Aetna Better Health of Florida 2026 Population Assessment

Review Cycle: MY2025

Report Date: 09/10/2026

AETNA BETTER HEALTH OF Florida

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Introduction

Aetna Better health of Florida (ABHFL) annually assesses member characteristics and needs to determine Population Health Management (PHM) strategies. Characteristics and needs include total enrollment, relevant subpopulations, physical determinants of health, and social determinants of health. ABHFL evaluates population trends to determine if changes to the overall population health management strategy are necessary.

Data sources include state enrollment files, ADT feeds/HIE, claims, lab results, health appraisal results, HRQ and Care Management assessment results, proprietary tools and processes, and publicly available community information. ABHFL uses data to identify disparate populations who may benefit from focused interventions.

Annual assessment of population size and demographic characteristics of members is critical to defining health service needs, ensuring accessible health care, and developing appropriate quality improvement interventions. The purpose of this document is to provide a comprehensive assessment of the demographics of the ABH membership to:

- Promote the delivery of health care services that meet the needs of the entire membership, including culturally and linguistically effective health care services.
- Identify opportunities for collaboration and programs based on evaluation of social and physical determinants of health data.
- Identify demographic shifts so that appropriate network adjustments can be made.
- Coordinate access to specialists.
- Facilitate access to care by providing appropriate language interpretation services and transportation.
- Update integrated care management processes and resources to meet the needs of the membership.

Purpose

Annually, Aetna Better Health assesses membership characteristics to identify the physical and social determinants of health needs for the total enrollment, members with severe mental illness (SMI) and / or serious emotional disturbance (SED), children/adolescents, members with disabilities, and two relevant subpopulations: members with a pregnancy that delivered during the lookback timeframe and members with diabetes. This annual document identifies population needs, geographic distribution, language preferences, cultural diversity trends, rate-group, and age distribution within the health plan membership. Data is used to identify screening needs for high-risk individuals, determine eligibility and need for services, and to link enrollees to available community resources. The information collected helps evaluate the current state of the social and physical environments to identify opportunities to promote good health for all. Evaluation of socioeconomic conditions is integral to identifying and promoting health equity. Aetna Better Health adopted the "National Standards on Culturally and Linguistically Appropriate Services (CLAS)" written by the Office of Minority Health (OMH) of the U.S Department of Health and Human Services. The National CLAS Standards were written as a guide to improve health care quality and promote culturally and linguistically appropriate care and services.[1]

This document helps identify characteristics of the population and subpopulations to determine the structure and resources for its population health strategy. After the initial PHM Strategy has been created, the annual population assessment is used to review and update the plan of action based on current population needs across the continuum of care. It evaluates the adequacy and effectiveness of the PHM Strategy, its ability to meet defined goals, provision for wellness services, interventions for members at highest risk (i.e., those requiring complex case management), resources,

[1] Office of Minority Health (OMH) U.S. Department of Health and Human Services National Standards on Culturally and Linguistically Appropriate Services (CLAS) Standards US Dept of Health and Human Services - Office of Minority Health (The National CLAS Standards)

and identification of member populations with which to intervene are evaluated annually and as needed. The membership profile assesses health plan infrastructure, strategies, resources, and links to community-based resources to ensure that available resources meet the needs of the various membership populations served. Updates to the PHM program, process, and/or resources are implemented as necessary.

Summary

Study Population

This study includes all ABHFL Medicaid Managed Care (MMA) members and relevant subpopulations.

Study Period

The study period will be based on a Calendar year spanning January 1 through December 31, 2025. E.g., CY2025 = January 1, 2025 – December 31, 2025. The population assessment is conducted annually. The population assessment is conducted annually.

Methodology

Data found in this Population Assessment were extracted from the following sources:

Data Sources

1. **Enrollment**

   Information about race, ethnicity and primary spoken language of enrollees is collected at the state Medicaid office or Social Security office during the Medicaid enrollment process. Information is self-reported by the individual. The information is entered into the state system and provided to Aetna Better Health.

2. **Medicaid Aid Categories - QNXT**

   - Enrollment and Medicaid aid category data is extracted from the QNXT system.

3. **Language Assistance Service Reports**

   Aetna Better Health provides language assistance services, including interpreter services and bilingual staff acting in their job capacity, at no cost to members with limited English proficiency (LEP).

   Information on members requiring language assistance services is available by tracking interpretive services usage. At least annually, usage data and surveys are reviewed to identify threshold languages and to determine whether the plan meets the needs of its membership. In addition, Aetna Better Health performs a monthly reporting and evaluation of language services usage at Service Improvement Committee (SIC) to ensure language service utilization is monitored and is adequate to serve the needs of the members who access these services.

   - Aetna Better Health vendor report
   - Member Services supervisory report shows calls taken by bilingual MSRs

4. **Utilization and Experience Reports**

   Reports include top ten diagnoses, hospital, pharmacy, and readmission reports.

- Top ten diagnoses:
  - Emergency Department Utilization Rate: Emergency Department Utilization Report located in AAWeb / BIIG
  - Inpatient Admission Diagnoses: Readmission report located in AAWeb / BIIG

5. **Consolidated Outreach and Risk Evaluation (CORE) analysis**

   Aetna Better Health uses a proprietary, evidence-based process called Consolidated Outreach and Risk Evaluation (CORE) is used to provide further refinement to identify members with high health care needs who are the most likely to benefit from our care management services. To help identify the highest risk members who are the most impactable, we've created our proprietary Consolidated Outreach and Risk Evaluation (CORE) algorithm. CORE focuses on two main dimensions of risk:
   - Inpatient Admission (IP) risk based on predictive model estimates of the likelihood of the member having an inpatient stay within the next 12 months
   - Chronic Illness and Disability Payment System and Medicaid RX (CDPS+Rx) score from models that predict future medical costs based on diagnoses and prescribed medications

6. **Health Care Equity Dashboard (HCE)**

   This dashboard is a tool that integrates enrollment, HEDIS, utilization and claims, and CORE data to provide membership profile reporting which assists in the evaluation of population characteristics, with emphasis on pinpointing health disparities in relation to race/ethnicity and geographic location at the zip code level.
   - Chronic condition prevalence: Data is accessed in the HCE Dashboard through AAWeb > Population Health > Health Equity Dashboard

7. **Socially Determined®** (https://socialscape.sociallydetermined.com/my-people), *US Census*, *United for ALICE*, *CDC*

   Socially Determined® is a HITRUST-certified, cloud-based platform that surfaces social determinant of health (SDOH) insights for individuals and communities across the entire United States. Powered by a strong data supply chain, Socially Determined generates social risk scores and associated insights, offering comprehensive visibility into social risks and their impact. These insights help guide the development, execution, and refinement of key business strategies and initiatives related to social determinants of health (SDOH) to enhance health outcomes at scale.

Membership Profile

Membership profile data is used to increase awareness of health care needs with the membership and to prioritize quality improvement programs to improve health outcomes. Data points are trended year-over-year for comparison. F

1. **Total Membership**

   Percentage of total membership change year-over-year (YOY)
   Numerator: Current year's number of members
   Denominator: Prior year number of members

2. **Medicaid Category**

   Percentages of members enrolled by Medicaid Aid Category
   Numerator: Number of members in each category
   Denominator: Total membership for health plan

3. **County**

   Percentages of members enrolled in each county
   Numerator: Number of members in each specific county
   Denominator: Total membership for health plan

4. **Gender**

   Percentages of female and male members
   Numerator: Number of males or females
   Denominator: Total membership for health plan

5. **Age Band**

   Percentage of members in each age band
   Numerator: Number of individuals in each age band
   Denominator: Total membership for health plan

Membership by Age
Age < 1
Age 1- 4
Age 5 -14
Age 15 – 24
Age 25 – 44
Age 45 – 64
Age ≥ 65

6. **Race**

   Population or groups based on various sets of physical characteristics.
   Numerator: Number of members who identify in each race category
   Denominator: Total membership

Race Category	Definition
Caucasian/White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Race Category	Definition
American Indian or Alaskan Native	A person who has origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment
Asian / Pacific Islander	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
African American/Black	A person having origins in any of the black racial groups of Africa.
Unknown	The category used to report members whose race and ethnicity are not known.

7. **Ethnicity**

   Population groups whose members identify with each other based on common nationality or shared cultural traditions regardless of race.
   Numerator: Number of members who identify as Hispanic or Latino
   Denominator: Total membership

Ethnicity Category	Definition
Hispanic	Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin.

8. **Member Reported Language**

   Percentage of members by primary language identified and reported during the Medicaid enrollment process.
   Numerator: Number of members in each primary language category
   Denominator: Total membership for health plan

   Per NCQA standards, threshold languages are all languages other than English spoken by 5 percent of the population or by 1,000 eligible individuals, whichever is less.

9. **Language Assistance Utilization**

   Population of members requesting translation to a language other than English through the interpretation line
   Numerator: Number of translated calls by language

Denominator: Total number of translated calls

Child & Adolescent

1. **Child & Adolescent by Gender**

   Percentages of female and male members
   Numerator: Number of males or females aged 2-19
   Denominator: Total # members aged 2-19

2. **Child & Adolescent by Condition Prevalence**

   Prevalence of conditions within this subpopulation

   Numerator: Members aged 2-19 diagnosed with each condition

   Denominator: Total # members aged 2-19

3. **Child & Adolescent by County**

   Percentage of members enrolled in each county

   Numerator: Number of members aged 2-19 in each specific county
   Denominator: Total # members aged 2-19

4. **Child & Adolescent by Race & Ethnicity**

   Rate of Race & Ethnicity within each racial / ethnic group

   Numerator: Number of members who identify in each racial / ethnic group
   Denominator: Total # members aged 2-19

Condition Prevalence

1. **Condition Prevalence by Total Membership**

   Numerator: Number of members identified with a chronic condition
   Denominator: Total membership for health plan

2. **Condition Prevalence by Race**

   Numerator: Number of members with a chronic condition within each racial group (evaluated for each chronic condition)

   Denominator**:** Number of members with a chronic condition

3. **Condition Prevalence by Ethnicity**

   Numerator: Number of members with a chronic condition within each ethnic group (evaluated for each chronic condition)

   Denominator: Number of members with a chronic condition

4. **Condition Prevalence by County**

   Prevalence of chronic conditions within each county. The three (3) counties with the highest prevalence are reported for each condition (may not be the most populous counties).

   Numerator: Number of members with conditions in specified county

   Denominator: Total membership in specified county

Emergency Department Utilization

Top 10 diagnosis categories driving Emergency Department (ED) utilization

ED visits per 1000 member months (ED visits/k)

Overall, ED utilization rates and demographic drilldown for members who use the ED.

- Number of members who have utilized ED
- Total number of ED visits
- ED utilization by gender, age, race/ethnicity, and primary language

Serious Mental Illness (SMI) and / or Serious Emotional Disturbance (SED)

1. **SMI / SED by County**

   Top ten counties for SMI / SED prevalence

   Numerator: SMI / SED Members in County

   Denominator: Total SMI / SED Members

2. **SMI / SED by Race & Ethnicity**

   Rate of SMI / SED within each Racial / ethnic group

   Numerator: SMI / SED Members in each racial /ethnic group

   Denominator: Total members in each racial/ethnic group

Disabilities

1. **Condition Prevalence**

   Prevalence of chronic conditions within this population

   Numerator: Members with a disability that are diagnosed with each chronic condition

   Denominator: Total # members with a disability

2. **Emergency Room (ER) Visit Top Diagnoses: Disabilities Sub-Population**

   Top 5 diagnosis categories driving Emergency Department (ED) utilization within this subpopulation.

   ED visits per 1000 member months (ED visits/k)

Inpatient Utilization

Top 10 diagnosis categories driving Inpatient (IP) Admissions

IP authorizations per 1000 member months (IP Auths/k)

Subpopulations

Assess the needs of members in subpopulation

categories.

Defined Subpopulations
Pregnancy: Delivered
Members with Diabetes

1. **Pregnancy: Delivered**

   Females of Child-Bearing Age (FCBA)

   Numerator: # Female members of child-bearing age in each age group

   Denominator: Total FCBA

   Deliveries by Age

   Numerator: Deliveries to members in each age group

   Denominator: Total Deliveries

   Deliveries by Race /Ethnicity

   Numerator: Deliveries to members in each racial / ethnic group

   Denominator: Total Deliveries

   High Risk Deliveries within Racial / Ethnic Group

   Prevalence of high-risk deliveries for each race/ethnicity

   Numerator: High-Risk Deliveries to members in each racial / ethnic group

   Denominator: Total Deliveries to members in each racial / ethnic group

2. **Members with Diabetes**

   Subpopulation by Age

   Prevalence of diabetes mellitus diagnoses within each age group

   Numerator: Diabetic members in each age group

Denominator: Total # members in each age group

Subpopulation by Race & Ethnicity

Prevalence of diabetes mellitus diagnoses within each racial / ethnic group

Numerator: Diabetic members in each racial /ethnic group

Denominator: Total members in each racial/ethnic group

Language Needs

Percentage of members with diabetes mellitus diagnoses who have a non-English primary language

Number: Diabetic members in each primary language group

Denominator: Total # members in diabetes subpopulation

Risk Stratification / Segmentation

Number of members in each risk stratification level, based on ranked percentile.

