Statewide Medicaid Managed Care Long-term Care

Enrollee and Provider Protections

June 16, 2017

Re-procurement of SMMC Contracts

- SMMC contracts are for a five-year period and must be re-procured after each five-year period.
- This will be the first re-procurement since the program began in 2013.
- Agency anticipates release of an Invitation to Negotiate in Summer 2017.

While we have not yet entered the statutory blackout period as described in s. 287.057(23), due to the upcoming competitive procurements relating to the Statewide Medicaid Managed Care Program, we will not have any discussions relating to the scope, evaluation, or negotiation of those procurements.

As stated in s.287.057(23), F.S., "Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. ***Violation of this provision may be grounds for rejecting a response****."*

Presentation Outline

Section 1	Introduction- SMMC Overview
Section 2	Enrollee Protections • Case Management • Continuity of Care Provisions • Service Delivery Protections • Complaint, Grievance, and Appeal System • Independent Consumer Support Program • Long-term Care Ombudsman
Section 3	Provider Protections • Continuity of Care Provisions • Provider Services Functions • Independent Dispute Resolution • Agency Complaint Monitoring Process

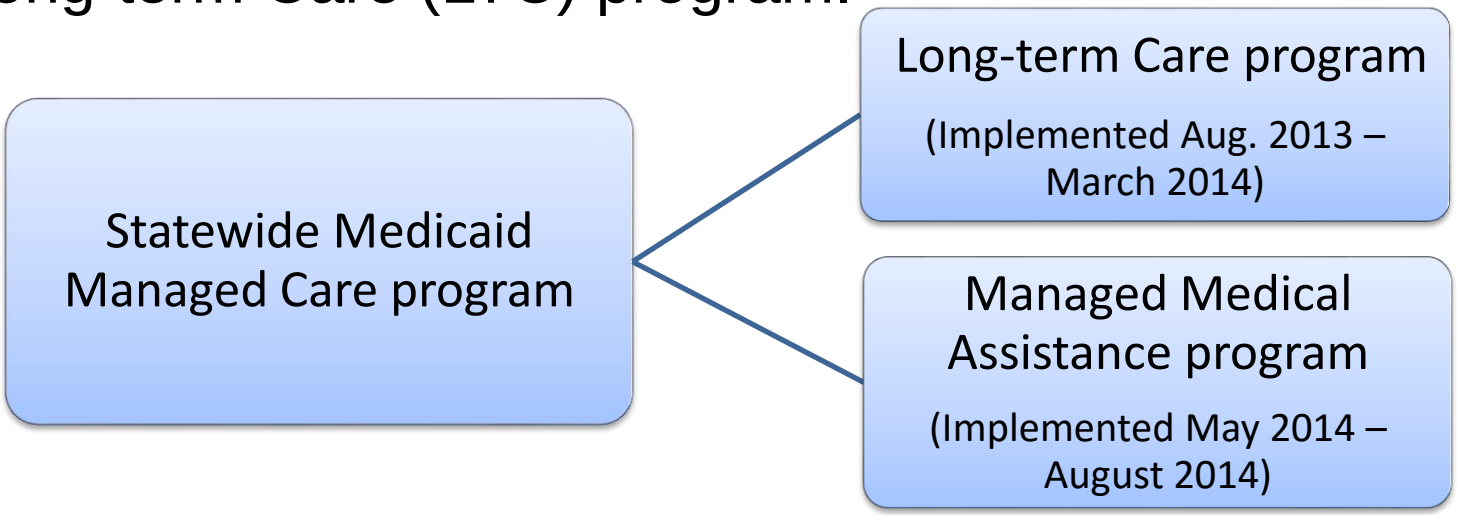
Section 1
Introduction
SMMC Overview

Overview

- In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program.
- Medicaid recipients are required to enroll in a Medicaid managed care plan unless specifically exempted under Chapter 409, Florida Statutes.
  - Approximately 85% of Medicaid recipients receive their services through a health plan in the SMMC program.
  - The majority of the remaining 15% of Medicaid recipients who are exempted from enrollment are only eligible for limited Medicaid benefits.
- Each Medicaid recipient has a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

SMMC Program Components

- The SMMC program has two key components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program.



