Florida Managed Care Program Features, as of 2019 (1 of 2)

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
Program type	Comprehensive MCO	MLTSS only (PIHP and/or PAHP)	Program of All-inclusive Care for the Elderly (PACE)
Statewide or region-specific?	Statewide	Statewide	Statewide
Federal operating authority	1115(a) (Medicaid demonstration waivers)	1915(b)/1915(c)	PACE
Program start date	08/01/2014	08/01/2013	01/01/2003
Waiver expiration date (if applicable)	06/30/2022	12/27/2021	
If the program ended in 2019, indicate the end date			
Populations enrolled: Low-income adults not covered under ACA Section VIII (excludes pregnant women and people with disabilities)	Mandatory	Mandatory	
Populations enrolled: Low-income adults covered under ACA Section VIII (excludes pregnant women and people with disabilities)			
Populations enrolled: Aged, Blind or Disabled Children or Adults	Mandatory	Mandatory	Voluntary
Populations enrolled: Non-Disabled Children (excludes children in foster care or receiving adoption assistance)	Mandatory	Mandatory	
Populations enrolled: Individuals receiving Limited Benefits (excludes partial duals)			
Populations enrolled: Full Duals	Mandatory	Mandatory	Voluntary
Populations enrolled: Partial Duals			
Populations enrolled: Children with Special Health Care Needs	Mandatory	Mandatory	

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
Populations enrolled: Native American/Alaskan Natives	Mandatory	Mandatory	Voluntary
Populations enrolled: Foster Care and Adoption Assistance Children	Mandatory	Mandatory	Exempt
Populations enrolled: Enrollment choice period	Other	60 days	N/A
Populations enrolled: Enrollment broker name (if applicable)	Automated Health Systems	Automated Health Systems	Automated Health Systems
Populations enrolled: Notes on enrollment choice period	Beneficiaries are enrolled immediately after being determined eligible. Beneficiaries are then given 120 days to pick another plan if they wish to do so.		Continuous while slots are available
Benefits covered: Inpatient hospital physical health	X		X
Benefits covered: Inpatient hospital behavioral health (MH and/or SUD)	X		X
Benefits covered: Outpatient hospital physical health	X		X
Benefits covered: Outpatient hospital behavioral health (MH and/or SUD)	X		X
Benefits covered: Partial hospitalization	X		X
Benefits covered: Physician	X		X
Benefits covered: Nurse practitioner	X		X
Benefits covered: Rural health clinics and FQHCs	X		X
Benefits covered: Clinic services	X		X
Benefits covered: Lab and x-ray	X		X
Benefits covered: Prescription drugs	X		X

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
Benefits covered: Prosthetic devices	X		X
Benefits covered: EPSDT	X		
Benefits covered: Case management		X	X
Benefits covered: SSA Section 1945-authorized health home			
Benefits covered: Health home care (services in home)	X	X	X
Benefits covered: Family planning	X		X
Benefits covered: Dental services (medical/surgical)			X
Benefits covered: Dental (preventative or corrective)			X
Benefits covered: Personal care (state plan option)	X	X	
Benefits covered: HCBS waiver services		X	X
Benefits covered: Private duty nursing	X	X	
Benefits covered: ICF-IDD			
Benefits covered: Nursing facility services	X	X	X
Benefits covered: Hospice care	X	X	X
Benefits covered: Non-Emergency Medical Transportation	X	X	X
Benefits covered: Institution for Mental Disease inpatient treatment for people ages 21-64 defined by 42 CFR §438.6(e) as an 'in lieu of' benefit	X		