Numerator: Number of members in risk stratification category or CORE level
Denominator: Total membership

1. **Consolidated Outreach and Risk Evaluation (CORE 2.0)**

   CORE leverages multiple machine learning model scores and clinical impact factors to identify and prioritize members who have high clinical and financial risk. It uses a proprietary process that incorporates plan specific needs and requirements to stratify members into the appropriate level of care management with a higher score indicating a greater need for care management. The model risk stratification categories are based on risk percentiles that were calculated through member clustering models below.

Risk stratification category	Definition
Low	• ABD 95% • Medicaid Adult 97% • Medicaid Kid 99%
Medium	• ABD 3% • Medicaid Adult 2.4% • Medicaid Kid 0.8%
High	• ABD 2% • Medicaid Adult 0.6% • Medicaid Kid 0.2%

2. **Population Health Management (PHM) Program Eligibility**

Members eligible to participate in PHM programs are segmented into subsets (relevant subpopulations) for targeted interventions. The focused areas of each program are:

- Keeping Members Healthy
- Managing Members with Emerging Risks
- Patient Safety and Outcomes across Settings
- Managing Multiple Chronic Conditions

Bias Testing

CVS Health Enterprise (which includes Aetna) has a standard policy and procedure governing algorithm bias-checking for all algorithms. Business units assess algorithms for potential bias, conduct ongoing monitoring for bias in operational programs, train colleagues responsible for advanced algorithms about the risk of bias and methods to detect and remediate algorithmic bias.

Three main types of technical bias checks are recommended, although all three are not used simultaneously as the appropriate method depends on the purpose of the algorithm:

- **Representation fairness:** The predicted positive rates, i.e., that positive events (e.g. inpatient admits), are predicted equally across protected attribute groups (e.g. male vs. female). Based on model predictions to calculate representation of groups with a positive prediction.
    - **Normalized Disparate Impact**: A normalized calculation of the ratio of a model's predicted positive rates between two protected attribute groups. The bias threshold for this fairness metric is 0.2.
    - **Statistical Parity Difference**: The difference in a model's predicted positive rates between two protected attribute groups. The bias threshold for this fairness metric is 0.1.
- **Assistive error-based fairness:** The predicted positive rates across protected attribute groups should differ (e.g. breast cancer prediction rates should differ for males vs. females), and interventions assigned by the algorithm are assistive in nature. Based on model predictions and ground truth. Calculates the rate of members not predicted correctly indicating the member needed an intervention but did not receive one.
    - **False Negative Rate Difference**: The difference in a model's false negative rates between two protected attribute groups. The bias threshold for this fairness metric is 0.1.
    - **False Omission Rate Difference**: The difference in a model's false omission rates between two protected attribute groups. The bias threshold for this fairness metric is 0.1.
- **Punitive error-based fairness:** The predicted positive rates across protected attribute groups should differ (e.g. breast cancer prediction rates should differ for males vs. females), and interventions assigned by the algorithm are punitive in nature. Based on model predictions and ground truth.
    - **False Positive Rate Difference**: The difference in a model's false positive rates between two protected attribute groups. The bias threshold for this fairness metric is 0.1.
    - **False Discovery Rate Difference**: The difference in a model's false discovery rates between two protected attribute groups. The bias threshold for this fairness metric is 0.1.

The goal of the Medicaid CORE algorithm for care management is to find members with high health care needs who are most likely to benefit from Care Management programs. The algorithm runs monthly across the entire Medicaid population. Bias testing has been completed on the CORE algorithm with no indication of bias.

Social Determinants of Health

Social determinants of health (SDOH) have a major impact on health outcomes, especially for the most vulnerable populations. Healthy People 2030 defines social determinates of health as "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[2] Aetna Better Health realizes the need to coordinate services and connect to community partners to improve health and well-being. Supplementing with community-level data allows for a greater understanding of the community characteristics and factors that impact the member's health. Data is from Socially Determined® Community Assessments and is evaluated annually for each Aetna Better Health plan.

Socially Determined is a social driver of health (SDoH) risk stratification platform. Key features include:

- Community-level risk stratification and mapping (capable of 200-meter drill-down)
- Individual-level risk stratification and insights, including mapping
- Key community asset overlays

This resource is meant to provide a brief overview of Socially Determiner's community-level risk stratification.

Social Risk Score Scale

1 = Little to no risk 2 = Low risk 3 = Moderate risk 4 = High risk 5 = Severe Risk

Community Risk Factor Snapshot

Risk Category	Description / Definition	Sample Data Attributes
Economic Climate	A measure of a community's financial resources and resiliency. Key influencers include cost of living, and median incomes.	• Income • Housing • Household size
Food Landscape	A measure of a community's ability to obtain healthy foods. Key influencers include accessibility, affordability, and food literacy.	• Locations of healthy and unhealthy food options • SNAP utilization • Estimated SNAP eligibility • Food budget
Housing Environment	A measure of the stability and nature of home environments within a community. Key influencers include housing affordability, crowding, and quality.	• Economic stability • Household members • Climate measures • Rent/Own ratios
Transportation Network	A measure of a community's transportation access and affordability. Key influencers include transportation access, combining both ownership and public transportation, and proximity to health resources.	• Location of health resources • Vehicle ownership • Work-from-home totals
Health Literacy	A measure of factors in a community that impact health system access and navigation. Key influencers include educational attainment, demographics, and cultural factors.	• Income • Time in US • Languages spoken at home
Digital Landscape	A measure of a community's digital access, affordability, digital literacy, and how they intersect. Key influencers include accessibility, affordability, and digital literacy.	• Availability of broadband internet and costs • Computer or smartphone ownership

[2] https://health.gov/healthypeople/priority-areas/social-determinants-health

Risk Category	Description / Definition	Sample Data Attributes
		• Income
Social Connectedness	A measure that describes the impact loneliness, social capital, and the quality of a community's social network can have on the ability to have meaningful social connections. Key influencers include loneliness, social capital, and social network quality.	• Age • Environmental factors • Gathering locations • Physical and mental well-being

Community Resource Integration

Aetna Better Health recognizes that many social, cultural, economic, and environmental factors can influence individuals and population health outcomes. Poverty, access to transportation, access to food and access to adequate housing are factors that the health plan evaluates when assessing community health needs. The factors included in the population assessment are just a few of the many factors that can have a relationship between health status and outcomes. Resources used to identify community resources may include United Way 2-1-1, Find Help, and / or Community Resource Directory.

Search Item	# Times Searched in 2025	# Times Searched in 2024
Food Assistance	1,135	2,104
Housing	300	1,308
Financial Assistance	318	1,105
Utility Assistance	160	669
Transportation	51	134
Employment Assistance	59	565

Results

Membership Profile

1. **Membership**

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership 2025			
	2025	**2024**	**2023**
Membership #	210,436	221,592	224,355
% Membership change YOY	↓ 5.03% (11,156)	↓ 1.23% (2,763)	↓ 15.23% (34,168)

Membership Quantitative Analysis

Membership declined each year from 2023 through 2025. In 2023, total membership was 224,355. Membership decreased to 221,592 in 2024, representing a reduction of 2,763 members, or 1.23%. In 2025, membership decreased furth to 210,436, a reduction of 11,156 members, or 5.03%, compared with 2024.

Overall, membership decreased by 13,919 members between 2023 and 2025, representing a total decline of 6.20%. The data show that the rate of membership accelerated in 2025, as the reduction from 2024 to 2025 was substantially greater than the reduction from 2023 to 2024.

Medicaid Category

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Medicaid Aid Category 2025						
	2025		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
TANF	111,962	53.20%	119,288	53.86%	134,366	59.89%
ABD Non-Dual Non LTC	9,223	4.38%	8,163	3.68%	9,893	4.41%
CHIP	72,007	34.22%	75,478	34.06%	62,569	27.89%
Dual Elig Non LTC	2,126	1.01%	2,094	0.94%	3,279	1.46%
Dual Elig LTC	1,784	0.85%	1,090	0.49%	1,127	0.50%
BH Int SMI	6,457	3.07%	10,717	4.84%	9,996	4.46%
ABD Non-Dual LTC	441	0.21%	185	0.08%	145	0.06%
LTC Only	6,421	3.05%	4,542	2.05%	2,910	1.30%
Other	15	0.01%	35	0.02%	70	0.03%
Total Members	***210,436***	***100%***	***221,592***	***100%***	***224,355***	***100%***

Medicaid Category Quantitative Analysis

Aetna Better Health of Florida's Medicaid membership distribution across all categories indicates a continued shift in enrollment patterns, with declines in traditionally larger population and growth in more specialized care segments.

The TANF (Temporary Assistance for Needy Families) category remains the largest membership group, with 111,962 members in 2025. However, this reflects a consistent decline over the three-year period (134,366 in 2023 to 119,288 in 2024), suggesting a reduction in eligible low-income families.

The CHIP (Children's Health Insurance Program) population represents the second largest category, with 72,007 members in 2025. While this is a slight decrease from 2024 (75,478), it remains significantly higher than 2023 (62,569), indicating that pediatric coverage expanded.

The BH Int SMI (Behavioral Health Severe Mental Illness) Category shows a notable decline in 2025 (6,457 members) compared to both 2024 (10,717) and 2023 (9,996). This sharp decrease may reflect changes in classification, service utilization, or transition of member into other programs.

The LTC (Long Team Care) Only category demonstrates significant growth, increasing to 6,421 members in 2025 from 4,542 in 2024 and 2,910 in 2023. This upward trend suggests a growing need for long-term care services, potentially driven by an aging population and increased demand for institutional or home-based care.

Overall, the data reflects a decline in broad based eligibility groups (TANF and CHIP) alongside growth in higher need population (LTC) and variability in behavioral health enrollment (BH int SMI). Trends highlight a shift toward more complex care needs within the Medicaid population.

2. County

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Top 10 Membership by County
2025

	County	2025		2024		2023	
		# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
1	Miami-Dade	62,292	29.60%	67,447	30.44%	69,618	31.03%
2	Orange	30,039	14.27%	30,829	13.91%	33,333	14.86%
3	Hillsborough	21,755	10.34%	23,467	10.59%	23,838	10.18%
4	Polk	15,365	7.30%	15,549	7.02%	14,840	6.68%
5	Osceola	11,941	5.66%	11,935	5.39%	12,643	5.64%
6	Brevard	9,635	4.58%	9,744	4.40%	11,155	4.97%
7	Seminole	7,154	3.40%	7,099	*3.20%*	7,629	3.40%
8	Manatee	4,442	2.11%	4,638	2.09%	4,699	2.09%
9	Palm Beach	5,891	2.80%	6,509	2.94%	5,454	2.47%
10	Broward	5,712	2.71%	5,716	2.58%	5,548	2.47%
	Total	***174,226***		***182,933***		***188,757***	

County Quantitative Analysis

Across the three-year period, membership within the top 10 counties declined overall, decreasing from 188,757 members in 2023 to 182,933 in 2024 and 174,226 in 2025. Miami-Dade consistently represented the largest concentration of membership, with 69,618 members in 2023, 67,447 in 2024 and 62,292 in 2025. Orange County remained the second-largest county, declining from 33,333 members in 2023 to 30,829 in 2024 and 30,839 in 2025. Hillsborough County ranked third, decreasing from 23,838 members in 2023 to 23,467 in 2024 and 21,755 in 2025. Membership trends varied among the remaining counties. Polk County increased from 14,840 members in 2023 to 15,549 in 2024 and remained relatively stable at 15,365 in 2025. Osceola county decreased from 12,643 in 2023 to 11,935 in 2024 and 11,941 in 2025. Brevard county declined from 11,155 members in 2023 to 9,744 in 2024 and 9,635 in 2025. Seminole and Manatee counties remained comparatively stable, while Palm Beach increased from 5,454 members in 2023 to 6,509 in 2024 before decreasing to 5,891 in

2025. Broward County remained relatively stable with 5,548 members in 2023, 5,716 in 2024 and 5,712 in 2025. Overall, the three-year data demonstrates a continued downward trend in membership among the top 10 counties, driven primarily by declines in the largest membership counties, particularly Miami-Dade, Orange and Hillsborough.

3. Geographical Group

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Geographic Group (2025)			
Geographical Group	**2025**	**2024**	**2023**
Large central metro	118,810	124,073	127,828
Medium metro	45,954	48,447	47,176
Large fringe metro	36,567	38,315	37,483
Small metro	5,078	5,319	5,466
Micropolitan	2,384	2,666	2,639
Noncore	1,130	1,251	1,154
Unknown	513	1,604	2,488
Total	*210,436*	*221,675*	*224,234*

Geographic Quantitative Analysis

The geographic distribution of Aetna Better Health of Florida's membership remained relatively stable from 2023 to 2025, with most members consistently residing in Large Central Metro. Although membership with this geographic category declined from 127,828 members in 2023, to 124.073 in 2024 and 118,810 in 2025, it continued to represent the largest concentration of members. This trend is consistent with the overall decline in total membership during the reporting period, in geographic distribution. Medium areas remained the second-largest geographic segment. Membership increased slightly from 47,176 in 2023 to 48,447 in 2024 before decreasing to 45,956 in 2025, reflecting minor fluctuations while maintaining a stable proportion of the overall membership. Large Fringe Metro membership increased slightly from 37,483 in 2023 to 38,315 in 2024, before de to 36,567 in 2025. Smaller geographic categories demonstrated similar fluctuations. Small Metro membership decreased from 5,466 in 2023 to 5,319 in 2024 and 5,078 in 2025. Micropolitan membership increased slightly from 2,639 in 2023 to 2,666 in 2024, before declining to 2,384 in 2025. Noncore membership increased from 1,154 in 2023 to 1,251 in 2024, followed by a decrease to 1,130 in 2025. The Unknown geographic category demonstrated the most significant change, decreasing from 2,488 members in 2023 to 1,604 in 2024 and 513 in 2025. Overall, while total membership declined in both 2024 and 2025, the geographic distribution remained generally consistent with Large Central Metro, Medium Metro and Large Fringe Metro continuing to account for the majority of the membership. The year-over-year fluctuations within most geographic categories were relatively modest, suggesting that the overall geographic composition of the population remained stable despite the declining enrollment.