- Each component required the Agency for Health Care Administration (Agency) to obtain Medicaid waivers from the Centers for Medicare and Medicaid Services.

Section 2
Enrollee Protections in the Long-term Care Program

Enhanced Care Coordination for All Enrollees

- A case manager will work with every LTC enrollee to:
  - ensure services are delivered during transition and beyond
  - identify the types and amount of services needed to live in the community and avoid institutionalization.
  - assist the enrollee to identify and choose which of the contracted providers can best meet the enrollee's needs.

Continuity of Care after Enrollment

- LTC plans must continue enrollees' **current** services for up to 60 days until a new assessment and care plan are complete and services are in place.
  - Same services
  - Same providers
  - Same amount of services
  - Same rate of pay (if the provider is not under contract)

Continuity of Care after Enrollment (Continued)

The LTC plan must:

- Pay service providers that are not under contract with an enrollee's LTC plan to continue serving the enrollee:
  - for up to 60 days, OR
  - until the enrollee selects another service provider and a new plan of care has been developed.
- Notify the non-contracted provider in writing that reimbursement will end on a specific date.

Continuity of Care after Enrollment (Continued)

- If a Medicaid recipient selects a LTC plan that does not have a contract with his or her current service provider,
  - The plan's case manager will work closely with the recipient to choose another service provider that can best meet his or her needs.

Service Delivery Protections

- Effective March 2017, LTC plans and providers must comply with the LTC Program Coverage Policy, adopted as a rule. This Policy can be found on AHCA's website at: http://www.ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf
- The Policy clarifies that the goal of the LTC Program is "to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization."

Service Delivery Protections (Continued)

- The contract between the state and the LTC plans prohibits the plans from requiring enrollees to enter alternative residential settings that may be less costly than remaining in their own homes.
- Enrollees residing in nursing facilities can choose to remain in that facility as long as they continue to meet nursing facility level of care requirements.

Service Delivery Protections (Continued)

- The contract prohibits the health plan from denying authorization solely because a caregiver is at work or is unable to participate in the enrollee's care, and the policy requires health plans to assess for caregiver availability
- The contract establishes minimum authorization timeframes for maintenance therapies
- The contract and policy require health plans to use an amended medical necessity definition for authorization of HCB services

Service Delivery Protections (Continued)

- The LTC plan cannot contract with an agency that provides both case management and any other covered service for an enrollee unless they meet the following:
  - The provider is the only willing and qualified case management provider in the geographic area
  - The provider renders LTC services, and the health plan cannot meet minimum network standards without the provider
  - The health plans use an independent conflict dispute resolution entity to process and resolve conflicts between the enrollee and the case management provider

Complaint, Grievance, **Appeal** & Fair Hearing Protections

Enrollee Appeal Rights

- Enrollees maintain the right to disagree with any change in their services.

- LTC plans must notify enrollees of their right to appeal a denial, termination, suspension, or reduction of services.

For a complete description of the grievance and appeal system, please see the Agency's web page for a copy of the presentation on the SMMC Grievance and Appeal System and Fair Hearing Overview at http://ahca.myflorida.com/medicaid/mcac/docs/2017-02-01/MCAC_Grievance_and_Appeal_System_Overview_Presentation_020117.pdf.

Enrollee Appeal Rights (Continued)

- Case managers will help enrollees file complaints, grievances, and plan appeals.
- The LTC plan will contact the enrollee in writing to confirm receipt of an appeal and to notify the enrollee of the plan's response to the appeal.
- Enrollees have the right to continue receiving their current level of services while the appeal is under review.

Overview

- The **requirements for the grievance and appeal system** are established by the federal government, Florida Statutes, and the SMMC contract.
- **The health plan must maintain a system for receiving and processing enrollee complaints, grievances, and plan appeals.** The health plan must also provide information to enrollees on requesting a Medicaid fair hearing.
- **The Office of Fair Hearings is housed at AHCA.**

Terminology

- **Adverse Benefit Determination** - The denial or limited authorization of a requested service, or a reduction, suspension or termination of a previously authorized service.
- **Notice of Adverse Benefit Determination (NABD) –** A written notice sent by the health plan to the enrollee when an adverse benefit determination has been made by the plan.
- **Plan Appeal –** The review by a health plan of an adverse benefit determination.
- **Expedited Appeal –** A plan appeal that must be resolved faster than a standard appeal, due to the enrollee's health condition or other factors requiring expedited resolution.