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
Benefits covered: Other (e.g., nurse midwife services, freestanding birth centers, podiatry, etc.)	Midwife, Birth Center, Podiatry, and Targeted Case Management. In addition, the Agency also negotiated expanded benefits above the Medicaid state plan service package. These expanded benefits vary by plan and include expanded outpatient hospital visits, physician home visits, and many other expanded benefits. We have attached a pdf to our response that contains a listing of the expanded benefits.	Home Health Prosthetic Devices, Intermittent and Skilled Nursing Services. In addition, the Agency also negotiated expanded benefits above the Medicaid state plan service package and 1915(c). These expanded benefits vary by plan and include, but are not limited to, cellular phone service, mobile personal emergency response system, over-the-counter medications and supplies, and support to transition out of a nursing facility.	All other FL Medicaid covered services and other services as determined by the multidisciplinary team
Quality assurance and improvement: HEDIS data required?	Yes	Yes	No
Quality assurance and improvement: CAHPS data required?	Yes	Yes	No
Quality assurance and improvement: Accreditation required?	Yes	Yes	No
Quality assurance and improvement: Accrediting organization	NCQA, AAAHC, Nationally recognized accrediting organizations	NCQA, AAAHC, Nationally recognized accrediting organizations	
Quality assurance and improvement: EQRO contractor name (if applicable)	Health Services Advisory Group	Health Services Advisory Group	
Performance incentives: Payment bonuses/differentials to reward plans	X		
Performance incentives: Preferential auto-enrollment to reward plans			
Performance incentives: Public reports comparing plan performance on key metrics	X		
Performance incentives: Withholds tied to performance metrics			
Performance incentives: MCOs/PHPs required or encouraged	X		

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
to pay providers for value/quality outcomes			
Participating plans: Plans in Program	Prestige Health Choice; Community Care Plan; Simply Healthcare Plans, Inc.; Staywell Health Plan of Florida; Sunshine State Health Plan, Inc.; United Healthcare of Florida; Magellan Complete Care, LLC; Clear Health Alliance; Staywell-Serious Mental Illness; Sunshine State Health Plan – Child Welfare; Children's Medical Services Network; Vivida Health; Aetna Better Health; Florida Community Care; Humana Medical Plan; Lighthouse Health Plan, LLC; Miami Children's Health Plan; Molina Healthcare of Florida	Simply Healthcare Plans, Inc.; Aetna Better Health; Florida Community Care; Humana Medical Plan, Inc.; Molina Healthcare of FL, Inc.; Sunshine State Health Plan, Inc.; United Healthcare of Florida; Staywell	Florida Pace Center; Hope Select Care; Morselife Home Care, Inc.; Suncoast Neighborly Care, Inc.
Notes: Program notes	Pregnant women who meet all other criteria for Medicaid eligibility are mandatorily enrolled into the MMA program. Presumptively eligible pregnant women are excluded. Full Dual recipients are mandatorily enrolled in the MMA program if they receive fee-for-service Medicare or are enrolled in a Medicare Advantage plan that is not fully liable. Full Duals enrolled in a fully liable Medicare Advantage plan or in a Medicare Advantage Special Needs plan are excluded. The MMA program includes MMA specialty plans for recipients in the child welfare system, recipients under the age of 21 with chronic conditions, recipients with HIV or AIDS, recipients with a serious mental illness. The MMA specialty plans cover the same health care services as the standard MMA plans.	A recipient must be 18 years of age or older and meet Nursing Facility level of care in order to enroll in the Long-Term Care program. Recipients aged 18 to 64 must be eligible for Medicaid by reason of a disability as determined by the Social Security Administration in order to enroll in the Long-Term Care program. In addition to the 60 day enrollment period, once a recipient is enrolled with a plan, they have 120 days to change plans if they wish to do so.	Low income adults age 55 and older who are non-disabled may enroll if they meet all other PACE eligibility requirements. Aged, Blind or Disabled adults age 55 and older may enroll if they meet all other eligibility requirements. Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organizations provide pre-paid, capitated, comprehensive health care services. To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care and reside in the designated service area of a PACE organization. At the time of the enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who

Features	Managed Medical Assistance Program	Long-Term Care Program	Program of All-Inclusive Care for the Elderly
Notes: Program notes (continued)			are Medicare beneficiaries and/or Medicaid recipients. The PACE organization receives a prospective monthly payment for each Medicare participant based on a rate similar to the rate paid to Medicare Advantage, and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. PACE organizations may charge a premium to individuals who do not have Medicaid eligibility. The PACE benefit package for all participants, regardless of the source of payment, must include all Medicaid-covered services, as specified in the State's approved Medicaid plan, all Medicare-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the individual's overall health status. While enrolled in a PACE program, the participant must receive all Medicare and Medicaid benefits solely through the PACE organization.