4. Gender

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership by Gender 2025						
Category	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**

Male	96,010	45.53%	101,769	45.91%	102,618	45.78%
Female	114,869	54.47%	119,883	54.09%	121,538	54.22%
Total Members	***210,879***		***221,652***		***224,156***	

Gender Quantitative Analysis

The membership population remained predominantly female throughout the three-year period, although both male and female membership declined over time, consistent with the overall decrease in total membership.

- Female membership decreased from121,538 in 2023 to 119,886 in 2024, and further to 114,869 in 2025. This represents a decline of 849 members between 2023 and 2024 and an additional decline of 5,014 members between 2024 and 2025, for an overall decrease of 6,669 members over the three-year period.
- Male membership decreased from 102,618 in 2023 to 101,769 in 2024 and then to 96,010 in 2025. This reflects a decrease of 849 members from 2023 to 2024 and a larger decline of 5,759 members from 2024 to 2025. Overall, the male population declined by 6,608 members between 2023 to 2025.

Despite these decreases the gender distribution remained relatively stable, with females consistently representing approximately 54% of the membership and males approximately 46%. The similar decline across both genders suggests that membership reductions occurred proportionately rather than indicating a significant shift in the plan's gender composition.

5. Gender Identity

Data Location: *https://aetnao365.sharepoint.com/:x:/r/sites/PHM-PopulationAssessment*

Membership by Gender Identity 2025						
Category	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
Female	114,476	54.40%	119,757	54.02%	121,439	54.16%
Male	95,565	45.41%	101,525	45.80%	102,438	45.68%
Transgender	389	0.18%	391	0.18%	354	0.16%
Other	4	0.00%	2	0.00%	1	0.00%
CNTD	2	0.00%	N/A	N/A	2	0.00%
Total Members	*210,436*		*221,675*		*224,234*	

Gender Identity Quantitative Analysis

In 2025, the female membership totaled 114,456, reflecting a continued decline from 119,757 in 2024 and 121,439 in 2023. This represents a steady downward trend in female membership over the three-year period.

The male membership in 2025 was 95,565, which decreased from 101,525 in 2024 and 102,438 in 2023, also indicating a consistent year-over-year decline.

The transgender membership in 2025 was 389, showing a slight decrease from 391 in 2024, but an increase compared to 354 in 2023. This suggests a relatively stable population with minor fluctuations over time.

Overall, the data indicates a general decline in both male and female membership populations from 2023 through 2025, while the transgender population has remined relatively stable with a modest increase over the longer term.

6. Sexual Orientation

Data Location: *https://aetnao365.sharepoint.com/:x:/r/sites/PHM-PopulationAssessment*

Membership by Sexual Orientation 2025						
Category	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
Unknown	198,988	94.56%	211,043	95.20%	215,662	96.18%
Heterosexual	10,649	5.06%	10,214	4.61%	8,277	3.69%
Don't Know	661	0.31%	264	0.12%	190	0.80%
Other	78	0.04%	107	0.05%	56	0.02%
Homosexual (Lesbian / Gay)	42	0.02%	38	0.02%	41	0.02%
Bisexual	8	0.00%	7	0.00%	5	0.00%
Sexually attracted to neither male or female	1	0.00	N/A	N/A	N/A	N/A
Something else	4	0.00%	N/A	N/A	N/A	N/A
Choose not to disclose	5	0.00%	2	0.00%	3	0.00%
Total Members	*210,436*		*221,675*		*224,234*	

Sexual Orientation Quantitative Analysis

In 2025, sexual orientation was categorized as Unknown for the majority of the membership, representing 198,988 members (94.56%). Heterosexual was the largest identified category, accounting for 10,649 members (5.06%), while all other reported sexual orientation categories individually represented less than 1% of total membership. It is important to note that during calendar years 2024 and 2025, ABHFL was not actively collecting sexual orientation information. Therefore, the data presented for this year should not be interpreted as representing new or comprehensive sexual orientation data collected from the membership, and a meaningful year-over-year comparison cannot be made. Although the percentage categorized as unknown decreased from 96.18% in 2023 to 95.20% in 2024 and 94.56% in 2025, this change should not be interpreted as evidence of improved data collection given the absence of active collection during 2024 and 2025. The high percentage of members with an Unknown sexual orientation continues to demonstrate a significant data completeness limitation. As a result, the available data is insufficient to reliably identify trends or evaluate protentional disparities among sexual orientation groups. Future collection of sexual orientation information will provide an opportunity to establish move complete baseline and support for meaningful year-over-year analysis.

7. Age Band

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership by Age Bands 2025						
Age Band	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
Age <1	7,034	3.34%	7,935	3.58%	7,891	3.52%
Age 1-4	24,793	11.78%	25,567	11.57%	26,599	11.86%
Age 5-14	91,445	43.45%	95,973	43.31%	88,779	39.57%
Age 15-24	42,778	20.33%	46,066	20.53%	55,957	22.00%
Age 25-44	21,882	10.40%	31,268	13.94%	46,072	18.12%
Age 45-64	8,594	4.08%	12,050	5.37%	16,825	6.62%
Age ≥ 65	13,910	6.61%	11,702	5.22%	10,000	3.93%
Total Members	***210,436***		***221,592***		***224,355***	

Age Band Quantitative Analysis

Membership across age bands for Aetna Better Health of Florida shows a consistent concentration in younger populations, particularly among school age children.

The largest age band in 2025 was ages 5-14, with 91,445 members. This group also represented the highest membership in 2024 (95,973) and 2023 (88,779), indicating sustained enrollment dominance over the three-year period. The second largest age group was ages 15-24, 42,778 members in 2025, decreasing from 46,066 in 2024 and 55,957 in 2023, reflecting a notable downward trend in this segment. The next highest membership was among ages 1-4, with 24,793 members in 2025, compared to 25,567 in 2024 and 26,599 in 2023, also showing a gradual decline over time.

Overall, Aetna Better Health of Florida's membership spans all life stages, including newborns, children, adolescents, young adults, and elderly adults but remains heavily concentrated in pediatric and young populations, particularly those under age 15.

8. Race

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership by Race 2025						
Race	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
African American/Black	36,285	17.24%	39,278	17.51%	27,226	10.72%
Caucasian/ White	54,829	26.05%	48,514	21.89%	48,902	21.80%
Asian/Pacific Islander	3,121	1.48%	3,060	1.38%	3,062	1.36%
American Indian or Alaskan Native	317	0.15%	332	0.15%	357	0.16%
Unknown/Not Reported	37,863	17.99%	64,878	29.28%	56,416	34.03%

Some Other Race	22,029	10.47%	N/A	N/A	N/A	N/A
Total Members	**154,444**		**156,062**		**135,963**	

Race Quantitative Analysis

Membership across the race categories shown increased from 135,963 in 2023 to 156,062 in 2024 and increased of 20,099 members (14.78%). In 2025, the total decreased to 154,444, a decline of 1,618 members (1.04%). Comparison should account for the addition of the Some Other Race category in 2025.

- African American/Black: Membership increased from 27,226 in 2023 to 39,278 in 2024, an increase of 12,052 members (44.27%). In 2025, membership decreased by 2,993 members (7.62%) to 36,285. The reported membership share increased from 10.72% in 2023 to 17.51% in 2024, then decreased to 17.24% in 2025
- Caucasian/White: Membership decreased from 48,902 in 2023 to 48,514 in 2024, a decline of 388 members (0.79%). In 2025, membership increased by 6,315 members (13.02%) to 54,829. The reported membership share increased from 21.80% in 2023 to 21.89% in 2024 and 26.05% in 2025.
- Asian/Pacific Islander: Membership remained relatively stable, decreasing from 3,062 in 2023 to 3,060 in 2024, a decline of two members (0.07%). In 2025, membership increased by 61 members (1.99%) to 3,121. The reported membership share increased from 1.36% in 2023 to 1.38% in 2024 and 1.48% in 2025.
- American Indian or Alaskan Native: Membership decreased from 357 in 2023 to 332 in 2024, a decline of 25 members (7.00%). Membership decreased by another 15 members (4.52%) to 317 in 2025. The reported membership share decreased from 0.16% in 2023 to 0.15% in 2024 and remained at 0.15% in 2025.
- Unknown/Not Reported: Membership increased from 56,416 in 2023 to 64,878 in 2024, an increase of 8,462 members (15.00%). In 2025, membership decreased by 27,015 members (41.64%) to 37,863. Despite the increase in count in 2024, the analysis suggests a declining membership over the three-year period.
- Some other Race: In 2025, this category included 22,029 members, representing a reported 10.47% of membership. Data was not captured in 2023 or 2024 therefore, year-over-years changes cannot be calculated.

Overall, the shows a general decline in African American/Black membership, while Caucasian/White membership increased over the reporting period. Changes were also observed among the other race groups, indicating that the racial composition of the membership population shifted from year to year.

9. Ethnicity

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership by Ethnicity 2025						
Ethnicity	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
Hispanic or Latino	55,981	26.60%	62,862	28.36%	71,953	32.09%
Not Hispanic or Latino	54,852	26.07%	57,168	25.79%	55,107	24.58%
Unknown/Not Reported	99,603	47.33%	101,645	45.85%	97,174	43.34%
Total Members	***210,436***		***221,675***		***224,234***	

Ethnicity Quantitative Analysis

In 2025, the highest reported ethnicity category was Unknown or Not Reported, with 99,603 members. This reflects a slight decrease from 2024 (101,645), but an overall increase compared to 2023 (94,174), indicating some fluctuation with a modest upward trend over the three-year period.

The second largest ethnicity group reported was Hispanic or Latino, with 55,981 members in 2025. This represents a continued decline from 62,862 in 2024 and 71,953 in 2023, demonstrating a consistent downward trend. Membership reported as Not Hispanic or Latino totaled 54,852 in 2025, decreasing from 57,168 in 2024 and slightly below 55,107 in 2023. Although this category shows a moderate decline from 2024, overall membership has remained stable across the three-year period.

The data shows that while Unknown or Not Reported remains the largest category, there is a notable consistent decrease in Hispanic or Latino membership, alongside relatively stable but slightly declining trends in Not Hispanic or Latino population.

10. Reported Language

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Primary Language Top Reported 2025							
Language		2025		2024		2023	
		# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
1	English	153,308	72.85%	158,916	71.69%	163,204	72.78%
2	Spanish	52,282	24.84%	57,506	25.94%	55,813	24.89%
3	Unknown	4,310	2.05%	4,602	2.08%	4,512	2.01%
4	Creole	265	0.13%	N/A	N/A	N/A	N/A
5	Haitian Creole	255	0.12%	N/A	N/A	N/A	N/A
6	Other Language	36	0.01%	651	0.29%	705	0.31%
Total		***210,436***		***221,675***		***224,234***	

11. Request for Language Services

Data Location: *https://aetnao365.sharepoint.com/sites/LanguageLineInformarion/*

Requests for Language Services 2025							
Language		2025		2024		2023	
		# of Calls	% of Translated Calls	# of Calls	% of Translated Calls	# of Calls	% of Translated Calls
1	Spanish	29,193	88.78%	40,681	90.40%s	41,012	93.03%
2	Haitian/Creole	3,111	9.46%	3,057	6.79%	2,152	4.88%
3	Mandarin	117	0.36%	134	0.30%	110	0.25%
4	Russian	187	0.57%	308	0.68%	225	0.51%
5	Vietnamese	64	0.19%	89	0.20%	62	0.14%
6	Arabic	211	0.64%	215	0.48%	80	0.18%
Total		***32,883***		***44,484***		***43,641***	

Language Services Quantitative Analysis

In 2025, English remained the most frequently reported primary language, representing 153,308 members, or 72.85% of total membership. Spanish was the second most requesting reported language, accounting for 52,282 members, or 24.84%. The percentage of members reporting English remained relatively stable compared with 2024 (71.69%) and 2023 (72.78%), while Spanish decreased slightly from 25.94% in 2024 to 24.84% in 2025. Members with an unknown primary language represented 2.05% o membership in 2025, while Creole, Haitian Creole, and other languages each represented less than 1%,

Consistent with the primary language distribution, Spanish continued to generate the greatest need for language services. In 2025, Spanish account for 29,193 calls, or 88.78% of all translated calls, followed by Haitian Creole with 3,111 calls, or 9.46%. All other reported languages individually represented less than 1% of translated Calls. Overall, language services request decreased by 26.08%, from 44,484 in 2024 and 32,883 in 2025. Spanish requests decreased by 28.24%, from 40,681 to 29,193, while Haitian Creole requests increased slightly by 1.77%, from 3,057 to 3,111. This finding demonstrate that Spanish and Haitian Creole remain the primary drivers of ABHFL's language service needs.

Overall Member Profile Qualitative Analysis

The overall membership profile reflects a diverse, predominantly pediatric and family-centered population with shifting demographics and utilization patterns over the 2023-2025 period.

Membership trends show a consistent year-over-year decline, suggesting potential impacts from eligibility determination, policy changes, or border Medicaid enrollment shifts. Despite this decline, the composition of population remains relatively stable.