Terminology (continued)

- **Notice of Plan Appeal Resolution –** A written notice from a plan to an enrollee resolving the enrollee's plan appeal.
- **Complaint -** Any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day.
- **Grievance –** An expression of dissatisfaction about any matter other than an adverse benefit determination.
- **Medicaid Fair Hearing** – The opportunity for an enrollee to present his or her case to a reviewing authority if the enrollee feels that the Agency or health plan has made an error in the enrollee's case.

Complaint

- What is a **complaint**?
  - **Any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day**.
- A complaint can be filed at any time.

Complaint: Example

- Mrs. Jones receives home delivered meals, but she does not like her home delivered meals provider because she thinks the meals are too salty. She submits this complaint to her SMMC health plan.
- Mrs. Jones' health plan offers to replace her home delivered meals provider with another provider in the network, and Mrs. Jones is satisfied. Her complaint is resolved.
- If the health plan was not able to resolve Mrs. Jones' complaint by close of business the following business day, the complaint automatically becomes a grievance.

Grievance

- What is a **grievance**?
  - **An expression of dissatisfaction about any matter other than an adverse benefit determination**.
- A grievance can be filed at any time.
- Health plans must **resolve a grievance within 90 days.**
- Enrollees do not have to file a complaint before filing a grievance. **If a complaint is filed, but is not resolved by the health plan by close of business the following business day, the complaint automatically becomes a grievance.**

Grievance: Example

- Mr. Smith had an appointment with his cardiologist. The receptionist at the cardiologist's office was new and very rude to him. Mr. Smith filed a grievance with his health plan about the rude encounter he had with the receptionist.
- Mr. Smith's health plan contacted the cardiologist's office to discuss the rude staff member.
- Mr. Smith's health plan contacted Mr. Smith to inform him that they had spoken with the provider, and to counsel him on other cardiologists available in the network.

Adverse Benefit Determination

- Sometimes, a health plan will deny an enrollee's request for a particular service, or will limit, suspend, or terminate a previously authorized service. This is called an adverse benefit determination.
- Health plans must notify enrollees of all adverse benefit determinations in writing.

Notice of Adverse Benefit Determination (NABD)

- The **NABD** is mailed to the enrollee by the health plan for standard authorization decisions **within seven days of the request for service.**
- The **timeframe can be extended up to seven additional days** if the enrollee or the provider requests extension or the health plan justifies how the extension is in the enrollee's interest.
- The **timeframe can be shortened to 48 hours** if the standard timeframe could seriously jeopardize the enrollee.

Notice of Adverse Benefit Determination (NABD) – (continued)

- The **NABD must contain the following components**:
- The adverse benefit determination and the reason it was made.
- The enrollee's right to receive all records relevant to the decision, including any medical necessity criteria, free of charge.
- The enrollee's right to request a plan appeal and fair hearing, and the process for exercising those rights.
- The circumstances under which a plan appeal can be expedited and how to request it.
- The enrollee's right to have benefits continue pending resolution of the plan appeal and how to request it, and the circumstances under which the enrollee may be required to pay the cost of those services.

Plan Appeal

- If an enrollee disagrees with an adverse benefit determination, the enrollee may file a plan appeal.
  - **A plan appeal is the review by a health plan of an adverse benefit determination.**
- An enrollee must **file the plan appeal within 60 days** of the date of the adverse benefit determination.
- Health plans must **resolve the plan appeal within 30 days** of the receipt of the plan appeal.

Appeal: Example

- Mrs. Jones' doctor determined that she needs a wheel chair because she has trouble walking and standing after a while.
- Mrs. Jones' health plan denies her request for a wheel chair and sends her a notice of adverse benefit determination.
- Mrs. Jones files a plan appeal. Her health plan reviews and resolves her plan appeal within the 30 day timeframe. Her health plan overturns its original decision and provides the wheel chair.

