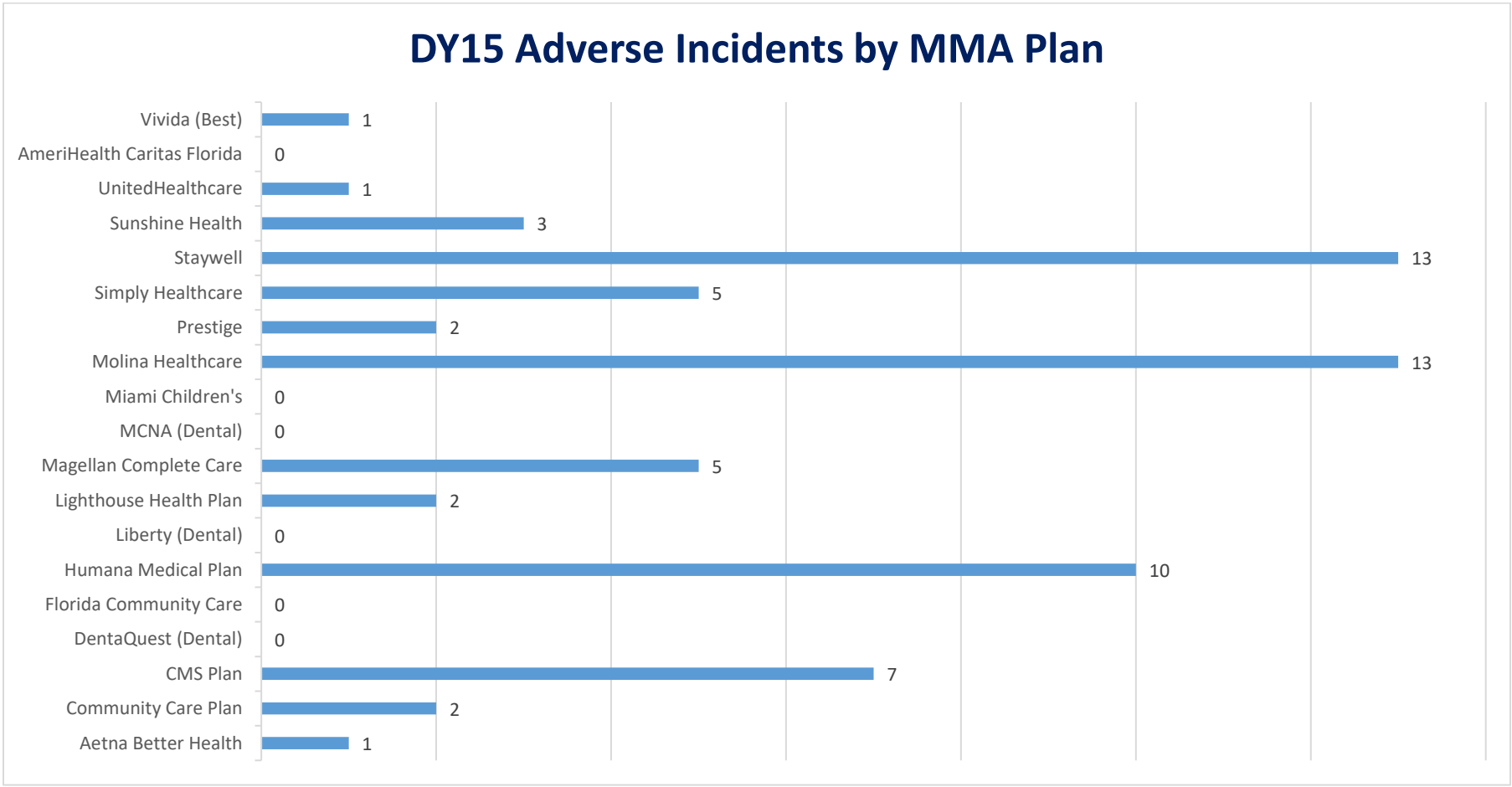
There were 44 fewer adverse incidents reported in DY15 when compared to DY14, and while there was fluctuation across most of the reporting categories, the reporting category with the most deviation was the condition resulting in a transfer acute care category, which decreased by 23 occurrences. The only adverse incident category to increase in DY15 was enrollee death, which increased by two. The following graphs detail historical adverse incident reporting, first by incident type followed by demonstration year totals, for further comparison. The final graph details DY15 adverse incidents by MMA Plan.



	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	Permanent Disfigurement
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	
DY15	13	4	21	10	9	6	1	1

As illustrated above, there were decreases in six of the eight adverse incident reporting categories during DY15. Of the two without decreases, only remain consistent and the other increased by two incidents. In addition to the new category reported on in DY14, permanent neurological or physical damage, there was another adverse incident category added in DY15; permanent disfigurement, which had one occurrence during DY15.


DY10-DY15 Adverse Incident Totals
400
300
200
100
0
144
337
101
79
109
65
DY10
DY11
DY12
DY13
DY14
DY15


DY15 Adverse Incidents by MMA Plan
Vivida (Best) 1
AmeriHealth Caritas Florida 0
UnitedHealthcare 1
Sunshine Health 3
Staywell 13
Simply Healthcare 5
Prestige 2
Molina Healthcare 13
Miami Children's 0
MCNA (Dental) 0
Magellan Complete Care 5
Lighthouse Health Plan 2
Liberty (Dental) 0
Humana Medical Plan 10
Florida Community Care 0
DentaQuest (Dental) 0
CMS Plan 7
Community Care Plan 2
Aetna Better Health 1

Section III: Evaluation

Evaluation of the Demonstration

The demonstration evaluation is an ongoing process conducted continuously throughout the Demonstration's approval period. Under STC 111, the Agency was required to complete a revised evaluation design pertinent to the demonstration extension period, January 2021 through June 2030, by July 15, 2021.