The population is largely youth-driven, with the highest concentration in the ages 5-14, followed by young adults and early childhood groups. This indicates a strong presence of families with dependent children, reinforcing the importance of pediatric care, preventive services, and school-based or family-oriented programs.

From a race and ethnicity perspective, the membership is highly diverse, with Hispanic/Latino individuals representing the largest identified group, followed closely by White/Caucasian members, and a significant portion categorized as unknown or unreported. The high rate of unreported demographic data suggests an opportunity to improve data collection to better inform culturally responsive care strategies.

In terms of reported primary language and language service utilization, English remains the predominant language reported by members. Spanish is the most frequently reported non-English language and continues to account for the largest share of language service requests, although Spanish service requests declined from 41,012 in 2023 to 40,681 in 2024 to 29,193 in 2025. In contrast, Haitian Creole service requests increased from 2,152 in 2023 to 3,057 in 2024 and 3,111 in 2025, indicating a growing need with this population. Overall, the relationship between members reported languages and their use of language services supports the continued availability of Spanish and Haitian Creole resources, culturally appropriate outreach, and ongoing monitoring to ensure services remain responsive to changing needs.

Gender distribution indicates a slightly higher proportion of female members compared to male members, with both groups experiencing gradual declines. The transgender population remains small but present, underscoring the need for inclusive and equitable healthcare practices.

Across enrollment categories, most members are enrolled through TANF and CHIP related programs, further reinforcing that the population is largely composed of low-income families and children. These categories also experienced declines, aligning with the overall membership trend.

Additionally, a significant portion of member-reported data, such as ethnicity, race, and sexual orientation falls under Unknown or Not Reported, which limits deeper population insights. This gap highlights an opportunity for enhanced member engagement and data accuracy initiatives.

Provider Profile – Network Cultural Needs and Preferences

1. **Providers in Network**

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Provider Profile Count 2025			
	2025	**2024**	**2023**
Provider Count #	34,133	28,540	25,743
% Membership change YOY	↓ 5.17% (11,156)	↓ 1.25% (2,763)	↓12% (28,279)

Quantitative Analysis

The provider network has demonstrated consistent growth over the past three years, increasing from 25,743 providers in 2023 to 28,540 in 2024, and reaching 34,133 in 2025. This reflects a strong upward trend in overall provider participation, with the most significant growth occurring between 2024 and 2025, representing an increase of 5,593 providers (approximately 19.6% year-over-year).

While provider growth is substantial, membership trends show a decline over the same period, with a 1.25% decrease in 2024 and a more pronounced 5.17% decrease in 2025. This divergence indicates that provider network expansion is outpacing membership demand.

Overall, the data suggests a strengthening network footprint with improved provider availability; however, the declining membership base may impact network utilization and efficiency. This trend may guarantee further evaluation to ensure alignment between network capacity and membership needs.

2. **Provider Geography**

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Geographic Group 2025			
	2025	**2024**	**2023**
Rural	203*	183*	178*
Urban	33,847	32,318	28,597
Total	34,054	32,501	28,775

**Total Includes Providers that has both Rural and Urban Office Locations and Provider that have no Active Locations (telehealth)*

Geography Quantitative Analysis

The provider network has demonstrated consistent growth over the three-year period, increasing from 28,775providers in 2023 to 32,501 in 2024, and reaching 34,054 in 2025. This reflects a steady upward trend in overall provider participation, with the most significant growth occurring between 2023 and 2024, representing an increase of 3,731 providers (12.9% year-over-year), followed by more moderate growth of 1,632 providers (5.0% year-over-year) between 2024 and 2025.

Urban providers comprise most of the network and have driven nearly all growth during the measurement period, increasing from 28,597 in 2023 to 32,318 in 2024, and 33,847 in 2025. In contrast, rural provider participation remains limited, growing modestly from 178 providers in 2023 to 183 in 2024, and 203 in 2025, with the most notable rural increase occurring in 2025 (+10.9% year-over-year).

While overall provider growth is strong, the distribution remains heavily concentrated in urban areas, with rural providers consistently representing less than 1% of the total network. This indicates that although network expansion is occurring, growth is disproportionately concentrated in urban regions.

Overall, the data shows continued strengthening of the provider network with increased capacity and availability, particularly in urban markets. However, the limited proportional growth in rural provider participation may indicate potential geographic access considerations, warranting continued monitoring and targeted expansion strategies to ensure balanced network adequacy across all regions.

3. Provider Language Reported

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Primary Language Reported 2025							
Language		2025		2024		2023	
		# of Providers	% of Provider Population	# of Providers	% of Provider Population	# of Providers	% of Provider Population
1	English	32,007	93.8%	22,710	79.6%	18,013	59.7%
2	Spanish	804	2.4%	983	3.4%	1,056	3.5%
3	Arabic	491	1.4%	361	1.3%	307	1%
4	Creole	203	0.6%	171	0.6%	149	0.5%
5	French	90	0.3%	94	0.3%	104	0.3%
6	Hindi	83	0.2%	85	0.3%	91	0.3%
7	Chinese	90	0.3%	68	0.2%	52	0.2%
8	Italian	19	0.1%	25	0.1%	31	0.1%
9	Gujarati	22	0.1%	17	0.1%	22	0.1%
10	Portuguese	13	0.1%	30	0.1%	22	0.1%
Total		***34,133***		***24,544***		***25,743***	

Provider Language Quantitative Analysis

The provider population continued to expand significantly over the three-year period, increasing from 25,743 in 2023 to 28,540 in 2024, and reaching 34,133 in 2025. Alongside this growth, there has been a notable improvement in the completeness and distribution of primary language data.

English remains the predominant primary language among providers and shows the most significant increase both in count and proportion. English-speaking providers rose from 18,013 (59.7%) in 2023 to 22,710 (79.6%) in 2024, and further to 32,007 (93.8%) in 2025. This sharp increase suggests improved data capture and standardization of language reporting rather than a true shift in linguistic diversity.

Among non-English languages:

- Spanish remains the second most reported language; however, it shows a decline in both count and percentage over time, decreasing from 1,056 (3.5%) in 2023 to 983 (3.4%) in 2024, and 804 (2.4%) in 2025.

- Arabic demonstrates steady growth, increasing from 307 (1.0%) in 2023 to 361 (1.3%) in 2024, and 491 (1.4%) in 2025, indicating expanding representation.
- Creole shows gradual increases from 149 (0.5%) in 2023 to 171 (0.6%) in 2024, and 203 (0.6%) in 2025, maintaining a stable proportion with increasing counts.
- Chinese providers increased steadily from 52 (0.2%) in 2023 to 68 (0.2%) in 2024, and 90 (0.3%) in 2025, reflecting incremental growth.
- French and Hindi remained relatively stable but show slight decreases in recent years.
- Italian, Gujarati, and Portuguese remain minimally represented, with small fluctuations across the reporting period.

Overall provider volume increased substantially year over year. There is a significant shift toward English being recorded as the primary language, which may reflect improved standardization in data entry or default selections rather than actual language changes. Several non-English language categories (e.g., Arabic, Creole, Chinese) show consistent growth in provider counts, indicating some diversification. Other languages, particularly Spanish, show declines in proportional representation, warranting further review. The distribution suggests potential data capture or classification changes, rather than purely demographic shift.

4. Provider Reported Race

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Provider Population by Race 2025						
Race	**2025**		**2024**		**2023**	
	# of Providers	**% of Provider Population**	**# of Providers**	**% of Provider Population**	**# of Providers**	**% of Provider Population**
African American/Black	136	0.4%	109	0.4%	69	0.3%
Caucasian/ White	555	1.6%	244	0.9%	167	0.6%
Asian/Pacific Islander	54	0.2%	42	0.1%	18	0.1%
American Indian or Alaskan Native	0	0%	0	0%	0	0%
Other Race	21	0.1%	13	0%	2	0%
Unknown/Not Reported	33,019	96.4%	27,805	97.4%	25,278	98.2%
Total Providers	**34,133**		**28,540**		**25,743**	

Provider Reported Race Quantitative Analysis

The provider population demonstrates consistent growth over the three-year period, increasing from 25,743 in 2023 to 28,540 in 2024, and reaching 34,133 in 2025, reflecting a significant upward trend in network size.

Race data completeness remains a key opportunity area. The Unknown/Not Reported category continues to comprise the vast majority of records; however, there has been a modest but consistent improvement over time. The percentage of unknown race decreased from 98.2% in 2023 to 97.4% in 2024, and further to 96.4% in 2025, indicating incremental progress in capturing provider's demographic information.

Among providers with reported race data, all categories show year-over-year increases in volume:

- Caucasian/White providers experienced the most significant growth, increasing from 167 (0.6%) in 2023 to 244 (0.9%) in 2024, and to 555 (1.6%) in 2025.
- African American/Black providers increased steadily from 69 (0.3%) in 2023 to 109 (0.4%) in 2024 and 136 (0.4%) in 2025, reflecting stable proportional representation with increased counts.
- Asian/Pacific Islander providers rose from 18 (0.1%) in 2023 to 42 (0.1%) in 2024 and 54 (0.2%) in 2025, demonstrating gradual growth.
- Other Race increased from 2 providers in 2023 to 13 in 2024 and 21 in 2025, though overall representation remains minimal.
- American Indian or Alaskan Native providers remain unreported across all years.

The total provider population is expanding year after year. There is a slight but positive trend toward improved race data capture. Despite gains, race data incompleteness remains a significant limitation, with over 96% of providers lacking reported race in 2025. All reported race categories show increases in absolute numbers, suggesting either improved reporting practices or incremental diversification of the provider network.

5. Age Band

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Providers Serving Members by Age Bands 2025						
Age Band	**2025**		**2024**		**2023**	
	# of Providers	**% of Provider Network**	**# of Providers**	**% of Provider Network**	**# of Providers**	**% of Provider Network**
Age 15-24	42	0.1%	76	0.2%	73	0.3%
Age 25-44	15,883	46.5%	15,508	47.7%	13,779	47.9%
Age 45-64	14,242	41.7%	13,251	40.8%	11,686	40.6%
Age 65-85	3,385	9.9%	3,123	9.6%	2,763	9.6%
Age > 85	48	0.1%	62	0.2%	47	0.2%
Total Providers	***33,600***		***32,020***		***28,348***	

Age Band Quantitative Analysis

The provider network age distribution remained relatively stable over the three-year period, with the majority of most providers concentrated in the 25–44 and 45–64 age bands. The total number of providers increased across all primary working-age groups, reflecting overall network growth.

Providers aged 25–44 represented the largest segment of the network, increasing from 13,779 (47.9%) in 2023 to 15,508 (47.7%) in 2024, and 15,883 (46.5%) in 2025. While the number of providers in this age group continued to grow, their proportional representation decreased slightly over time, indicating expansion across other age bands.

Providers aged 45–64 demonstrated consistent growth, increasing from 11,686 (40.6%) in 2023 to 13,251 (40.8%) in 2024, and 14,242 (41.7%) in 2025. This age group shows both numerical and proportional increases, suggesting a strengthening presence of more experienced providers within the network.

Providers aged 65–85 also increased steadily from 2,763 (9.6%) in 2023 to 3,123 (9.6%) in 2024, and 3,385 (9.9%) in 2025, reflecting gradual growth in late-career providers while maintaining a stable share of the network.

Younger providers aged 15–24 and those aged over 85 continue to represent a very small proportion of the network, each accounting for approximately 0.1%–0.3% across all years, with minor fluctuations in both counts and percentages.

In parallel, total membership declined from 224,355 in 2023 to 221,592 in 2024, and further to 210,436 in 2025, representing decreases of 1.25% and 5.03%, respectively. This indicates that provider network growth is occurring alongside a contracting membership base.

Overall, the data demonstrates a maturing and expanding provider network, with growth concentrated in mid- to late-career age bands. While the age distribution remains stable, the increasing proportion of providers age 45 and older may warrant ongoing monitoring to ensure long-term workforce sustainability and alignment with future network capacity needs.

6. Provider Reported Ethnicity

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Provider Population by Ethnicity 2025						
Is the provider of Hispanic or Latino origin or descent?	**2025**		**2024**		**2023**	
	# of Providers	**% of Provider Population**	**# of Providers**	**% of Provider Population**	**# of Providers**	**% of Provider Population**
Yes	555	1.6%	327	1.1%	175	0.7%
No	33,578	98.4%	28,213	98.9%	25,568	99.3%
Total Providers	34,133		28,540		25,743	

Provider Reported Ethnicity Quantitative Analysis

The proportion of providers identifying as Hispanic or Latino has increased steadily over the three-year period. In 2023, 175 providers (0.7%) reported Hispanic or Latino ethnicity, which increased to 327 providers (1.1%) in 2024, and further to 555 providers (1.6%) in 2025. This reflects a consistent year-over-year upward trend, both in total count and percentage representation within the provider network.

Specifically, the provider count grew by 152 (approximately 86.9%) from 2023 to 2024, and by an additional 228 providers (approximately 69.7%) from 2024 to 2025. Overall, the Hispanic/Latino provider population has more than tripled since 2023, indicating meaningful progress in diversifying the network.

Conversely, providers reporting as non-Hispanic continue to represent the vast majority of the network, though their proportional share has gradually declined from 99.3% in 2023 to 98.9% in 2024, and 98.4% in 2025. This shift reflects the growing contribution of Hispanic/Latino providers within an expanding overall provider base.

Overall, the data demonstrates a positive trend toward increased ethnic diversity among providers; however, Hispanic/Latino representation remains relatively low compared to the total network, suggesting continued opportunity for targeted recruitment and engagement efforts.