Expedited Appeal

- Sometimes, an enrollee may need their health plan to review and resolve a plan appeal request more quickly than the standard 30 day review timeframe, because the enrollee's health condition or other factors may require it.
- This **fast review is called an expedited appeal**.
- An enrollee must **file the expedited appeal within 60 days** of the date of the adverse benefit determination.
- The health plan must **resolve the expedited appeal within 72 hours** of the receipt of the expedited appeal.
- If the health plan determines that the appeal does not actually need to be expedited, the request reverts back to a standard plan appeal, and the 30 day resolution timeframe applies.

Example: Expedited Appeal

- Mr. Smith just visited his dentist, and his dentist referred Mr. Smith to an oral surgeon to have his wisdom teeth removed. After his exam with the oral surgeon, the oral surgeon determined that Mr. Smith needs all four wisdom teeth removed, and scheduled his surgery for a week later.
- Five days before his surgery, Mr. Smith's health plan sends him a notice of adverse benefit determination, informing him that the health plan will not cover the wisdom teeth removal surgery.
- Because his surgery is scheduled for five days from now, Mr. Smith files an expedited appeal with his health plan.
- Following his expedited appeal request, his health plan reviews and resolves his appeal within 72 hours. The health plan upholds its original decision, and denies the wisdom teeth removal surgery.

Medicaid Fair Hearing Request

- An enrollee may request a fair hearing when the plan appeal process is completed in the following circumstances:
  - After receiving notice that the health plan is upholding the adverse benefit determination (i.e., **after the plan appeal is denied**)
  - If the health plan **fails to meet the notice and timing requirements** for resolving a plan appeal.
- The **parties** to the Medicaid fair hearing include: the health plan, the enrollee and the enrollee's authorized representative or the representative of a deceased enrollee's estate.
- The hearing officer's **final order may be appealed** by the enrollee to the Florida District Courts of Appeal.

Example: Medicaid Fair Hearing

- Mr. Smith just visited his dentist, and his dentist referred Mr. Smith to an oral surgeon to have his wisdom teeth removed. After his exam with the oral surgeon, the oral surgeon determined that Mr. Smith needs all four wisdom teeth removed, and scheduled his surgery for a week later.
- Five days before his surgery, Mr. Smith's health plan sends him a notice of adverse benefit determination, informing him that the health plan will not cover the wisdom teeth removal surgery.
- Because his surgery is scheduled for five days from now, Mr. Smith files an expedited appeal with his health plan.
- Following his expedited appeal request, his health plan reviews and resolves his appeal within 72 hours. The health plan upholds its original decision, and denies the wisdom teeth removal surgery.
- **Mr. Smith can now request a Medicaid Fair Hearing.**

Continuation of Benefits

- If a health plan terminates or reduces a benefit, an enrollee can ask the health plan to continue the benefit while their plan appeal or fair hearing is pending.
- **For services to continue during a plan appeal**, the enrollee or the enrollee's authorized representative must file the appeal within the required timeframe and request continuation of benefits **on or before the later of the following**:
  - Within 10 days after the notice of the adverse benefit determination is mailed; or
  - The intended effective date of the proposed adverse benefit determination.
- **For benefits to continue during a fair hearing**, the enrollee must request a fair hearing and continuation of benefits within 10 days of the notice of the adverse plan appeal resolution (i.e., the plan appeal decision).

Filing and Resolution Time Frames

Type of Action	Filing Time Frame	Resolution Time Frame
Plan Appeal	60 days from the date of the adverse benefit determination	30 days from the day the health plan receives the plan appeal
Expedited Appeal	60 days from the date of the adverse benefit determination	72 hours after the health plan receives the expedited appeal
Grievance	Can be filed at any time	90 days from the day the health plan receives the grievance
Fair Hearing	120 days after the enrollee receives notice that the health plan is upholding the adverse benefit determination (i.e., after the plan appeal is decided)	90 days from the date the enrollee filed the plan appeal (with some exceptions)

Other Requirements

- The enrollee is entitled to a free copy of his or her case file.
- Limitations exist regarding which health plan staff can make decisions on grievances and plan appeals.
- There are certain times when an enrollee may request a fair hearing before the health plan finishes its appeals process.
- The health plan is required to notify the enrollee of any delays or extensions in processing grievances or plan appeals.
- A record with required information on each grievance and plan appeal must be kept by the health plan and be accessible to the Agency.
- Health plans are required to use standard, mandatory notice templates for the NABD and notice of plan appeal resolution provided by the Agency.