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. The Agency submitted the revised evaluation design on July 16, 2021. CMS' review is ongoing, and the Agency is currently awaiting approval on the submission of the most recent evaluation design

Summary of Evaluation Activities DY15 (SFY 2020-21)

- 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 DY13 (SFY20-21) data to the evaluators in Spring 2020. The Agency provided DY14 (SFY19-20) data to the evaluators in October, November, and December 2020. This data included the DY14 MMA Program Component 10, Housing Assistance Pilot data.
- The evaluators developed and submitted telephonic enrollee survey materials and health plan qualitative administrative interview materials for Demonstration Years 13 and 14 in October 2020.
- The evaluators submitted the draft and final DY13 and 14 evaluation reports for Components 1-4, 6, and 7 during Spring 2021.
- The evaluators submitted the Waiver of Medicaid Retroactive Eligibility Report for DY13 and DY14 during Fall 2020 and the report was finalized in Spring 2021.
- In late Spring 2021, the Agency began working on drafting Amendment 8 to the Agency's contract with the evaluation team.
    - This amendment revised the contract deliverables to align with new MMA Waiver evaluation requirements issued in January 2021.

DY13 and DY14 Final Report Findings

The Demonstration Evaluation Report for DY13 and DY14 was finalized in Spring 2021. The summary of results are as follows:

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

- Overall plan performance on HEDIS measures related to access to care remained stable between CY 2015 and 2019.
    - 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.
    - The measures with the greatest improvements from the pre-MMA period to the post-MMA period were Adults' Access to Preventive/Ambulatory Health Services 65+ years (15% increase), Immunizations for Adolescents Combination 1 (14% increase), Timeliness of Prenatal Care (13% increase), and Timeliness of Postpartum Care (13% increase).
- Results from the CAHPS surveys indicate that in 2019, approximately 77% of adult MMA enrollees rated their overall health plan as an 8, 9, or 10 on a scale of 1 to 10.
- On average, the contractual standard for all urgent wait times were met for all medical services and non-urgent appointment wait times were met for all services.
- Average PMPM expenditures continue to be lower for all eligibility groups during the MMA period compared to the pre-MMA period.
- In DY13, 88.1% of 3,148,714 enrollees who used any service, utilized expanded benefits; in DY14, 85.2% of 2,958,426 enrollees who used any service, utilized expanded benefits.
- In DY13, 91.08 percent of 234,509 enrollees were enrolled under Express Enrollment; in DY14, 94.7 percent of 131,225 enrollees were enrolled under Express Enrollment using auto-enrollment, where they were automatically assigned to an MMA plan.
- On average, new enrollees accessed services approximately 66.38 days after enrollment in DY13 and approximately 74.64 days after enrollment in DY14. However, the number of days varies by enrollment method. The average number of days for a new enrollee to access services by method varied, as follows, in each demonstration year:

Demonstration Year 13	
Enrollment Method	**Days to Access Services**
Express Enrollment	68.58 days
Voluntary Choice	43.87 days
Total (Both Enrollment Methods)	66.38 days
Demonstration Year 14	
Enrollment Method	**Days to Access Services**
Express Enrollment	75.94 days
Voluntary Choice	51.94 days
Total (Both Enrollment Methods)	74.64 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 11 different types of Healthy Behaviors programs offered across Florida's 18 MMA plans.
- Of the mandatory programs required by all plans, the medically directed weight loss program reported the highest number of enrollments in Quarters 3-4 of DY13 (320), and the smoking cessation program reported the highest number in DY14 (2,461).
- Of all programs offered (mandatory or optional), the program with the highest number of enrollments in Quarters 3-4 of DY13 was preventive adult care visits (13,000) and well-child/adolescent visits in DY14 (33,571).
- The program with the second highest number of enrollments for DY13 was the well-child visit program (8,257) and for DY14 was the pregnancy/maternity program (12,197). The program with the third highest number of enrollments for DY13 and DY14 was the preventive adult care visits (4,282 and 12,078, respectively).
- 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 $708 million and $835 million in LIP payments in DY13 and DY14, respectively.
- Out of the 172 hospital providers that received LIP funding, 159 of those hospitals reported milestone data for individuals eligible for uncompensated charity care in DY13 and 167 of those hospitals reported milestone data for individuals eligible for uncompensated care in DY14.
- Out of approximately 8.0 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 2.5 million total encounters;
    2. Inpatient days with 2.0 million total encounters; and
    3. Outpatient visits with 1.7 million total encounters.

Project 4: Dual-Eligible Enrollees (Component 6)

- The January 2019 Florida Statewide Medicaid Enrollment Report indicated that 190,549 dual-eligibles were enrolled in the MMA program and the January 2020 Florida Statewide Medicaid Enrollment Report indicated that 182,894 dual-eligibles were enrolled in the MMA program, representing declines of 5.1 percent and 4.0 percent, respectively.
- 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

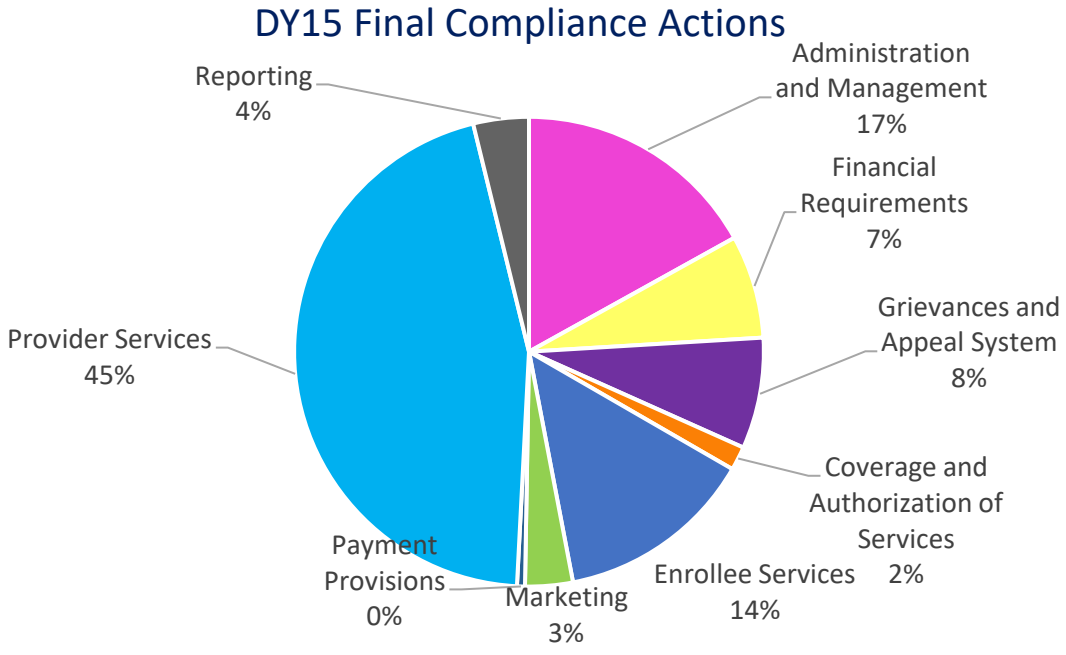
The Agency monitors the MMA plans' performance through a variety of mechanisms including plan reports and submissions, desk and on-site compliance reviews, and reviews of complaint and grievance data.