7. Provider Gender

Data Location: Provider Profile- QNXT (Operating System- Provider Database)-Florida

Provider Gender 2025

Category	2025		2024		2023	
	# of Providers	% of Provider Population	# of Providers	% of Provider Population	# of Providers	% of Provider Population
Male	13,198	38.7%	10,965	38.4%	9,702	37.7%
Female	20,832	61.0%	17,514	61.4%	15,388	59.8%
Unknown/Not Reported	103	0.3%	61	0.2%	653	2.5%
Total Providers	***34,133***		***28,540***		***25,743***	

Provider Gender Quantitative Analysis

The gender distribution of the provider network has remained relatively stable over the three-year period, with a consistent majority of providers identifying as female. Female providers increased from 15,388 (59.8%) in 2023 to 17,514 (61.4%) in 2024, and to 20,832 (61.0%) in 2025. Despite a slight decrease from 2024 to 2025, the overall trend reflects steady growth in both total count and proportional representation compared to 2023.

Male provider representation has also grown in absolute numbers, increasing from 9,702 (37.7%) in 2023 to 10,965 (38.4%) in 2024, and to 13,198 (38.7%) in 2025. The percentage of male providers has shown a modest but consistent upward trend over the three years.

Notably, the proportion of providers with unknown or unreported gender has significantly decreased, from 653 (2.5%) in 2023 to 61 (0.2%) in 2024 and slightly increasing to 103 (0.3%) in 2025. This indicates a marked improvement in data completeness and reporting accuracy beginning in 2024.

Overall, the data reflects a stable gender distribution with a predominantly female provider network, gradual growth in both male and female provider counts aligned with overall network expansion, and improved data quality over time.

8. Member Complaints Concerning Ethnic, Cultural, Racial or Language Needs

Data Location: DAG

Member Complaint/Grievance 2025			
	2025	**2024**	**2023**
Access: Geographic availability of practitioner who meets cultural or language needs	0	1	0
Attitude and Service: Cultural insensitivity or language related barrier	0	1	1
Attitude and Service: Interpreter Services	0	0	0

Member Complaints Concerning Ethnic, Cultural, Racial or Language Needs Quantitative Analysis

Complaint and grievance volumes remained very low across all categories during the 2023 to 2025 reporting period. A total of one complaint was reported in 2023, increasing to two complaints in 2024, before declining to zero complaints in 2025. This trend reflects an overall favorable outcome, with no reported complaints in any category during the most recent year. The Access category, which measures concerns related to the geographic availability of practitioners who meet cultural or language needs, experienced a single complaint in 2024 but returned to zero in 2025. The Attitude and Service category related to cultural insensitivity or language barriers remained stable with one complaint reported in both 2023 and 2024, followed by a 100% decrease to zero complaints in 2025. No complaints were reported in the Attitude and Service: Interpreter Services category throughout the entire three-year period, demonstrating a consistently stable trend. Overall, no recurring issues

were identified in the Access or Interpreter Services categories, and concerns related to cultural insensitivity or language barriers were not reported in 2025. Given the extremely low complaint volumes, year-over-year percentage changes appear substantial despite being driven by only one or two cases. Continued monitoring is recommended to determine whether the absence of complaints in 2025 represents a sustained improvement or normal variation within a low-volume population.

Overall Trending Results

The three-year trend is favorable, with total complaints increasing from 1 in 2023 to 2 in 2024, then declining to zero in 2025. No recurring concerns were identified in the geographic access or interpreter services categories. Although the cultural insensitivity or language-related barrier category had one complaint in both 2023 and 2024, no complaints were reported in 2025.

Because the overall volumes are very small, percentage changes can appear significant even when driven by only one or two cases. Continued monitoring is recommended to confirm that the 2025 decline represents a sustained improvement rather than normal variation in low-volume data.

9. Adult CAHPS Results (Cultural Needs and Preferences)
Data Location:

Adult CAHPS 2025			
Responded "usually" or "always"	**2025**	**2024**	**2023**
In the last 6 months, how often were you able to find a doctor or other health professional who met your cultural, racial, ethnic, or language needs or preferences?	76.3%	N/A-	N/A
In the last 6 months, how often did you receive health care services in a language that you could understand?	86.5%	-N/A	N/A

Adult CAHPS Quantitative Analysis

Adult CAHPS (Cultural Needs and Preferences) results for 2025 establish the baseline performance for this measure. Among surveyed respondents, 86.5% reported receiving health care services in a language they could understand, while 76.3% reported being able to find a doctor or other health professional who met their cultural, racial, ethnic, or language needs and preferences. The measure related to receiving services in a language respondents could understand performed 10.2% higher than the measure related to finding a provider who met cultural, racial, ethnic, or language preferences. These results suggest that while most members were able to receive services in an understandable language, a smaller proportion reported success in finding providers who fully met their cultural, racial, ethnic, or language needs and preferences. The 2023 and 2024 fields are blank because this questions was not included in the CAHPS surveys. Because 2025 is the first year the data collection, prior year data are unavailable, and trend analysis cannot yet be conducted; however, these baseline results will be used to monitor future performance and identify opportunities to strengthen access to culturally and linguistically appropriate care.

10. Child CAHPS Results (Cultural Needs and Preferences)
Data Location:

Child CAHPS 2025			
Responded "usually" or "always"	**2025**	**2024**	**2023**
In the last 6 months, how often were you able to find a doctor or other health professional who met your child's cultural, racial, ethnic, or language needs or preferences?	79.6%	-N/A	N/A
In the last 6 months, how often did your child receive health care services in a language that you could understand?	85.2%	-N/A	N/A

Child CAHPS Quantitative Analysis

Child CAHPS (Cultural Needs and Preferences) 2025 results establish the baseline performance for this measure. Among surveyed respondents, 85.2% reported that their child received health care services in a language they could understand, while 79.6% reported being able to find a doctor or other health professional who met their child's cultural, racial, ethnic, or language needs and preferences. The measure related to receiving services in a language respondents could understand performed 5.6% higher than the measure related to finding a provider who met cultural, racial, ethnic, or language preferences. The 2023 and 2024 fields are blank because this questions was not included in the CAHPS surveys. Because 2025 is the first year the data collection, prior year data are unavailable, and trend analysis cannot yet be conducted; however, these baseline results will be used to monitor future performance and identify opportunities to strengthen access to culturally and linguistically appropriate care.

9. Religious Landscape Study (Cultural Needs and Preferences)

Data Location: PEW Research
https://www.pewresearch.org/religious-landscape-study/database/

PEW Religion by Geographical Area Florida			
Religion Reported	**2007**	**2014**	**2023-2024**
Christian	77%	70%	64%
Non-Christian Faiths	<1%	<1%	<1%
Other Faiths	1%	<1%	<1%
Atheist	1%	3%	4%
Agnostic	3%	4%	5%
Nothing in Particular	12%	17%	18%

Provider Profile Qualitative Analysis

The Provider Profile analysis demonstrates that Aetna Better Health of Florida (ABHFL) maintains a large and growing provider network that generally aligns with the demographic, cultural, ethnic, racial, and linguistic needs of its membership. Network expansion has occurred despite an overall decline in membership, resulting

in increased provider availability and continued network adequacy across the service area. The network is predominantly concentrated in urban markets, which is consistent with the geographic distribution of the membership population, where most members reside in large central metropolitan and large fringe metropolitan areas.

The member population is culturally and ethnically diverse, with substantial Hispanic/Latino representation, growing Haitian/Creole language needs, and significant concentrations of members residing in South and Central Florida metropolitan areas. Members primarily report English (72.9%) and Spanish (24.8%) as their preferred languages, while language assistance requests demonstrate continued high demand for Spanish interpretation services and increasing utilization of Haitian/Creole interpreter services.

Provider language data indicates that English-speaking practitioners comprise much of the network, while Spanish, Creole, Arabic, Chinese, French, and other language capabilities are present in smaller numbers. Although Spanish-speaking providers remain the largest non-English provider segment, provider representation (2.4%) is significantly lower than the percentage of members reporting Spanish as their primary language (24.8%). Similarly, Haitian Creole-speaking providers represent less than 1% of the network despite increasing interpreter utilization among Haitian-speaking members.

This disparity does not necessarily indicate inadequate access, as interpreter services remain available and complaint data demonstrates minimal concerns regarding language access. However, the analysis identifies an opportunity to further strengthen recruitment and retention efforts for bilingual practitioners, particularly Spanish-speaking and Haitian Creole-speaking providers in high-volume counties such as Miami-Dade, Broward, Palm Beach, and Orange.

ABHFL assessed potential unmet cultural, ethnic, racial, and linguistic needs through:

- Member demographic and language preference data.
- Provider demographic and language capability data.
- Member complaint and grievance analysis.
- Adult and Child CAHPS Cultural Needs and Preferences measures.
- Interpreter utilization trends.
- Population assessment and geographic distribution analyses.
- Community demographic and religious landscape information.

The overall findings indicate limited evidence of widespread unmet needs. Member complaints related to cultural, ethnic, racial, or linguistic barriers remained extremely low throughout the measurement period and declined to zero in 2025. No interpreter-related grievances were reported during the three-year period.

Additionally, Adult and Child CAHPS results established favorable baseline performance, with most respondents indicating they were usually or always able to find providers who met their cultural, racial, ethnic, or language preferences and receive services in a language they understood.

These results suggest that current network resources, interpreter services, and provider access are generally meeting member expectations and supporting culturally responsive care.

Several barriers limit ABHFL's ability to fully assess and optimize network alignment with member needs.

Provider demographic data completeness remains the most significant limitation. More than 96% of providers have race recorded as Unknown or Not Reported, significantly restricting the organization's ability to compare provider demographics with member demographics and evaluating racial concordance within the network. Similarly, ethnicity reporting remains limited despite recent improvements.

Potential causes include:

- Optional demographic disclosure during credentialing and recredentialing.
- Historical limitations within provider enrollment systems.
- Provider reluctance to self-report demographic information.
- Variability in data collection practices across network entities and delegated groups.

Language data also presents challenges. While provider language reporting has improved, available data may reflect primary language rather than all languages spoken in practice settings. This may underrepresent actual multilingual capabilities within the network and create challenges when evaluating language concordance between practitioners and members.

Geographic barriers persist in rural areas. Although the rural member population is small, rural provider participation constitutes less than 1% of the network. This may create access challenges for members requiring culturally responsive services within rural and noncore regions, particularly for specialty care and behavioral health services.

Several factors likely explain the favorable cultural and linguistic access outcomes observed:

- Significant network growth has expanded overall provider capacity.
- Membership declines have improved provider-to-member ratios.
- Interpreter services remain readily available and highly utilized.
- The network is concentrated in metropolitan areas where culturally diverse providers are more readily available.
- Ongoing network adequacy monitoring ensures sufficient practitioner coverage.
- Provider engagement and credentialing processes include cultural competency and nondiscrimination requirements.
- Community-based outreach and population health programs help address cultural and language-related barriers outside traditional clinical settings.

The growth in Haitian Creole interpretation requests likely reflects demographic shifts within South Florida communities rather than deficiencies in provider access. Continued monitoring is warranted to ensure network composition evolves alongside changing community characteristics.

While provider growth supports the overall needs of the disability population, several barriers remain:

- Rural provider participation remains limited, which could impact access for members with disabilities requiring specialty, transportation-supported, or home-based services in non-urban markets.
- Provider demographic data does not consistently identify disability-related expertise, cultural competence in serving persons with disabilities, or specialized training, making targeted network gap analysis more difficult.
- Increasing complexity among aging and disabled members may require enhanced care coordination and specialized provider recruitment strategies.

ABHFL monitors disability-related membership trends through annual population assessments, network adequacy reviews, provider recruitment efforts, and access monitoring activities. Network Management, Provider Engagement, Quality Management, and Population Health Management teams collaborate to identify emerging service needs and recruit providers capable of supporting ABD, Dual Eligible, and behavioral health populations.

Based on current network adequacy monitoring, complaint data, and access measures, no widespread access barriers have been identified for members with disabilities. However, the health plan will continue monitoring membership growth and specialty provider availability to ensure network capacity remains aligned with future member needs.

The age distribution of ABHFL membership reflects a predominantly pediatric and family-oriented population. The largest membership consists of children ages 5-14 (91,445 members), followed by members ages 15-24 (42,778 members) and children ages 1-4 (24,793 members). Collectively, pediatric and young adult populations account for a substantial majority of total membership.

At the same time, the population aged 65 years and older continues to increase, growing from 10,000 members in 2023 to 13,910 members in 2025. This trend corresponds with the growth observed in Dual Eligible populations and indicates increasing need for providers experienced in geriatric care, chronic disease management, and long-term services and supports.

The provider network profile demonstrates a mature workforce capable of supporting the healthcare needs of members across all life stages. Most providers fall within the 25-44 age group (46.5%) and 45-64 age group (41.7%), representing more than 88% of the total network. This distribution suggests a stable provider workforce with a broad range of clinical experience.

The provider age distribution aligns well with member needs because:

- The large pediatric population is supported through an extensive primary care and pediatric provider network.
- Family-centered populations enrolled through TANF and CHIP have access to providers experienced in preventive care, maternal health, and pediatric services.
- The network includes providers with clinical expertise necessary to manage both pediatric and aging populations.