AHCA's Office of Fair Hearings

- **Beginning March 1, 2017, most Medicaid Fair Hearing requests must be filed with AHCA** (when requesting a fair hearing, the notice of hearing rights provides important instructions specifying whether AHCA or the Department of Children and Families (DCF) is responsible for providing a Medicaid Fair Hearing).
- Notices of Medicaid Fair Hearing rights issued prior to March 1, 2017 identify DCF as the agency responsible for providing a Medicaid Fair Hearing.
- Notices of Medicaid Fair Hearing rights issued on or after March 1, 2017 identify AHCA as the agency responsible for providing a Medicaid Fair Hearing. (**DCF will have some limited Medicaid Fair Hearing responsibilities after March 1, 2017**).
- A rule on Medicaid Fair Hearings was adopted and became effective on March 1, 2017. This rule delineates AHCA's jurisdiction for fair hearings.

Medicaid Fair Hearings and DCF

- **On or after March 1, 2017, DCF's Office of Appeal Hearings will administer and conduct** the following Medicaid fair hearings**:**
  - All fair hearings arising from **Medicaid financial eligibility** determinations made by DCF
  - All fair hearings arising from eligibility determinations or service denials, reductions, terminations or suspensions pertaining to the **iBudget Waiver** administered by the Florida Agency for Persons with Disabilities.
  - All fair hearings arising from the **Pre-admission Screening and Resident Review,** as mandated by Section 1917(e)(7) of the Social Security Act and Title 42, Code of Federal Regulations (CFR), Sections 483.100 through 483.138, Subpart C.
  - All fair hearings resulting from **resident transfers or discharges** as those terms are defined in Section 400.0255, Florida Statutes.

Medicaid Fair Hearings and AHCA

- **On or after March 1, 2017**, **the AHCA Office of Fair Hearings will administer and conduct** the following Medicaid fair hearings:
  - Medicaid fair hearings directly related to **Medicaid programs directly administered by AHCA.**
  - Medicaid fair hearings related to Florida's Statewide Medicaid Managed Care **(SMMC) program and associated federal waivers, filed on or after March 1, 2017**.

Requesting a Medicaid Fair Hearing from AHCA

- Requesting a Medicaid fair hearing from AHCA will utilize AHCA's new fair hearing intake process. A **Medicaid fair hearing may be requested from AHCA's Medicaid Hearing Unit intake** by contacting:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
Telephone:(877)254-1055 (toll-free)
Fax: (239)338-2642
E-mail: MedicaidHearingUnit@ahca.myflorida.com

AHCA Office of Fair Hearings

- AHCA's Office of Fair Hearings (OFH or Office), is responsible for acknowledging Medicaid fair hearing requests filed with AHCA. The Office will assign a Hearing Officer who will schedule a hearing, or take other appropriate action on the hearing request pursuant to Rule 59G-1.100, F.A.C**. Contact information for the AHCA's Office of Fair Hearings is:**

  Agency for Health Care Administration

  Office of Fair Hearings

  2727 Mahan Drive, MS#11

  Tallahassee, Florida 32308

  Email: OfficeOfFairHearings@ahca.myflorida.com

Independent Consumer Support Program

- DOEA leads the coordinated effort between the Aging and Disability Resource Centers (ADRCs), Long-Term Care Ombudsman Program (LTCOP), and the Agency Bureau of Long-Term Care and Support (LTCS) to provide independent and conflict-free support and education to help Medicaid enrollees handle disputes with their Long-Term Care (LTC) plan.
- These efforts include, but are not limited to, the following:
  - Information and referral
  - Advocacy and assistance
  - Data collection and trend analysis
  - Monitoring and evaluation

Provider Protections in the Long-term Care Program

How Will Providers Know Whether to Continue Services?

Providers should continue to provide services until they receive instructions from the LTC plan.