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 DY15, the Agency took 186 final compliance actions, 45 more than in DY14. 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 30 occurrences, untimely and/or inaccurate reporting with 38 occurrences, and network adequacy standards with 23 occurrences.

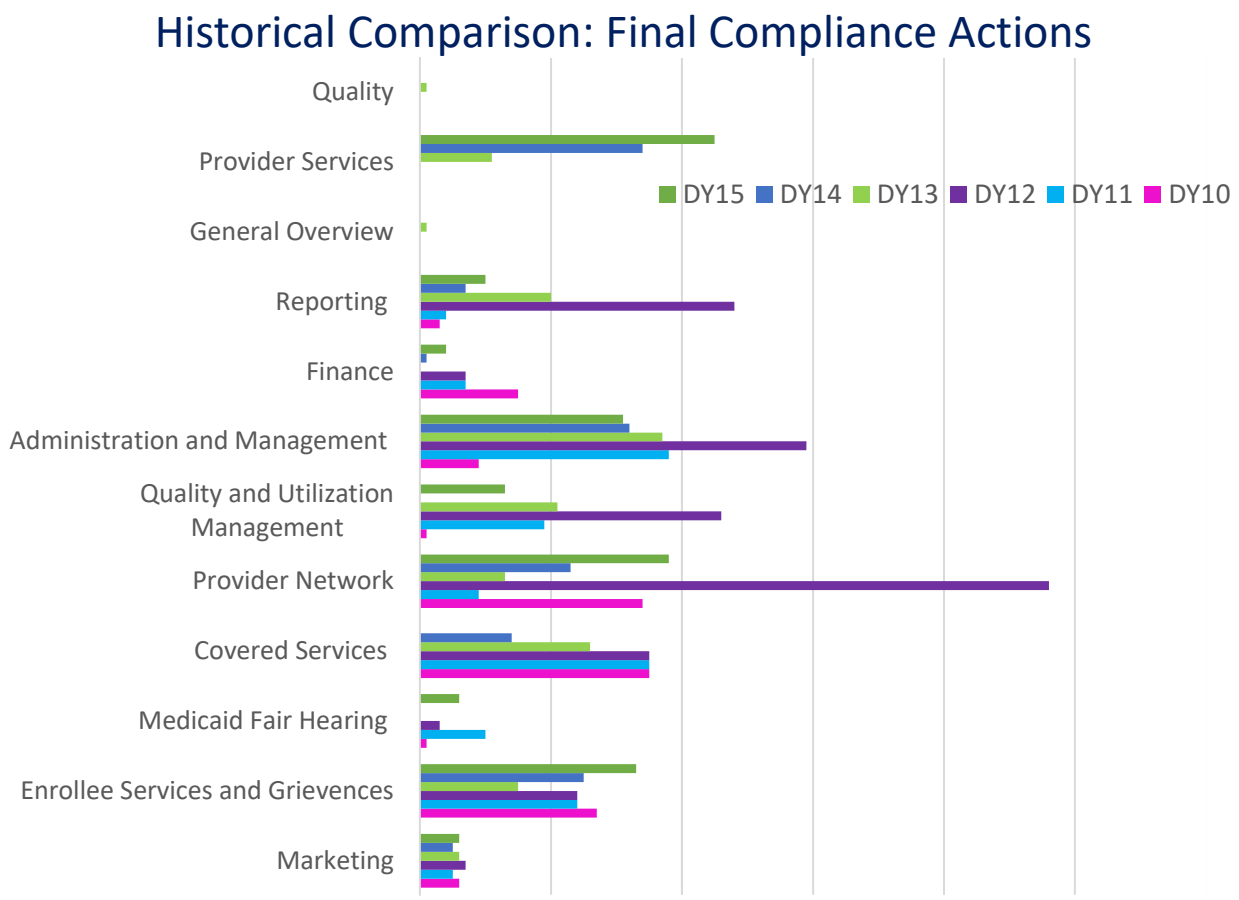
The following graph and table further detail the compliance actions taken during DY15.



DY15 Itemized Final Compliance Actions

Category and Subcategories of Non-Compliance	Occurrences
Administration and Management	**31**
Encounter Data Requirements	30
Subcontracts	1
Coverage and Authorization of Services	**13**
Prescribed Drug Services	13
Enrollee Services	**14**
Online Enrollee Materials	13
Provider Directory	1
Financial Requirements	**3**
Untimely and/or Inaccurate Reporting	2
Surplus Requirements	1
Grievances and Appeal System	**25**
Enrollee Notice Requirements	19
Medicaid Fair Hearings	6
Marketing	**6**
Use of Unapproved Marketing Material	6
Payment Provisions	**1**
Achieved Savings Rebate	1
Provider Services	**83**
Claims and Provider Payment	18
Network Adequacy Standards	38
Provider Complaint System	3
Provider Credentialing and Contracting	1
Transportation Timeliness	1
Untimely and/or Inaccurate Reporting	22
Reporting	**10**
HIPAA Reporting	6
Untimely and/or Inaccurate Reporting	4
Total	***186***

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 DY15, the number of occurrences decreased from those in DY14 and were at the lowest reported level since DY10. Additionally, the total number of final compliance actions the Agency took in DY15 increased from DY14 and was at the highest level since DY12.