Although the network currently appears well positioned to serve member age-related needs, several areas warrant ongoing monitoring:

- The continued decline in pediatric membership may require periodic reassessment of pediatric network distribution to ensure provider supply remains appropriately aligned with demand.
- Approximately 51.6% of providers are age 45 or older, which may indicate future workforce succession considerations as portions of the provider network approach retirement age.

ABHFL evaluates age-specific membership trends annually through the Population Assessment process and incorporates findings into network planning activities. Network Management and Provider Engagement teams use membership demographic data when developing provider recruitment strategies and assessing network adequacy.

The health plan continues to monitor pediatric, adult, and behavioral health service capacity to ensure providers are available to meet the evolving needs of the member population. Based on current network adequacy reviews, grievance activity, and member experience data, no significant age-related access deficiencies have been identified within the provider network.

Based on the 2025 assessment, ABHFL's provider network generally meets the cultural, ethnic, racial, and linguistic needs of its membership. Complaint trends, CAHPS results, interpreter utilization, and network growth do not indicate significant unmet needs requiring immediate structural network changes. However, opportunities remain to strengthen demographic data collection, increase recruitment of bilingual providers, particularly Spanish- and Haitian Creole-speaking practitioners, and continue monitoring emerging culturally diverse populations. Currently, the health plan has identified targeted enhancement opportunities rather than

systemic network deficiencies, and current interventions are considered appropriate to support continued access to culturally responsive care.

Condition Prevalence

1. **Top 10 Conditions by Claims**

   Data Location:
   https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Top 10 Conditions 2025						
Condition	2025		2024		2023	
	# of Members	% of Membership N=210,436	# of Members	% of Membership N=221,592	# of Members	% of Membership N=224,355
Obesity	27,965	13.29%	27,544	12.43%	15,564	6.94%
Other Upper Respiratory Disease	25,874	12.30%	25,577	12.43%	24,674	11.00%
Overweight	21,057	10.01%	20,595	9.29%	15,564	6.94%
Abdominal Pain	19,972	9.49%	20,110	9.07%	21,443	9.56%
Hyperlipidemia	19,580	9.30%	17,276	7.79%	17,531	7.82%
Anxiety Disorders	15,566	7.40%	14,343	6.47%	13,476	6.01%
HTN	12,964	6.16%	12,315	5.56%	12,710	5.67%
ADHD/Childhood Disorders	12,345	5.87%	12,008	5.42%	10,499	4.68%
Anemia	12,571	5.97%	10,888	4.91%	11,618	5.18%
Depression	10,470	4.98%	9,900	4.47%	8,575	3.82%
Total	***178,364***		***170,556***		***151,654***	

Top 10 Conditions Quantitative Analysis

Analysis of claims data over three-year period (2023-2025) indicates that the top conditions have remained consistent, with measurable changes in volume across categories.

Obesity remains the most prevalent condition, increasing from 15,564 in 2023 to 27,544 in 2024, representing a 77% increase, followed by an increase to 27,965 in 2025. Overall, obesity increased by 79.7% across the three-year period.

Upper respiratory disease consistently ranks second, with steady growth from 24,674 in 2023 to 25,577 in 2024 and 25,874 in 2025 reflecting an overall increase of 4.9%.

Overweight prevalence increased from 15,564 in 2023 to 20,595 in 2024 and further to 21,057 in 2025, resulting in an overall increase of 35.3%.

Abdominal pain shows a declining trend, decreasing from 21,446 in 2023 to 20,110 in 2024 and 19,972 in 2025, representing an overall reduction of 6.9%.

Hyperlipidemia demonstrates an increase with 17,531 in 2023, a slight decrease to 17,276 in 2024 followed by an increase to 19,580 in 2025. This reflects an overall increase of 11.7% across the three-year period.

Three of the five leading conditions (obesity, overweight, hyperlipidemia) show overall increases, with obesity experiencing the most significant growth. Upper respiratory disease remains stable with a slight increase, indicating consistent utilization. Abdominal pain is the only condition to decrease over time.

These trends indicate a measurable shift toward increased prevalence of chronic lifestyle-related conditions, alongside stable rates of acute conditions.

2. Condition Prevalence

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Condition	2025 # of Members	2025 % of Total Population	2024 # of Members	2024 % of Total Population	2023 # of Members	2023 % of Total Population
Chronic Condition						
Asthma	8,535	4.06%	8,257	3.72%	7,714	3.44%
Cerebrovascular Disease	2,471	1.17%	2,177	0.98%	2,279	1.02%
Chronic Obstructive Pulmonary Disease	1,808	0.86%	1,574	0.71%	1,664	0.74%
Chronic Kidney Disease	1,515	0.72%	1,235	0.56&	1,304	0.58%
Coronary Artery Disease	2,299	1.09%	2,053	0.93%	2,246	1.00%
Congestive Heart Failure	1,964	0.93%	1,669	0.75%	1,779	0.79%
Diabetes Management	5,500	2.61%	4,941	2.23%	5,177	2.31%
Lifestyle Management						
Hyperlipidemia	19,580	9.30%	1,318	0.59%	17,531	7.82%
Hypertension	12,964	6.16%	12,315	5.56%	12,710	5.67%
Obesity	27,965	13.29%	27,544	12.43%	15,564	6.94%
Tobacco Abuse	4,113	1.95%	3,786	1.71%	7,575	2.04%
Behavioral Health						
Anxiety Disorders	15,566	7.40%	14,343	6.47%	13,476	6.01%
Bipolar Disorders and other Affective Disorders	1,793	0.85%	1,422	0.64%	1,395	0.62%
Senility/Dementia/Organic Disorders	2,921	1.39%	2,612	1.18%	2,229	0.99%
Depression	10,470	4.98%	9,900	4.47%	8,575	3.82%
Schizophrenia/Other Psychotic Disorders	1,456	0.69%	1,195	0.54%	1,217	0.54%
Substance Abuse	844	0.40%	857	0.39%	998	0.45%

3. Condition Prevalence by County

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Condition Prevalence by County					
Condition	**Top 3 Counties**	**# of Members**	**Total Membership of County**	**% of county membership**	**2025 % of Total Population *(N=210,436)***
Chronic Condition					
Asthma	Miami-Dade	2,624	62,233	4.22%	2.23%
	Orange	1,145	29,940	3.82%	

Condition Prevalence by County					
Condition	**Top 3 Counties**	**# of Members**	**Total Membership of County**	**% of county membership**	**2025 % of Total Population *(N=210,436)***
	Hillsborough	905	21,764	4.16%	
Cerebrovascular Disease	Miami-Date	878	62,233	1.41%	0.76%
	Orange	433	29,940	1.45%	
	Hillsborough	285	21,764	1.31%	
Chronic Obstructive Pulmonary Disease	Miami-Dade	657	62,233	1.06%	0.73%
	Orange	245	29,940	0.82%	
	Brevard	243	9,667	2.51%	
Chronic Kidney Disease	Miami-Dade	542	62,233	0.87%	0.48%
	Orange	313	29,940	1.05%	
	Hillsborough	155	21,764	0.71%	
Coronary Artery Disease	Miami-Dade	871	62,233	1.40%	0.74%
	Orange	415	29,940	1.39%	
	Hillsborough	262	21,764	1.20%	
Diabetes	Miami-Dade	2,140	62,233	3.44%	1.75%
	Orange	892	29,940	2.98%	
	Hillsborough	646	21,764	2.97%	
Lifestyle Management					
Hypertension	Miami-Dade	5,296	62,233	8.51%	4.29%
	Orange	1,998	29,940	6.67%	
	Hillsborough	1,730	21,764	7.95%	
Hyperlipidemia	Miami-Dade	8,795	62,233	14.13%	6.34%
	Orange	2,615	29,940	8.73%	
	Hillsborough	1,929	21,764	8.86%	
Obesity	Miami-Dade	8,992	62,233	14.45%	7.36%
	Orange	3,634	29,940	12.14%	
	Hillsborough	2,874	21,764	13.21%	
Tobacco Abuse	Miami-Dade	1,148	62,233	1.84%	1.14%
	Orange	692	29,940	2.31%	
	Hillsborough	549	21,764	2.52%	
Behavioral Health					
Anxiety Disorders	Miami-Dade	4,456	62,233	7.16%	3.86%
	Orange	2,047	29,940	6.84%	
	Hillsborough	1,612	21,764	7.41%	
Substance Abuse	Miami-Dade	220	62,233	0.35%	0.25%
	Orange	177	29,940	0.59%	
	Hillsborough	126	21,764	0.58%	
Depression	Miami-Dade	3,879	62,233	6.23%	3.00%
	Orange	1,387	29,940	4.63%	
	Hillsborough	1,046	21,764	4.81%	

Condition Prevalence by County					
Condition	**Top 3 Counties**	**# of Members**	**Total Membership of County**	**% of county membership**	**2025 % of Total Population *(N=210,436)***
Bipolar Disorders and other Affective Disorders	Miami-Dade	558	62,233	0.90%	0.50%
	Orange	273	29,940	0.91%	
	Hillsborough	224	21,764	1.03%	
Senility /Dementia and Organic Disorders	Miami-Dade	1,312	62,233	2.11%	0.98%
	Orange	428	29,940	1.43%	
	Hillsborough	323	21,764	1.48%	
Schizophrenia / other Psychotic Disorders	Miami-Dade	648	62,233	1.04%	0.48%
	Orange	208	29,940	0.69%	
	Hillsborough	150	21,764	0.69%	

Condition Prevalence Quantitative Analysis

A review of chronic condition prevalence from 2023 through 2025 identified asthma as the most prevalent chronic condition among members. Asthma prevalence increased steadily from 7,715 in 2023 to 8,257 in 2024 and 8,535 in 2025, representing an overall increase of 10.6% over the three-year period. Diabetes remained second most prevalent chronic condition, affecting 5,177 in 2023, decreasing slightly to 4,941 in 2024 and increasing to 5,500 members in 2025. This reflects an overall increase of 6.2% compared to 2023. Cerebrovascular disease affected 2,279 members in 2023, decreased to 2,177 members in 2024, and increased to 2,471 members in 2025, resulting in an overall increase of 8.4% from 2023. Coronary artery disease followed a similar pattern, decreasing for 2,246 members in 2023 to 2,053 members in 2024 before increasing to 2,299 members in 2025. Likewise, congestive heart failure decreased from 1,779 members in 2023 to 1,669 members in 2024 and increased to 1,964 members in 2025. COPD decreased from 1,664 members in 2023 to 1,574 members in 2024 before increasing to 1,808 members in 2025, chronic kidney disease demonstrated a similar trend, decreasing from 1,304 members in 2023 to 1,235 members in 2024 and then increasing to 1,515 members in 2025, representing the largest proportional increase among the conditions reviewed. The three-year trend demonstrates that several chronic conditions experienced a decline in 2024 followed by increases in 2025. Asthma and diabetes continue to represent the greatest chronic disease burden with the membership, while chronic kidney disease exhibited the most significant rate of increase during the measurement period.

Review of Lifestyle Management conditions for 2025 identified obesity as the most prevalent condition among members, affecting 27,965 members. Hyperlipidemia was the second most prevalent, impacting 19,580 members, followed by hypertension with 12,964 members. Tobacco use was the least prevalent of the conditions affecting 4,113 members.

Review of behavioral health condition prevalence for 2025 identified anxiety disorders as the most prevalent condition, affecting 15,566 members. Depression was the second most prevalent, impaction 10,470 members. Dementia affected 2,921 members, followed by bipolar disorders with 1,793 members and schizophrenia with 1,456 members.

Review of condition prevalence by county identified Miami-Dade had the most membership across all chronic conditions reviewed, indicating the greatest concentration of members with chronic healthcare needs. Orange County consistently reported the second-highest prevalence across most conditions while Hillsborough County generally ranked third.

A review of conditions prevalence data was conducted to identify the most common chronic lifestyle management, behavioral health, and county-specific health conditions affecting the membership. The analysis found that asthma and diabetes remained the most prevalent conditions, while obesity, hyperlipidemia and hypertension represented the most common lifestyle management conditions. Within behavioral health, anxiety disorders and depression accounted for the largest share of behavioral health diagnosis.

Overall, the conditions prevalence analysis demonstrates that chronic disease, lifestyle-related, and behavioral health continue to significantly impact the membership population. The results support ongoing disease management, preventive care, health education, Care coordination, and community partnership initiatives designed to improve health outcomes, reduce health disparities, and address the evolving healthcare needs of members.