Continuity of Care

- Current LTC providers are required to cooperate and communicate with a new or transitioning enrollee's LTC plan.
- This includes providing information pertinent to an enrollee's plan of care and continuing to provide services to an enrollee for up to 60 days after the enrollee's transition.
- During this transition period, the LTC plan must pay network providers the rate agreed to in their executed subcontracts, and must pay non-network providers the rate they are currently being paid.
- LTC plans may require providers to submit documentation of the current pay rate (e.g., recent referral agreements, subcontracts, paid claims).

What Should Providers Do if They Have Difficulty Getting Paid?

- Contact the health plan's provider services department or the toll-free provider help line
- Access the claims dispute resolution program
- Report a complaint to the Agency

Reporting an SMMC Complaint

- Complaints or issues about Medicaid Managed Care, made be submitted electronically by completing the online form accessible at: https://apps.ahca.myflorida.com/smmc_cirts/
- Or, click on the “Report a Complaint” button in the right corner of the SMMC page.
- To report an issue by phone, or get help completing the online form, call **1-877-254-1055.**
- Monthly complaint reports are posted online at: http://ahca.myflorida.com/Medicaid/statewide_mc/program_issues.shtml.

Provider Services Functions

- Each health plan must provide a formal provider relations function to respond timely and adequately to inquiries, questions, and concerns from providers
- Each health plan must operate a toll-free help line to respond to provider questions, comments, and inquiries
  - Operates 24 hours a day, 7 days a week to respond to prior authorization requests
  - Operates 8 a.m. to 7 p.m. on business days in the provider's time zone for all other questions

Claims Dispute Resolution Program

- Assists health care providers and health insurance plans in resolving health care claims disputes
- MAXIMUS is the Agency's contracted independent dispute resolution organization
- Available to SMMC providers and health plans
- Information about the program available via:
  - http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml
  - Florida Medicaid Complaint Helpline -- (877) 254-1055
  - Application forms and instructions on how to file claims can be obtained directly from MAXIMUS by calling 1-866-763-6395 and selecting Option 2 -- Ask for Florida Provider Appeals Process

Monthly Complaint Report

SMMC Managed Medical Assistance (MMA) Program Issues

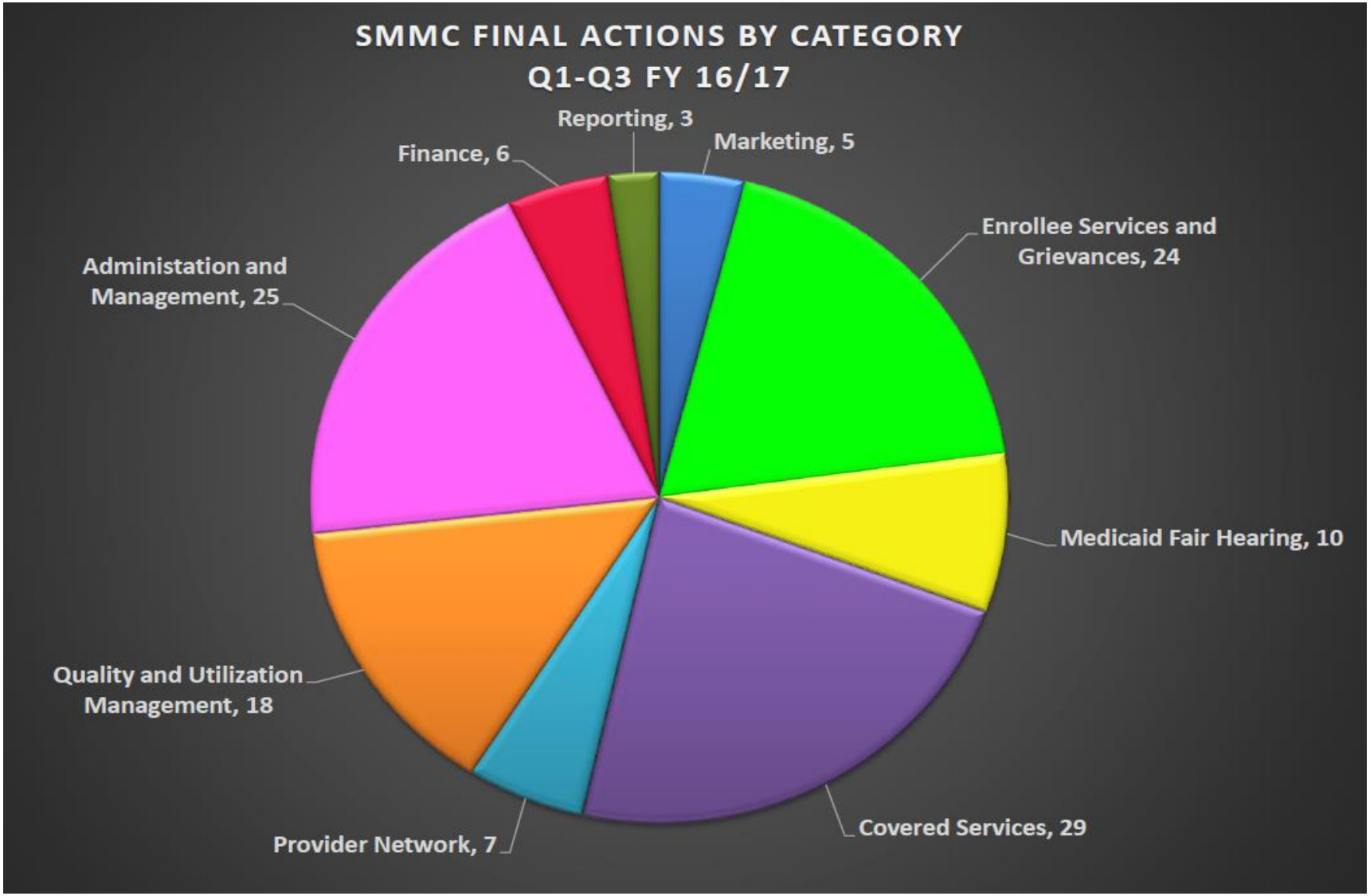
Report Period: April, 2017 *Run Date: 5/1/2017*