Area of Non-Compliance	DY10	DY11	DY12	DY13	DY14	DY15
Marketing	6	5	7	6	5	6
Enrollee Services and Grievances	27	24	24	15	25	33
Medicaid Fair Hearing	1	10	3			6
Covered Services	35	35	35	26	14	
Provider Network	34	9	96	13	23	38
Quality and Utilization Management	1	19	46	22		13
Administration and Management	9	38	59	37	32	31
Finance	15	7	7		1	4
Reporting	3	4	48	20	7	10
General Overview				1		
Provider Services				11	34	45
Totals	**131**	**151**	**325**	**151**	**141**	**186**

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.

Twelve MMA plans contracted with the Agency reported an MLR less than the required 85% threshold; they are highlighted in the Annual Medical Loss Ratio Evaluation Report contained on the following page. The twelve plans include all the Prepaid Dental Health plans. The MMA plans reporting below the 85% threshold are as follows:

1. Coventry Healthcare of Florida D/B/A Aetna Better Health of Florida
2. Prestige Health Choice
3. United Healthcare of Florida, Inc.
4. Bestcare Assurance D/B/A/ Vivida Health
5. Community Care Plan
6. Lighthouse Health Plan
7. Miami Children's Health Plan, Inc.
8. Florida Community Care, LLC
9. Children's Medical Services Network
10. DentaQuest of Florida, Inc.
11. Liberty Dental of Florida Inc.
12. Managed Care of North America, Inc.

Each of the MMA Plans reported their annual Medical Loss Ratio (MLR) for calendar year (CY) 2020 during DY15. The CY2020 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 CY2020)							
Plan Type	**MMA Plan Name**	**Capitation Paid Less Fed/State Taxes/Fees**	**Total Expenses**	**Funds & Contributions**	**Capitation - Total Expenses**	**Medical Loss Ratio**	**Difference**
Standard MMA Plans	Coventry Healthcare of Florida D/B/A/ Aetna Better Health of Florida	$365,266,989	$310,017,534	$0	$55,249,455	84.87%	-0.13%
	Humana Medical Plan, Inc.	$1,785,977,980	$1,588,846,730	$0	$197,131,250	88.96%	3.96%
	Molina Healthcare of Florida, Inc.	$375,968,540	$325,997,366	$0	$49,971,174	86.71%	1.71%
	Prestige Health Choice	$316,053,284	$249,268,668	$0	$66,784,616	78.87%	-6.13%
	Simply Healthcare Plans, Inc.	$1,655,230,773	$1,443,246,063	$0	$211,984,710	87.19%	2.19%
	Sunshine State Health Plan, Inc.	$1,681,050,513	$1,449,089,882	$0	$231,960,631	86.20%	1.20%
	United Healthcare of Florida, Inc.	$963,374,267	$783,803,804	$0	$179,570,463	81.36%	-3.64%
	WellCare of Florida D/B/A/ StayWell Health Plan of Florida	$2,970,825,725	$2,620,253,498	$0	$350,572,227	88.20%	3.20%
Standard Plans < 50,000 Members	Bestcare Assurance D/B/A/ Vivida Health	$41,360,879	$28,922,771	$0	$12,438,108	69.93%	-15.07%
	Community Care Plan	$140,956,718	$114,816,512	$0	$26,140,206	81.46%	-3.54%
	Lighthouse Health Plan	$103,471,177	$86,530,147	$0	$16,941,030	83.63%	-1.37%
	Miami Children's Health Plan, Inc.	$72,839,201	$59,469,736	$0	$13,369,465	81.65%	-3.35%
	Florida Community Care, LLC	$31,058,073	$26,050,688	$0	$5,007,385	83.88%	-1.12%
Specialty Plans	Clear Health Alliance-HIV/AIDs Specialty Plan	$318,883,085	$272,577,263	$0	$46,305,822	85.48%	0.48%
	Children's Medical Services Network	$1,393,094,200	$1,131,163,203	$0	$261,930,997	81.20%	-3.80%
	Magellan Complete Care	$170,390,287	$147,494,220	$0	$22,896,067	86.56%	1.56%
	Sunshine-Child Welfare Specialty Plan	$229,799,294	$195,643,400	$0	$34,155,894	85.14%	0.14%
	StayWell-Serious Mental illness Specialty Plan	$820,536,675	$713,524,932	$0	$107,011,743	86.96%	1.96%
Dental Plans	DentaQuest of Florida, Inc.	$166,256,154	$121,190,830	$0	$45,065,324	72.89%	-12.11%
	Liberty Dental of Florida Inc.	$114,986,238	$81,114,044	$0	$33,872,194	70.54%	-14.46%
	Managed Care of North America, Inc.	$78,737,359	$50,853,495	$0	$27,883,864	64.59%	-20.41%
Grand Total		**$13,796,117,413**	**$11,799,874,786**	**$0**	**$1,996,242,627**	**85.53%**	**0.53%**

Encounter Data Activities

During DY15, 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 #82(e).

Per Member Per Month Cap

Table A shows the Per Member Per Month (PMPM) cap established in the MMA Waiver as specified in STC #97(b). These caps are compared to actual waiver expenditures using date of service tracking and reporting.

TABLE A		
PMPM Targets		
WOW[1] 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.

[1] 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, 2021. 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
DY15/Q57	Jul-Sep 2020	1,638,652	$1,791,573,746	$1,093.32
DY15/Q58	Oct-Dec 2020	1,620,939	$1,720,217,729	$1,061.25
DY15/Q59	Jan-Mar 2021	1,644,835	$1,986,894,619	$1,207.96
DY15/Q60	Apr-Jun 2021	1,656,076	$1,921,695,266	$1,160.39
Managed Medical Assistance- MEG 1 Total[2]		**70,476,587**	**$67,696,521,882**	**$960.55**

* 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.

[2] 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
DY15/Q57	Jul-Sep 2020	7,735,127	$1,855,851,269	$239.93
DY15/Q58	Oct-Dec 2020	8,520,870	$2,255,393,137	$264.69
DY15/Q59	Jan-Mar 2021	8,707,149	$2,177,770,361	$250.11
DY15/Q60	Apr-Jun 2021	9,079,808	$2,268,916,341	$249.89
Managed Medical Assistance- MEG 2 Total[3]		**366,257,503**	**$82,612,593,425.00**	**$225.56**

* 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 MEG2 Total (from DY01 on)

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.