Florida Managed Care Program Features, as of 2019 (2 of 2)

Features	**Dental**
Program type	Dental only (PAHP)
Statewide or region-specific?	Statewide
Federal operating authority	1115(a) (Medicaid demonstration waivers)
Program start date	12/01/2018
Waiver expiration date (if applicable)	06/30/2022
If the program ended in 2019, indicate the end date	
Populations enrolled: Low-income adults not covered under ACA Section VIII (excludes pregnant women and people with disabilities)	Mandatory
Populations enrolled: Low-income adults covered under ACA Section VIII (excludes pregnant women and people with disabilities)	
Populations enrolled: Aged, Blind or Disabled Children or Adults	Mandatory
Populations enrolled: Non-Disabled Children (excludes children in foster care or receiving adoption assistance)	Mandatory
Populations enrolled: Individuals receiving Limited Benefits (excludes partial duals)	
Populations enrolled: Full Duals	Mandatory
Populations enrolled: Partial Duals	
Populations enrolled: Children with Special Health Care Needs	Mandatory
Populations enrolled: Native American/Alaskan Natives	Mandatory

Features	Dental
Populations enrolled: Foster Care and Adoption Assistance Children	Mandatory
Populations enrolled: Enrollment choice period	Other
Populations enrolled: Enrollment broker name (if applicable)	Automated Health Systems
Populations enrolled: Notes on enrollment choice period	Beneficiaries are enrolled immediately after being determined eligible. Beneficiaries are then given 120 days to pick another plan if they wish to do so.
Benefits covered: Inpatient hospital physical health	
Benefits covered: Inpatient hospital behavioral health (MH and/or SUD)	
Benefits covered: Outpatient hospital physical health	
Benefits covered: Outpatient hospital behavioral health (MH and/or SUD)	
Benefits covered: Partial hospitalization	
Benefits covered: Physician	
Benefits covered: Nurse practitioner	
Benefits covered: Rural health clinics and FQHCs	
Benefits covered: Clinic services	
Benefits covered: Lab and x-ray	
Benefits covered: Prescription drugs	
Benefits covered: Prosthetic devices	
Benefits covered: EPSDT	
Benefits covered: Case management	

Features	Dental
Benefits covered: SSA Section 1945-authorized health home	
Benefits covered: Health home care (services in home)	
Benefits covered: Family planning	
Benefits covered: Dental services (medical/surgical)	X
Benefits covered: Dental (preventative or corrective)	X
Benefits covered: Personal care (state plan option)	
Benefits covered: HCBS waiver services	
Benefits covered: Private duty nursing	
Benefits covered: ICF-IDD	
Benefits covered: Nursing facility services	
Benefits covered: Hospice care	
Benefits covered: Non-Emergency Medical Transportation	
Benefits covered: Institution for Mental Disease inpatient treatment for people ages 21-64 defined by 42 CFR §438.6(e) as an 'in lieu of' benefit	
Benefits covered: Other (e.g., nurse midwife services, freestanding birth centers, podiatry, etc.)	
Quality assurance and improvement: HEDIS data required?	Yes
Quality assurance and improvement: CAHPS data required?	Yes

Features	Dental
Quality assurance and improvement: Accreditation required?	Yes
Quality assurance and improvement: Accrediting organization	NCQA, Nationally recognized accrediting organizations
Quality assurance and improvement: EQRO contractor name (if applicable)	Health Services Advisory Group
Performance incentives: Payment bonuses/differentials to reward plans	
Performance incentives: Preferential auto-enrollment to reward plans	
Performance incentives: Public reports comparing plan performance on key metrics	X
Performance incentives: Withholds tied to performance metrics	
Performance incentives: MCOs/PHPs required or encouraged to pay providers for value/quality outcomes	X
Participating plans: Plans in Program	MCNA Dental; DentaQuest; Liberty

Features	Dental
Notes: Program notes	Under the Medically Needy program, Floridians who would be eligible for Medicaid except for their income can “spend down” to the Medicaid limit using qualified medical expenses. Once they spend down (meet their “share of cost”) each month, they are eligible for Medicaid services, including dental, until the end of the month. Medically Needy recipients who meet their monthly share of cost are enrolled into a dental plan at the point in the month when they meet their share of cost. Eligibility for dental services through the plans lasts through the end of the month once share of cost is met. The Medically Needy recipient will be enrolled into that same plan each month that they meet their share of cost.