	# MMA Enrollees as of End of Month - *Source: HealthTrack*	# of Issues Received in April, 2017	# of Issues, per 1,000 enrollees, April, 2017	# of Beneficiary Issues Resolved - April, 2017	# of Provider Issues Resolved - April, 2017	# of Issues Resolved Incomplete / Informational ****	# of Issues Pending for Resolution *as of run date*
MMA PLANS (Standard Plans)							
Aetna Better Health of Florida (Coventry Health Care of Florida, Inc.)	58,634	22	0.37	10	2	1	17
Amerigroup Florida, Inc.	337,314	108	0.32	46	21	24	89
Better Health, Inc.	101,182	32	0.32	12	6	7	20
Community Care Plan	45,190	14	0.31	6	2	5	5
Humana Medical Plan, Inc.	327,670	149	0.45	90	22	31	91
Molina Healthcare of Florida, Inc.	345,025	94	0.27	64	21	11	99
Prestige Health Choice	324,017	99	0.31	57	23	19	65
Simply Healthcare Plans, Inc.	82,632	42	0.51	22	9	14	21
Staywell Health Plan of Florida	666,410	187	0.28	127	29	33	146
Sunshine Health Plan, Inc.	478,709	139	0.29	86	26	33	116
United Healthcare of Florida, Inc.	273,768	114	0.42	76	22	27	44
MMA PLANS (Specialty)							
Children's Medical Services (CMS)	50,636	38	0.75	19	10	2	12
Clear Health Alliance HIV/AIDS Specialty Plan (Simply Healthcare Plans, Inc.)	9,427	9	0.95	4	2	1	12
Freedom Health, Inc. Cardiovascular/ CHF/ COPD/ Diabetes Disease Specialty Plans	122	0	0.00	0	0	0	1
Magellan Complete Care Serious Mental Illness Specialty Plan (Florida MHS, Inc.)	66,899	95	1.42	65	6	17	51
Positive Healthcare Florida HIV/AIDS Specialty Plan (AHF MCO of Florida, Inc.)	2,028	1	0.49	0	2	0	3
Sunshine Health Plan, Inc. Child Welfare Specialty Plan	31,942	6	0.19	5	1	2	6
NON-PLAN SPECIFIC							
MMA System (Non-Plan Specific) Issues		588					131

Enforcing Compliance

- The Agency monitors health plans to ensure they comply with their contract:
  - Weekly reviews of recipient and provider complaints
  - Analysis of dozens of regular reports from plans
  - “Secret Shopper” calls and visits related to marketing and verifying the plans’ provider networks
- If plans are out of compliance with their contract the Agency can impose:
  - Corrective action plans
  - Monetary liquidated damages, and/or
  - Sanctions (monetary or non-monetary)

Enforcing Compliance



Additional Resources

Recipient Resources

Information about Florida Medicaid can be found on the Agency's website at: http://ahca.myflorida.com/Medicaid/index.shtml

Welcome to Medicaid!