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%
DY15– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY15 Total	6,560,502	$7,420,381,360	$1,131.07
WOW DY15 Total	6,560,502	$7,582,497,002	$1,155.78
Difference		$162,115,642	
% of WOW PMPM MEG 1			97.86%
DY15– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY15 Total	34,042,954	$8,557,931,108	$251.39
WOW DY15 Total	34,042,954	$10,432,463,253	$306.45
Difference		$1,874,532,145	
% of WOW PMPM MEG 2			82.03%

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.

– For DY15, MEG 1 has a PMPM of $1,131.07 (Table D), compared to WOW of $1,155.78 (Table A), which is 97.86% of the target PMPM for MEG 1. MEG 2 has a PMPM of $251.39 (Table D), compared to WOW of $306.45 (Table A), which is 82.03% 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	33,801,497	$14,117,725,754	$417.67
WOW	33,801,497	$15,065,022,271	$445.69
Difference		$947,296,517	
% Of WOW			93.71%
DY 15	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	40,603,456	$15,978,312,468	$393.52
WOW	40,603,456	$18,014,960,255	$443.68
Difference		$2,036,647,787	
% Of WOW			88.69%

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 $445.69. 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 $417.67. Comparing the calculated weighted averages, the actual PMPM is 93.71% of the target PMPM.
- For DY15, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $443.68. 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 $393.52. Comparing the calculated weighted averages, the actual PMPM is 88.69% 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 #99. 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**	**DY15**	**TOTAL**
PMPM	$1,004.22	$1,004.22	$1,004.22	$1,004.22	
Actual MM	275,692	581,563	588,524	740,156	
Cap Cost	$276,855,420	$584,017196	$591,007,571	$743,279,458	
Total spend	$360,056,121	$674,592,451	$696,696,467	$774,224,628	$3,331,057,587
Hypothetical Variance	$(83,200,701)	$(90,575,255)	$(105,688,896)	$(30,945,170)	$ (310,410,021)

DY15 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), The Program for All-Inclusive Care for Children (PACC) (MEG 7), and The Behavioral Health and Supportive Housing Assistance Pilot (MEG 8) are authorized as Cost Not Otherwise Matchable (CNOM) services under the 1115 MMA Waiver. Table G identifies the DY15 costs for these four 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 DY15 in Table E on the previous page.

Table G **WW/WOW Difference Less CNOM Costs**				
DY15 Difference July 2020 - June 2021:				$1,388,099,380
CNOM Costs July 2020 – June 2021:				
	MEG 5 AIDS			$904,449
	MEG 6 Healthy Start			$42,865,616
	MEG 7 PACC			$1,804
	MEG 8 BH SH Pilot			$10,686,330
DY15 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
DY15/Q57	$0
DY15/Q58	$0
DY15/Q59	$1,067,190,454
DY15/Q60	$0
Total Paid[4]	**$14,374,516,783**

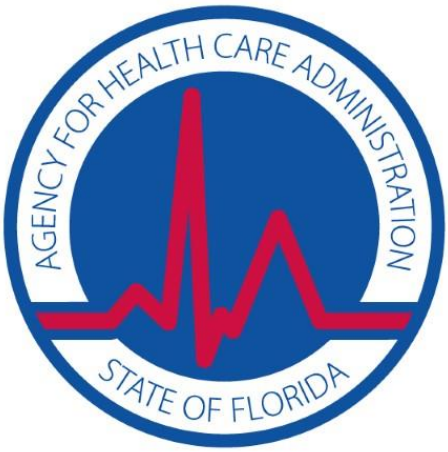
[4] MMA MEG3 Total (from DY01 on)

Low-Income Pool DY14 Expenditures

Expenditures for DY15 for **MEG 3**, Low Income Pool (LIP), were $1,067,190,454 (70.75%) 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%
DY15	$1,067,190,454	$1,508,385,773	70.75%

* STC #62 a. The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773 through DY16.



Attachments

Attachment I	Statewide Medicaid Managed Care Expanded Benefits
Attachment II	MMA Enrollment Report
Attachment III	Healthy Behaviors Program Enrollment Statistics

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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

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[5]
(July 1, 2020 – June 30, 2021)

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				
Aetna Better Health	STANDARD	**133,422**	**10,567**	**60**	**9,353**	**153,402**	**3.90%**	**129,317**	**18.62%**
Florida Community Care	STANDARD	**4**	**909**	**5**	**14,442**	**15,360**	**0.39%**	**10,719**	**43.30%**
Humana Medical Plan	STANDARD	**539,114**	**58,428**	**238**	**52,798**	**650,578**	**16.52%**	**579,208**	**12.32%**
Lighthouse Health Plan	STANDARD	**376**	**56**	**1**	**127**	**560**	**0.01%**	**40,175**	**-98.61%**
Miami Children's Health Plan	STANDARD	**696**	**91**	**1**	**557**	**1,345**	**0.03%**	**28,046**	**-95.20%**
Molina Healthcare Of Florida	STANDARD	**103,731**	**9,812**	**99**	**7,783**	**121,425**	**3.08%**	**117,081**	**3.71%**
Prestige Health Choice	STANDARD	**98,267**	**6,830**	**31**	**3,244**	**108,372**	**2.75%**	**99,729**	**8.67%**
South Florida Community Care Network	STANDARD	**48,437**	**3,721**	**21**	**1,928**	**54,107**	**1.37%**	**50,461**	**7.23%**
Simply Healthcare	STANDARD	**548,624**	**53,950**	**332**	**33,464**	**636,370**	**16.16%**	**544,209**	**16.93%**
Staywell Health Plan	STANDARD	**816,386**	**82,765**	**139**	**31,984**	**931,274**	**23.65%**	**921,078**	**1.11%**
Sunshine State Health Plan	STANDARD	**530,005**	**43,823**	**118**	**49,624**	**623,570**	**15.84%**	**615,077**	**1.38%**
United Healthcare Of Florida	STANDARD	**268,732**	**28,154**	**74**	**22,860**	**319,820**	**8.12%**	**301,775**	**5.98%**
Vivida Health	STANDARD	**19,364**	**1,345**	**2**	**669**	**21,380**	**0.54%**	**16,002**	**33.61%**
Standard Plans Total		**3,107,158**	**300,451**	**1,121**	**228,833**	**3,637,563**	**92.39%**	**3,452,877**	**5.35%**
Magellan Complete Care	SPECIALTY	15,159	7,795	3	2,919	**25,876**	**0.66%**	**25,337**	**2.13%**
Simply Healthcare	SPECIALTY	3,797	5,831	2	3,302	**12,932**	**0.33%**	**12,431**	**4.03%**
Wellcare of Florida/Staywell	SPECIALTY	87,655	36,453	49	16,042	**140,199**	**3.56%**	**118,729**	**18.08%**
Sunshine State Health Plan	SPECIALTY	37,447	1,755	-	2	**39,204**	**1.00%**	**39,029**	**0.45%**
Children's Medical Services Network	SPECIALTY	50,314	31,101	-	183	**81,598**	**2.07%**	**71,596**	**13.97%**
Specialty Plans Total		**194,372**	**82,935**	**54**	**22,448**	**299,809**	**7.61%**	**267,122**	**12.24%**
MMA TOTAL		**3,301,530**	**383,386**	**1,175**	**251,281**	**3,937,372**	**100%**	**3,719,999**	**5.84%**