Condition Prevalence by Race

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Membership – Condition by Race/Ethnicity												
	African Am./Black (N=36,285)		Am. Indian/ Alaska Native (N=317)		Asian/Pacific Islander (N=3,121)		Caucasian/ White (N=54,82)		Hispanic (N=55,981)		Unknown / Not Reported (N=37,863)	
Condition	#	%	#	%	#	%	#	%	#	%	#	%
Chronic Condition												
Diabetes	1,092	2.97%	6,000	1.82%	120	3.80%	1,381	2.39%	1,326	2.45%	1,173	3.11%
Coronary Artery Disease	115	1.14%	2,000	0.61%	45	1.43%	738	1.28%	536	0.99%	434	1.15%
Chronic Kidney Disease	344	0.93%	5,000	1.52%	20	0.63%	394	0.68%	316	0.58%	315	0.83%
Chronic Obstructive Pulmonary Disease	235	0.64%	1,000	0.30%	11	0.35%	682	1.18%	356	.66%	419	1.11%
Cerebrovascular Disease	488	1.33%	3,000	0.91%	36	1.14%	783	1.35%	543	1.00%	412	1.09%
Asthma	1,486	4.04%	12	3.64%	98	3.11%	2,172	3.75%	2,485	4.59%	1,682	4.46%
Lifestyle Management												
Tobacco Use	798	2.17%	7,000	2.12%	21	0.67%	1,539	2.66%	783	1.45%	765	2.03%
Obesity	5,489	14.91%	37	11.21%	266	8.43%	7,039	12.17%	8,204	15.16%	5,151	13.65%
Hypertension	2,489	6.99%	17	5.15%	173	5.48%	3,503	6.05%	2,928	5.41%	2,760	7.31%
Hyperlipidemia	2,763	7.50%	26	7.88%	291	9.22%	5,151	8.90%	5,933	10.96%	4,008	10.62%
Behavioral Health												
Anxiety Disorder	1,763	4.79%	28	8.48%	152	4.82%	5,429	9.38%	4,196	7.75%	3,116	8.26%
Substance Use	228	0.62%	3	0.91%	3	0.10%	276	0.48%	177	0.33%	349	0.45%
Schizophrenia / Other	281	0.76%	1	0.30%	15	0.48%	341	0.59%	331	0.61%	730	0.94%
Depression	1,348	3.66%	17	5.15%	94	2.98%	3,380	5.84%	2,690	4.97%	3,747	4.80%
Senility / Dementia and Organic Disorders	373	1.01%	7	2.12%	36	1.14%	893	1.54%	750	1.39%	1,044	1.34%
Bipolar	263	0.71%	1	0.30%	12	0.38%	591	1.02%	609	0.76%	458	1.21%

Condition Prevalence by Race Quantitative Analysis

A review of condition prevalence by race and ethnicity for 2025 identified notable difference in the distribution of chronic lifestyle management, and behavioral health conditions across member population.

Among chronic conditions, diabetes was one of the most prevalent conditions across all racial and ethnic groups. Diabetes affected 1,381 Caucasian members, 1,326 Hispanic members, 1,173 members with unknown race/ethnicity, and 1,092 African American members. Asthma also represented a significant disease burden, affecting 2,485 Hispanic members, 2,172 Caucasian members, 1,682 members with unknown race/ethnicity, and 1,486 African American members, these findings indicate that asthma and diabetes continue to be the most prevalent chronic conditions across diverse member populations. Within lifestyle management conditions, obesity was the most prevalent conditions, affecting 8,204 Hispanic members, 7,039 Caucasian members, 5,489 African American members, and 5,151 members with unknown race/ethnicity. Hyperlipidemia was the second most prevalent lifestyle-related conditions, impacting 5,933 Hispanic members, 5,151 Caucasian members, 4,008 members with unknown race/ethnicity, and 2,763 African American members. Hypertension affected 3,503 Caucasian members, 2,928 Hispanic members, 2,760 members with unknown race/ethnicity, and 2,489 African Amirian members. Behavioral Health identified anxiety disorders as the most prevalent behavioral health condition across all racial and ethnic groups. Anxiety disorders affected 5,429 Caucasian members, 4,196 Hispanic members, 3,116 members with unknown race/ethnicity, and 1,763 African American members. Depression was the second most prevalent behavioral health condition affecting 3,747 members with Unknown race/ethnicity, 3,380 Caucasian members, 2,290 Hispanic members, and 1,348 African American members.

These findings support continued efforts to address health disparities through culturally and linguistically appropriate outreach, disease management programs, preventive health initiatives, behavioral health services, and community-based interventions tailored to the unique needs for the population served.

Overall Condition Prevalence Qualitative Analysis

The condition prevalence analysis demonstrates that chronic lifestyle management, and behavioral health conditions continues to represent significant health care needs with the membership population. Asthma and diabetes remained the most prevalent chronic conditions, while obesity, hyperlipidemia, and hypertension were the most common lifestyle management conditions. Anxiety disorders and depression represented the highest prevalence behavioral health conditions, highlighting the importance of addressing both physical and behavioral health needs through an integrated approach to care.

The finding suggests that many of the most prevalent conditions are interconnected and influenced by modifiable risk factors, including nutrition, physical activity, tobacco use, access to preventive services, and management of existing chronic disease. The high prevalence of obesity, hyperlipidemia, and hypertension may contribute to the development and progression of chronic conditions such as diabetes, coronary artery disease, chronic kidney disease, and cerebrovascular disease.

Analysis by race and ethnicity identified difference in condition prevalence across member populations, reinforcing the need for culturally and linguistically appropriate interventions that address the unique needs of diverse communities. County-level analysis further demonstrated that certain geographic regions, particularly Miami-Dade County, experience a higher concentration of chronic conditions, indicating opportunities for targeted outreach and resource allocation.

Potential barriers impacting member health outcomes may include limited access to healthy food options, transportation challenges, housing instability, socioeconomic factors, health literacy limitations, language barriers, lack of awareness of available healthcare resources, behavioral health stigma, and difficulties accessing timely primary and specialty care services. Additionally, members managing multiple chronic conditions may experience challenges with medication adherence, care coordination, and engagement in preventive health service, which can contribute to disease progression and poorer health outcomes.

Overall, the results underscore the importance of continued disease management programs, preventive health initiatives, behavioral health integrations, member education, and community partnerships. ABHFL will continue to leverage condition prevalence data to identify emerging healthcare needs, prioritize interventions, address barriers to care, reduce health disparities, and improve overall health and well-being of the population served.

Emergency Department Utilization

Data Location: https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/EDUtilization

Top 10 Diagnoses – ED Visits 2025						
Diagnosis	**2025**		**2024**		**2023**	
	Visit Count	**Per 1000 mbrs** N=*210,436*	**Visit Count**	**Per 1000 mbrs** N = **221,592**	**Visit Count**	**Per 1000 mbrs** N=224,355
Musculoskeletal Disorder	11,700	65	10,570	61	11,269	62
Digestive Disorders	11,248	63	10,684	61	11,846	65
Ear/Nose/Throat Disorders	15,100	85	15,577	89	18,424	101
Injury/Poisoning	7,590	42	6,907	40	6,828	37
Respiratory Disorders	9,119	51	8,797	50	8,888	49
Cardiac Disorders	3,216	18	2,834	16	3,468	19
Neurologic Disorders	3,552	20	3,042	17	3,445	19
Infectious Disease	7,793	44	7,089	41	8,468	46
Skin Disorder	4,831	27	4,652	27	4,861	27
Obstetric Care	6,188	35	5,150	30	5,695	31
Total	***80,337***		***75,302***		***83,192***	

ED Utilization Quantitative Analysis

The top 10 diagnoses for ED visits from Calendar years 2023 through 2025 demonstrate fluctuation in overall utilization and changes among the leading diagnoses categories. Total ED visits decreased from 83,192 in 2023 to 75,302 in 2024, before increasing to 80,337 visits in 2025. Despite the 2025 increase, total ED utilization remained below 2023 levels.

Ear/Nose/Throat Disorders remained the leading diagnosis across the three-year period, with 18,424 visits in 2023, 15,577 in 2024 and 15,100 in 2025, demonstrating a continued decline. Digestive Disorders decreased from 11,846 visits in 2023 to 10,684 in 2024, before increasing to 11,248 visits in 2025. Musculoskeletal Disorders followed a similar pattern, decreasing from 11,269 visits in 2023 to 10,570 in 2024, then increasing to 11,700 visits in 2025, exceeding the 2023 visit count. Several diagnoses categories demonstrated increases over the three-year period. Injury/Poisoning, Respiratory Disorder, and Obstetric Care. Other Categories showed increases from 2024 to 2025, Cardiac Disorders, Neurologic Disorders, and Infectious disease.

Overall, the data demonstrates that while total ED utilization in 2025 remained below 2023, utilization increased compared with 2024 across most of the top diagnostic categories. Eat/Nose/Throat Disorders continued to account for the highest volume of ED visits but showed a consistent downward trend, while increases in Musculoskeletal Disorders, Injury/Poisoning, Respiratory Disorders, and Obstetric Care represent notable areas for continued monitoring.

ED Utilization Qualitative Analysis

The Three-year ED utilization trend demonstrates an overall improvement from 2023, with utilization decreasing from 83,192 visits in 2023 to 75,302 visits in 2024, followed by an increase to 80,337 visits in 2025. Although 2025 utilization remained below the 2023 level, the increase from 2024 suggests a need for continued monitoring to better understand the factors contributing to increased ED use.

The increase across several diagnosis categories may reflect multiple factors, including access to timely primary and specialty care, member understanding of appropriate care settings, availability of after-hours services, chronic condition management, and use of the ED for conditions that may potentially be managed in outpatient or urgent care settings. Social determinants of health, transportation barriers, provider availability, and changes in member health needs may also influence ED utilization.

Continued Collaboration among Quality Management, Care Management, Utilization Management, and the provider network will support identification of utilization drivers and opportunities for improvement. Targeted member education, care management, and promotion of appropriate urgent care, telehealth, and primary care services may help reduce potentially avoidable ED utilization.

Child & Adolescent

1. **Child & Adolescent Membership**

   Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Child/Adolescent Members (Ages 2-19) 2025			
	2025	**2024**	**2023**
# Members	147,746	154,078	144,583
% of Total Membership	70.21%	69.53%	64.44%

Child & Adolescent Membership Quantitative Analysis

Child and adolescent membership (ages 2-19) remained a significant segment of the overall membership throughout the 2023 – 2025 reporting period. Membership increased from 144,583 members in 2023 to 154,078 members in 2024, representing an increase of 9,495 members. In 2025, membership decreased to 147,746 members, a decline of 6,332 compared to 2024. Despite this decrease, the 2025 child and adolescent population remained 3,163 members higher than in 2023.

Overall, the data indicates relatively stable child and adolescent population over the three-year period with a temporary peak in 2024, followed by a modest decline in 2025, while continuing to account for approximately half of the plan's total membership.

2. **Child & Adolescent Membership by Gender**

   Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Child / Adolescent (Ages 2-19) by Gender 2025						
Gender	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
Male	73,972	50.07%	77,566	50.34%	72,878	50.41%
Female	73,774	49.93%	76,566	50.34%	71,706	49.59%

Total Members	***147,746***	***154,079***	***144,584***

Child & Adolescent Membership by Gender Quantitative Analysis

The child and adolescent membership remained relatively balanced between males and females throughout the 2023 – 2025 reporting period. Male membership increased from 72,876 members in 2023 to 77,566 members in 2024, and increase of 4,688 members, before declining to 73, 972 members in 2025, a decrease of 3,594 members from 2024. Female member ship followed a similar trend, increasing for 71,706 members in 2023 to 76,566 members in 2024, an increase of 4,860 members, and then decreasing to 73,774 members in 2025, a decline of 2,792members from 2024.

Overall, both male and female child and adolescents' population experienced growth in 2024 followed by a modest decline in 2025. However, membership for both genders remained above 2023, levels and the distribution between males and females continued to be nearly equal, indicating a stable gender composition within the child and adolescent populations.

3. Child & Adolescent Condition Prevalence

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Child & Adolescent Condition Prevalence
2025

Condition	2025		2024		2023	
	# of Members	% of Membership N=147,746	# of Members	% of Membership N=154,078	# of Members	% of Membership N=144,583
Other Upper Respiratory Disease	20,491	14.96%	20,639	14.37%	25,395	18.90%
Obesity	17,791	12.99%	17,527	12.21%	6,926	5.15%
Overweight	15,021	10.96%	14,309	9.96%	3,979	2.96%
Abdominal Pain	11,361	8.29%	11,367	7.92%	10,686	7.95%
ADHD/Childhood Disorders	10,882	7.94%	10,852	7.56%	9,242	6.88%
Anxiety Disorders	7,471	5.45%	6,933	4.83%	5,997	4.46%
Serious Emotional Disturbance	7,373	5.38%	6,753	4.70%	3,836	2.86%
Hyperlipidemia	7,105	5.19%	5,791	4.03%	5,034	3.75%
Asthma	5,787	4.22%	5,798	4.04%	5,077	3.78%
Other Lower Respiratory Disease	5,188	3.79%	5,542	3.86%	4,917	3.66%
Total	***108,470***		***105,511***		***81,089***	

Child & Adolescent Condition Prevalence Quantitative Analysis

The condition prevalence among the child and adolescent population increased overall between 2023 and 2025, with the total number of members identified with one or more of the top ten conditions increasing from 81,089 in 2023 to 105,511 in 2024 and 108,470 in 2025. This represents an increase of 30.1% from 2023 to 2024 and an additional 2.8% increase from 2024 to 2025, indicating a continued rise in documented health conditions despite a slight decline in overall child and adolescent membership.

Other upper respiratory diseases remained the most prevalent condition across all three years, affecting 20,491 members in 2025 compared with 20,639 in 2024 and 25,395 in 2023. Although the number of affected members declined from 2023, it continues to represent the largest disease burden within the pediatric population.

Several chronic conditions demonstrated steady year-over-year growth. Obesity increased from 6,926 members in 2023 to 17,527 in 2024 and 17,791 in 2025, more than doubling over the three-year period. Similarly overweight prevalence increased 2.96% in 2023 to 9.96% in 2024 and 10.96% in 2025. These findings suggest a growing burden on weight related health conditions among children and adolescents.

Behavioral health conditions also continued to increase. ADHD/Childhood disorders rose from 9,242 members in 2023 to 10,852 in 2024 and 10,882 in 2025. Anxiety disorders increased from 5,997 members in 2023 to 6,933 in 2024 and 7,471 in 2025, while serious emotional disturbance nearly doubled from 3,836 members in 2023 to 6,753 in 2024 and 7,373 in 2025. These trends highlight the continued need for behavioral health screening, early intervention and access to pediatric mental health services.