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.

In Florida, the Agency for Health Care Administration (Agency) is responsible for Medicaid. The Agency successfully completed the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014. Under the SMMC program, most Medicaid recipients are enrolled in a health plan. Nationally accredited health plans were selected through a competitive procurement for participation in the program.

The Division of Medicaid's website is designed to align with our functional organizational structure.

Some examples of where key information can be found under the new structure are below:

Looking for information on:	Go to:
Behavior Analysis Services Information	Bureau of Medicaid Policy
Health Plan Contracts and Information	Statewide Medicaid Managed Care
Health Plan Enrollment	Bureau of Medicaid Data Analytics
Health Plan Rates	Bureau of Medicaid Data Analytics
HEDIS Performance Measures	Bureau of Medicaid Quality
Institutional Rates	Bureau of Medicaid Program Finance
LIP/DSH/GME Operations	Bureau of Medicaid Program Finance
Medicaid Eligibles	Bureau of Medicaid Data Analytics

Beth Kidder
Deputy Secretary for Medicaid

2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308
Phone: (850) 412-4000

Information about the SMMC program can be found on the SMMC website at: http://ahca.myflorida.com/smmc

Health Plan Report Card

http://www.floridahealthfinder.gov/HealthPlans/Search.aspx?p=5

Better Health Care for All Floridians
AHCA.MyFlorida.com

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2015

◉ Medicaid Health Plan Report Card
To view individual measures in a category, click one of the following:

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

Sorting Options:

Sort By Column ◉ Ascending (A-Z, 0-9) ○ Descending (Z-A, 9-0)

View Results

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	Mental Health Care
Amerigroup Florida, Inc.	★★★★★	★★★★☆	★★★☆☆	★★★★☆	★★★★★	★★★★☆
Better Health, LLC	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆
Children's Medical Services *	★☆☆☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★☆☆☆☆	★★★★☆
Clear Health Alliance	★☆☆☆☆	★★☆☆☆	★★☆☆☆	★★★★☆	★★☆☆☆	★★☆☆☆
Community Care Plan	★★★☆☆	★★★★☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆
Coventry Health Care of Florida	★★★★★	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★☆☆☆
Florida MHS (Magellan)	★☆☆☆☆	★★☆☆☆	★★☆☆☆	★★☆☆☆	★☆☆☆☆	★★☆☆☆
Freedom Health, Inc.	N/A	N/A	N/A	★★★★★	N/A	N/A
Humana Medical Plan, Inc.	★★★★★	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★★☆☆
Molina Healthcare of Florida, Inc.	★★★☆☆	★★★☆☆	★★★★☆	★★★☆☆	★★★☆☆	★★★☆☆
Positive Healthcare Florida	N/A	N/A	N/A	★★★★☆	★★☆☆☆	★★★☆☆
Prestige Health Choice	★☆☆☆☆	★★☆☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆
Simply Healthcare Plans, Inc.	★★★★☆	★★★★☆	★★★☆☆	★★★★☆	★★★☆☆	★★★☆☆
Staywell Health Plan	★★★★☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★☆☆
Sunshine Health Child Welfare Specialty Plan *	★☆☆☆☆	★★★★☆	★★★★★	★☆☆☆☆	N/A	★★★★★
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★☆☆	★★☆☆☆	★★★☆☆
United Healthcare of Florida, Inc.	★★★★☆	★★★★☆	★★★☆☆	★★★☆☆	★★★☆☆	★★★★★

Ratings Key:

★★★★★ **Best** at or above 50% of all Medicaid health plans' scores

Program Updates

Sign up to receive email updates about the SMMC program: http://ahca.myflorida.com/medicaid/statewide_mc/signupform.html