[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, 2020 – June 30, 2021)

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	114,341	13,502	9	7,878	135,730	3.45%	128,924	5.28%
02	Standard & Specialty	116,162	16,124	15	8,889	141,190	3.59%	134,021	5.35%
03	Standard & Specialty	286,755	38,121	15	20,446	345,337	8.77%	325,571	6.07%
04	Standard & Specialty	353,343	39,554	29	20,719	413,645	10.51%	390,671	5.88%
05	Standard & Specialty	189,471	26,154	40	19,632	235,297	5.98%	227,014	3.65%
06	Standard & Specialty	478,650	55,115	108	27,933	561,806	14.27%	529,708	6.06%
07	Standard & Specialty	454,504	52,405	76	24,522	531,507	13.50%	499,687	6.37%
08	Standard & Specialty	231,833	21,693	66	16,957	270,549	6.87%	252,786	7.03%
09	Standard & Specialty	302,726	27,830	78	21,553	352,187	8.94%	328,959	7.06%
10	Standard & Specialty	286,760	30,068	119	21,502	338,449	8.60%	318,356	6.31%
11	Standard & Specialty	486,985	62,820	620	61,250	611,675	15.54%	584,302	4.68%
MMA TOTAL		3,301,530	383,386	1,175	251,281	3,937,372	100%	3,719,999	5.84%
01	STANDARD	108,024	10,938	9	7,154	126,125	3.47%	120,147	4.98%
02	STANDARD	106,494	11,983	13	7,928	126,418	3.48%	120,593	4.83%
03	STANDARD	264,353	28,975	15	18,196	311,539	8.56%	295,548	5.41%
04	STANDARD	331,234	31,906	26	18,863	382,029	10.50%	362,137	5.49%
05	STANDARD	175,776	20,386	38	18,002	214,202	5.89%	208,095	2.93%
06	STANDARD	451,099	43,407	104	25,565	520,175	14.30%	492,857	5.54%
07	STANDARD	428,124	40,662	74	22,184	491,044	13.50%	463,760	5.88%
08	STANDARD	217,622	16,470	56	15,362	249,510	6.86%	234,377	6.46%
09	STANDARD	287,469	21,949	76	19,897	329,391	9.06%	308,328	6.83%
10	STANDARD	272,391	23,206	115	19,664	315,376	8.67%	297,771	5.91%
11	STANDARD	464,572	50,569	595	56,018	571,754	15.72%	549,264	4.09%
STANDARD TOTAL		3,107,158	300,451	1,121	228,833	3,637,563	100%	3,452,877	5.35%
01	SPECIALTY	6,317	2,564	-	724	9,605	3.20%	8,777	9.43%
02	SPECIALTY	9,668	4,141	2	961	14,772	4.93%	13,428	10.01%

03	SPECIALTY	22,402	9,146	-	2,250	33,798	11.27%	30,023	12.57%
04	SPECIALTY	22,109	7,648	3	1,856	31,616	10.55%	28,534	10.80%
05	SPECIALTY	13,695	5,768	2	1,630	21,095	7.04%	18,919	11.50%
06	SPECIALTY	27,551	11,708	4	2,368	41,631	13.89%	36,851	12.97%
07	SPECIALTY	26,380	11,743	2	2,338	40,463	13.50%	35,927	12.63%
08	SPECIALTY	14,211	5,223	10	1,595	21,039	7.02%	18,409	14.29%
09	SPECIALTY	15,257	5,881	2	1,656	22,796	7.60%	20,631	10.49%
10	SPECIALTY	14,369	6,862	4	1,838	23,073	7.70%	20,585	12.09%
11	SPECIALTY	22,413	12,251	25	5,232	39,921	13.32%	35,038	13.94%
SPECIALTY TOTAL		194,372	82,935	54	22,448	299,809	100%	267,122	12.24%

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, 2020 – JUNE 30, 2021)

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)	992,896	23.71%	854,207	16.24%
DentaQuest of Florida	1,811,606	43.27%	1,773,930	2.12%
Liberty Dental Plan of Florida	1,382,350	33.02%	1,293,839	6.84%
TOTAL	4,186,852	100%	3,921,976	6.75%

Attachment III

Healthy Behaviors Program Enrollment Statistics

Table A provides a summary of enrollees participating in Healthy Behaviors Programs during DY15, and **Table B** provides a summary of enrollees who completed a Healthy Behaviors Program during the DY15.

Table A: Healthy Behaviors Program DY15 Enrollment Statistics							
Program	**Total Enrolled**	**Gender**		**Age (years)**			
		Male	**Female**	**0–20**	**21–40**	**41–60**	**Over 60**
Aetna							
Medically Approved Smoking Cessation Program	2	2	0	0	0	1	1
Medically Directed Weight Loss Program	2	1	1	1	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Prenatal and Post-Partum Incentive Program	87	0	87	7	77	3	0
Children's Medical Services							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	3	2	1	3	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Initial Primary Care Provider (PCP) Visit	16	7	9	16	0	0	0
Well-Child: 0-15 Months	7	1	6	7	0	0	0
Well-Child: 3-6 Years	8	5	3	8	0	0	0
Annual Primary Care Provider Visit: 5-16 Years- Backpack	0	0	0	0	0	0	0
Annual Adolescent Check Up: 7-20 years	15	9	6	15	0	0	0
Initial Prenatal Care Visit	1	0	1	1	0	0	0
Completion of Second Prenatal Care Visit	1	0	1	1	0	0	0
Postpartum Care Visit	0	0	0	0	0	0	0
Diabetes: Annual Eye Exam	0	0	0	0	0	0	0
Diabetes: Annual Hb1A1C	0	0	0	0	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Diabetes: Blood Pressure Control	0	0	0	0	0	0	0
Chlamydia Screening	0	0	0	0	0	0	0
Community Care Plan							
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
Pregnancy- Completed prenatal and postpartum exam	1	0	1	0	1	0	0
Well child 15 months - 6 visits	0	0	0	0	0	0	0
Annual Well Child Exam ages 2-11	3	1	2	3	0	0	0
Annual Well Child Exam ages 12-19	2	1	1	2	0	0	0
Annual Well Adult Exam ages >= 20	3	0	3	0	3	0	0
Diabetes Screening (A1c, Microalbumin and Eye exam)	0	0	0	0	0	0	0
COVID Vaccination Incentive Program	44	14	30	20	9	14	1
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	11	2	9	0	2	6	3
Medically Directed Weight Loss Program	79	12	67	3	34	36	6
Medically Approved Alcohol or Substance Abuse Recovery Program	4	1	3	0	2	2	0
Mom’s First Prenatal & Postpartum	872	252	620	110	322	200	240
Pediatric Well Visit (PWV) Program	99	27	72	4	49	21	25
Baby Well Visit (BWV) Program	1224	0	1224	147	1062	15	0
Health Risk Assessment	11246	5658	5588	11246	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Magellan Complete 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
Maternity Incentive Program	112	0	112	16	93	3	0
Adult Diabetes Clinic Days	0	0	0	0	0	0	0
Teen and Adolescent Clinic Days	0	0	0	0	0	0	0
Inovalon Personal Health Visit	280	84	196	8	125	120	27
HRA Incentive	119	34	85	33	62	22	2
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
Pregnancy Rewards (Prenatal and Postpartum)	81	0	81	3	74	4	0
Preventative Health	50	28	22	49	0	1	0
Prestige Health Choice							
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
Behavioral Health Follow-Up Program	1	0	1	0	1	0	0
Diabetes Testing Program	1	0	1	0	0	1	0
Diabetes Eye Exam Program	1	0	1	0	0	1	0
Maternity Program	2	0	2	0	2	0	0
Postpartum Program	0	0	0	0	0	0	0
Well-Child (31 days to 15 months old) Program	7	5	2	7	0	0	0
Well-Child (3 to 6 years old) Program	0	0	0	0	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Adolescent Well-Care Program	14	8	6	14	0	0	0
Breast Cancer Screening Program	1	0	1	0	0	1	0
Lead Screening Program	5	0	5	5	0	0	0
Cervical Cancer Screening Program	4	0	4	0	1	3	0
Access to Preventive/Ambulatory Health Services Program	0	0	0	0	0	0	0
Simply							
Medically Approved Smoking Cessation Program	58	26	32	1	17	32	8
Medically Directed Weight Loss Program	68	10	58	10	25	29	4
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Services: Maternal Visits 1	338	0	338	37	285	16	0
Maternal Child Services: Maternal Visits 2	8	0	8	3	4	1	0
Maternal Child Services: Child	187	92	95	187	0	0	0
Well-Child Visits 1	53	30	23	53	0	0	0
Well Child Visits 2	55	29	26	55	0	0	0
Asthma Management	4	2	2	2	0	2	0
Staywell							
Medically Approved Smoking Cessation Program	122	10	112	2	105	14	1
Medically Directed Weight Loss Program	13	3	10	9	3	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	5	1	4	0	4	1	0
Children's Healthy Behaviors: Well Child Visit 0-15 Months	259	150	109	259	0	0	0
Children's Healthy Behaviors: Well Child 3-6 Years	23	10	13	23	0	0	0
Children's Healthy Behaviors: Annual Adolescent Check Up: 7-21 Years	53	15	38	52	1	0	0
Well Woman Healthy Behaviors: Screening Mammogram	15	0	15	0	0	10	5
Well Woman Healthy Behaviors: Cervical Cancer Screening	0			0	0	0	0

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Well Woman Healthy Behaviors: Chlamydia Screening	20	0	20	5	15	0	0
Diabetes Healthy Behaviors: Eye Exam	37	9	28	1	16	13	7
Diabetes Healthy Behaviors: HgbA1C Control	54	9	45	0	29	15	10
Diabetes Healthy Behaviors: Blood Pressure Control	61	15	46	0	32	18	11
New Member Healthy Behaviors: Health Risk Assessment	294	36	258	26	195	59	14
New Member Healthy Behaviors: Initial PCP	149	21	128	24	78	38	9
First Prenatal Visit	196	0	196	17	175	4	0
Second Prenatal Visit	151	0	151	9	140	2	0
Postpartum Visit	94	0	94	6	86	2	0
Adult Health Healthy Behaviors: Annual Adult Health Screening	219	25	194	7	155	44	13
Annual Primary Care Provider (PCP) Visit: 5-16 Years-MMA Backpack Project	0	0	0	0	0	0	0
Sunshine Health							
Medically Approved Smoking Cessation Program	7	3	4	0	0	6	1
Medically Directed Weight Loss Program	30	3	27	2	12	14	2
Medically Approved Alcohol or Substance Abuse Recovery Program	102	51	51	3	21	50	28
United Healthcare							
Medically Approved Smoking Cessation Program	26	8	18	0	9	13	4
Medically Directed Weight Loss Program	53	15	38	1	17	30	5
Medically Approved Alcohol or Substance Abuse Recovery Program	10	2	8	0	3	7	0
Healthy First Steps Rewards Program	64	0	64	5	56	3	0
Vivida Health							
Medically Approved Smoking Cessation Program	4	2	2	0	1	1	2

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
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

Table B: Healthy Behaviors Program DY 15 Completion Statistics							
Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Aetna							
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
Prenatal and Post-Partum Incentive Program	38	0	38	1	36	1	0
Children's Medical Services							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	5	3	2	5	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Initial Primary Care Provider (PCP) Visit	24	13	11	24	0	0	0
Well-Child: 0-15 Months	13	7	6	13	0	0	0
Well-Child: 3-6 Years	22	17	5	22	0	0	0
Annual Primary Care Provider Visit: 5-16 Years- Backpack	0	0	0	0	0	0	0
Annual Adolescent Check Up: 7-20 years	41	22	19	41	0	0	0
Initial Prenatal Care Visit	2	0	2	2	0	0	0
Completion of Second Prenatal Care Visit	2	0	2	2	0	0	0
Postpartum Care Visit	0	0	0	0	0	0	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Diabetes: Annual Eye Exam	0	0	0	0	0	0	0
Diabetes: Annual Hb1A1C	0	0	0	0	0	0	0
Diabetes: Blood Pressure Control	0	0	0	0	0	0	0
Chlamydia Screening	0	0	0	0	0	0	0
Community Care Plan							
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
Pregnancy- Completed prenatal and postpartum exam	1	0	1	0	1	0	0
Well child 15 months - 6 visits	0	0	0	0	0	0	0
Annual Well Child Exam ages 2-11	3	1	2	3	0	0	0
Annual Well Child Exam ages 12-19	2	1	1	2	0	0	0
Annual Well Adult Exam ages >= 20	3	0	3	0	3	0	0
Diabetes Screening (A1c, Microalbumin and Eye exam)	0	0	0	0	0	0	0
COVID Vaccination Incentive Program	44	14	30	20	9	14	1
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	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	3	0	3	0	1	1	1
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Mom’s First Prenatal & Postpartum	872	252	620	110	322	200	240
Pediatric Well Visit (PWV) Program	99	27	72	4	49	21	25
Baby Well Visit (BWV) Program	66	0	66	6	60	0	0
Health Risk Assessment	3351	1709	1642	3351	0	0	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Magellan Complete 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
Maternity Incentive Program	5	0	5	0	5	0	0
Adult Diabetes Clinic Days	0	0	0	0	0	0	0
Teen and Adolescent Clinic Days	0	0	0	0	0	0	0
Inovalon Personal Health Visit	280	84	196	8	125	120	27
HRA Incentive	119	34	85	33	62	22	2
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
Pregnancy Rewards (Prenatal and Postpartum)	27	0	27	1	25	1	0
Preventative Health	8	2	6	4	2	0	0
Prestige Health Choice							
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
Behavioral Health Follow-Up Program	0	0	0	0	0	0	0
Diabetes Testing Program	1	0	1	0	0	1	0
Diabetes Eye Exam Program	0	0	0	0	0	0	0
Maternity Program	1	0	1	0	1	0	0
Postpartum Program	0	0	0	0	0	0	0
Well-Child (31 days to 15 months old) Program	1	0	1	1	0	0	0
Well-Child (3 to 6 years old) Program	0	0	0	0	0	0	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Adolescent Well-Care Program	3	2	1	3	0	0	0
Breast Cancer Screening Program	0	0	0	0	0	0	0
Lead Screening Program	1	0	1	1	0	0	0
Cervical Cancer Screening Program	1	0	1	0	0	1	0
Access to Preventive/Ambulatory Health Services 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	3	2	1	2	0	0	1
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Services: Maternal Visits 1	1	0	1	0	1	0	0
Maternal Child Services: Maternal Visits 2	8	0	8	3	4	1	0
Maternal Child Services: Child	0	0	0	0	0	0	0
Well-Child Visits 1	32	18	14	32	0	0	0
Well Child Visits 2	31	15	16	31	0	0	0
Asthma Management	1	1	0	1	0	0	0
Staywell							
Medically Approved Smoking Cessation Program	259	29	230	6	192	55	6
Medically Directed Weight Loss Program	30	8	22	15	7	7	1
Medically Approved Alcohol or Substance Abuse Recovery Program	15	3	12	0	10	5	0
Children's Healthy Behaviors: Well Child Visit 0-15 Months	449	244	205	449	0	0	0
Children's Healthy Behaviors: Well Child 3-6 Years	85	47	38	85	0	0	0
Children's Healthy Behaviors: Annual Adolescent Check Up: 7-21 Years	159	67	92	156	3	0	0
Well Woman Healthy Behaviors: Screening Mammogram	45	0	45	0	0	30	15

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Well Woman Healthy Behaviors: Cervical Cancer Screening	0	0	0	0	0	0	0
Well Woman Healthy Behaviors: Chlamydia Screening	65	0	65	16	49	0	0
Diabetes Healthy Behaviors: Eye Exam	107	19	88	2	40	51	14
Diabetes Healthy Behaviors: HgbA1C Control	173	26	147	1	68	79	25
Diabetes Healthy Behaviors: Blood Pressure Control	174	33	141	1	71	78	24
New Member Healthy Behaviors: Health Risk Assessment	475	65	410	54	302	98	21
New Member Healthy Behaviors: Initial PCP	211	27	184	29	115	54	13
First Prenatal Visit	438	0	438	40	384	14	0
Second Prenatal Visit	365	0	365	27	328	10	0
Postpartum Visit	207	0	207	17	182	8	0
Adult Health Healthy Behaviors: Annual Adult Health Screening	521	61	460	14	335	134	38
Annual Primary Care Provider (PCP) Visit: 5-16 Years-MMA Backpack Project	0	0	0	0	0	0	0
Sunshine Health							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	1	0	1	0	1	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	17	12	5	0	2	11	4
United Healthcare							
Medically Approved Smoking Cessation Program	10	4	6	0	3	6	1
Medically Directed Weight Loss Program	26	9	17	0	5	13	8
Medically Approved Alcohol or Substance Abuse Recovery Program	7	3	4	0	5	1	1
Healthy First Steps Rewards Program	291	0	291	10	276	5	0

Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
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

STATE OF FLORIDA
RON DESANTIS, GOVERNOR

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MISSION STATEMENT
BETTER HEALTHCARE FOR ALL FLORIDIANS.