Other chronic conditions also demonstrated gradual increases. Hyperlipidemia increased from 5,034 members in 2023 to 5,791 in 2024 to 7,105 in 2025, while asthma increased from 5,077 members in 2023 to 5,798 and a slight decrease to 5,787 in 2025. Abdominal Pain remained relatively stable, increasing slightly from 2023 (10,686) to 11,361 in 2025. Other lower respiratory diseases remained stable overall, with prevalence fluctuating only slightly over the three-year period.

4. Child & Adolescent Race

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Membership by Race/Ethnicity 2025						
Race	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
African American/Black	24,273	16.43%	25,278	16.41%	23,914	16.54%
Caucasian/ White	39,180	26.52%	40,568	26.33%	37,479	25.92%
Asian/Pacific Islander	2,430	1.64%	2,474	1.61%	2,227	1.54%
American Indian or Alaskan Native	243	0.16%	282	0.18%	266	0.18%
Hispanic	40,694	27.54%	44,086	68.61%	45,831	31.70%
Unknown/Not Reported	29,396	19.90%	30,473	19.78%	24,402	16.88%
Total Members	147,746		154,079		144,584	

Child & Adolescent Race Quantitative Analysis

The racial composition of child and adolescent membership remained relatively stable from 2023 to 2025, despite an overall decline in total membership in 2025.

- Hispanic members represented the largest racial group across all three years, although membership declined from 45,831 members in 2023 to 44,086 in 2024 and 40,694 in 2025.

- Caucasian members remained the second-largest group and increased slightly between 2023 (37,479) and 2024 (40,568) before decreasing to 39,180 in 2025.
- African American/Black membership remained relatively consistent, increasing from 23,914 members in 2023 to 25,278 in 2024, followed by a slight decrease to 24,273 in 2025.
- Unknown/Not reported race increased from 24,402 members in 2023 to 30,473 in 2024and remained relatively high at 29,396 in 2025, indicating that a notable portion of the child and adolescent population continues to have incomplete race and ethnicity data.
- Asian/Pacific Islander membership remained stable with 2,227 members in 2023, 2,474 in 2024 and 2,430 in 2025.
- American Indian or Alaskan Native members represent the smallest population, remining below 300 members each year (266 in 2023, 282 in 2024 and 243 in 2025).

Overall, the child and adolescent population continued to be primarily composed of Hispanic, White and African American/Black members. While most racial and ethnic groups experienced a modest decline in 2025, the overall distribution remained consistent across the three-year period. The persistent proportion of members with Unknown/Not reported race highlights and opportunity improve demographic data collection, which can strengthen health outcomes analyses and support targeted interventions.

5. Child & Adolescent Language

Data Location: https://tableau.aetna.com/t/MedicaidInformatics/views/PopulationAssessment/Demographics

Child & Adolescent Language Reported 2025							
Language		2025		2024		2023	
		# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
1	English	112,816	76.36%	117,345	76.16%	110,618	76.51%
2	Spanish	32,035	21.68%	33,958	22.04%	31,864	22.04%
3	Unknown	2,595	1.76%	2,439	1.58%	1,809	1.25%
4	Other	300	0.20%	337	0.22%	293	0.20%
Total		***147,746***		***154,079***		***144,584***	

Child & Adolescent Language Quantitative Analysis

The preferred language of the child and adolescent population remained relatively stable from 2023 through 2025. English continued to be the predominant preferred language, 111,618 members in 2023, 117,345 members in 2024, and 112,816 members in 2025. Although the total number of English-speaking members declined in 2025 due to an overall decrease in membership, the proportion of member speaking English remained consistent. Spanish remained the second most common preferred language. Membership increased from 31,864 members in 2023 to 33,958 members in 2024, before declining slightly to 32,035 members in 2025. Despite the decrease in membership, Spanish-speaking members continued to represent more than one-fifth of the child and adolescent population, demonstrating the continued need for bilingual communication and culturally appropriate services.

Overall Child & Adolescent Qualitative Analysis

The child and adolescent population remained the largest segment of Aetna Better Health of Florida's membership throughout the 2023 – 2025 reporting period. While overall membership increased in 2024 a modest decline occurred in 2025, however, the demographic characteristics of this population remained largely consistent over the three-year period.

The gender distribution remained evenly balanced, with male and female membership representing nearly equal proportions of the population each year. Racial and ethnic diversity continued to characterize the child adolescent membership, with Hispanic members representing the largest racial group followed by White and African American/Black members. The proportion of members with unknown or unreported race remained notable, highlighting an opportunity to improve demographic data collection and enhance health outcome analyses.

The child and adolescent population continue to experience a substantial burden of both acute and chronic health conditions, with respiratory illnesses, obesity related diagnosis, behavioral health conditions, and developmental disorders representing the most prevalent health concerns. Although overall child and adolescent membership declined slightly between 2024 and 2025, the total number of documented conditions increased, suggesting a growing complexity of health care needs with the pediatric population.

Language preferences remained stable over the reporting period. English continued to be the predominant preferred language, while Spanish represented more than one-fifth of the child and adolescent population, reinforcing the ongoing need for bilingual communications, translated materials, and culturally responsive services. The gradual increase in members with unknown preferred language suggests an opportunity to strengthen language preference documentation to ensure members receive services in their preferred language.

Overall, the child and adolescent population demonstrated stable demographic trends despite fluctuation in total membership. The findings support continued investment in culturally and linguistically appropriate services, targeted health outcome initiatives, and improved demographic data collection to better understand member needs and reduce disparities across the pediatric population.

Serious Mental Illness (SMI) and / or Serious Emotional Disturbance (SED)

Members who meet criteria for serious mental illness (SMI) are those age 18 or over and serious emotional disturbances (SED) are members under the age of 18 at the end of the reporting period with a qualifying diagnosis over the last 12 months and at least one qualifying behavioral health utilization claim or categorized risk. Reporting methodology was enhanced for calendar year 2025 to help better identify areas of potential need.

1. SMI Prevalence by County

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

SMI Top 5 Counties 2025						
County	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
Miami-Dade	3,279	43.15%	4,230	54.57%	3,256	47.09%
Orange	1,133	14.91%	818	10.55%	842	12.18%
Hillsborough	825	10.86%	700	9.03%	711	10.28%
Brevard	622	8.19%	536	6.92%	575	8.32%
Polk	538	7.08%	446	5.75%	441	6.38%

SMI Top 5 Counties 2025						
County	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
Total	***6,397***		***6,730***		***5,825***	

SMI Prevalence by County Quantitative Analysis

In 2025, Aetna Better health of Florida identified 6,397 members with a Serious mental Illness (SMI), representing a decrease from 6,730 member in 2024 but an increase from 5,823 members in 2023. Miami-Dade County continued to have the largest concentration of members with SMI, with 3,279 members although this declined from 4,230 members in 2024. Orange County remained the second-highest county with 1,133 members increasing from 818 members in 2024 and 842 members in 2023. Hillsborough County ranked third with 825 members and an increase from 700 members in 2024 and 711 members in 2023. Brevard County reported 622 members compared to 536 members in 2024 and 575 members in 2023. Polk County completed the top five with 538 members, increasing from 446 members in 2024 and 441 members in 2023. Overall, while total SMI membership declined slightly between 2024 and 2025, the geographic distribution became less concentrated in Miami-Dade, with proportionally higher representation observed across Orange, Hillsborough, Brevard, and Polk counties. This suggests a broader distribution of members with SMI across multiple service areas and highlights the continued need for behavioral health resources throughout the High-volume counties. SMI refers to mental illnesses that substantially interfere with life activities and often require ongoing behavioral health treatment and support.

2. SMI by Race / Ethnicity

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

SMI by Race / Ethnicity 2025						
Race	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
African American/Black	1,098	14.45%	883	11.39%	900	13.31%
Caucasian/ White	2,369	31.18%	2,113	27.26%	1,943	28.10%
Asian/Pacific Islander	62	0.82%	44	0.57%	39	0.56%
Hispanic	1,841	24.23%	2,199	28.37%	2,139	30.94%
Unknown/Not Reported	1,763	23.20%	1,979	25.53%	1,460	21.12%
Total Members	7,133		7,218		6,481	

SMI by Race/Ethnicity Quantitative Analysis

In 2025, members identifying as Caucasian/white represented the largest proportion of the SMI population with 2,369 members, increasing from 2,113 members in 2024 and 1,943 members in 2023. This reflects a steady increase in the SMI population. The Hispanic population was the second largest group among members with SMI

in 2025, accounting for 1,841 members a decrease from 2,199 members in 2024 and 2,139 members in 2023. Although Hispanic members remained a significant portion of the SMI population, members with SMI showed a decline over the three-year period. Members with Unknown/Not reported represented 1,763 members in 2025, compared with 1,979 members in 2024, and 1,460 members in 2023. While there was a decrease from 2024, it remained higher than 2023, indicating continued opportunities to improve data collection. The African American/Black population increased to 1,098 members in 2025 from 883 members in 2024 and 900 members in 2023. This represents growth of the SMI population compared to prior years. The Asian/Pacific Islander population remained the smallest group across all three years increasing slightly from 39 members in 2023, to 44 members in 2024 and 62 members in 2025.

Overall, the SMI population remained relatively stable over the three-year period, with 6,481 members in 2023, 7,218 members in 2024, and 7,133 members in 2025. The racial distribution shifted modestly, with increases among White and Black members and decreases among Hispanic members, while the proportion of members with Unknown/Not Report race remained substantial highlighting the continued importance of improving demographic data collection.

11. SED Prevalence by County

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

SED Top 5 Counties 2025						
County	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
Miami-Dade	1,999	25.37%	2,000	28.01%	1,453	34.79%
Orange	904	11.47%	746	10.48%	473	11.33%
Hillsborough	634	8.05%	514	7.20%	301	7.21%
Polk	511	6.49%	433	6.06%	236	5.65%
Osceola	503	6.38%	362	5.07%	251	6.01%
Total	***4,551***		***4,055***		***2,714***	

SED Prevalence by County Quantitative Analysis

The distribution of members diagnosed with Serious Emotional Disturbance (SED) remained concentrated In small number of counties throughout the 2023 – 2025 period. Miami-Date County consistently had the highest number of members with SED, increasing from 1,453 in 2023 to 2,000 in 2024, with a slight decrease 1,999 in 2025. Orange County had the second-highest SED population increasing from 732 members in 2023 to 746 in 2024 and 904 in 2025. This reflects an overall increase from 2023 to 2025, with the largest growth occurring between 2024 – 2025. Hillsborough County demonstrated consistent year-over-year growth, increasing from 301 members in 2023 to 514 in 2024 and 634 in 2025. This represents the largest proportional increase among the top counties, with SED prevalence more than doubling over the three-year period. Polk County also experienced steady growth, rising from 236 members in 2023 to 433 in 2024 and 511 in 2025, representing an increase during the three-year period. Osceola County also had an increase of members with SED 251 in 2023, to 362 in 2024 and 500 in 2025.

Overall, the data demonstrate that Miami-Dade Consistently accounted for the largest SED population, while Hillsborough, Polk, and Osceola experienced the most substantial rates of growth. These findings suggest an

increasing concentration of SED members across several counties, highlighting the importance of continued behavioral health resources allocation and targeted interventions in these high-burden areas.

12. SED by Race / Ethnicity

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence]

SED by Race / Ethnicity 2025						
Race	2025		2024		2023	
	# of Members	% of Membership	# of Members	% of Membership	# of Members	% of Membership
African American/Black	1,085	2.95%	957	2.47%	629	1.55%
Caucasian/ White	2,461	4.25%	2,089	3.52%	1,078	1.90%
Asian/Pacific Islander	68	2.16%	56	1.74%	28	0.89%
American Indian or Alaskan Native	19	5.76%	13	3.56%	6	1.57%
Hispanic	2,269	4.19%	2,273	3.71%	1,526	2.16%
Unknown/Not Reported	1,558	4.13%	1,442	3.80%	665	2.14%
Total Members	7,460		6,830		3,932	

SED by Race/Ethnicity Quantitative Analysis

The number of members identified with Serious Emotional Disturbance (SED) increased from 3,932 in 2023 to 6,830 in 2024 and 7,460 in 2025. Caucasian/White members represented the largest identified racial group with 2,461 members, followed by African American/Black members with 1,085. Hispanic members account for 2,269 members, while 1,558 members had an unknown or unreported race/ethnicity.

All reported racial/ethnic categories increased in member count from 2024 to 2025. The percentage of membership with SED also increased across each group compared with 2024. Overall, the data demonstrates a continued upward trend in identified SED prevalence across the population, indicating a need for continued monitoring of behavioral health needs and potential disparities among racial and ethnic groups.

Overall, SMI and SED Qualitative Analysis

The SMI and SED data demonstrate a continued need for behavioral health services across the membership.

The SMI and SED data demonstrate a continued and increasing need for accessible, coordinated, and culturally responsive behavioral health services across the membership. Although the total number of members identified with SMI decreased slightly from 7,218 in 2024 to 7,133 in 2025, it remained higher than the 2023 total of 6,481. In contrast, the number of members identified with SED increased substantially from 3.932 in 2023, to 6,830 in 2024 and 7,460 in 2025. These trends suggest that behavioral health needs remain significant and support continued monitoring of screening, diagnosis, service utilization, care coordination, and treatment capacity.

Geographic trends indicate that Miami-Dade, Orange, Hillsborough, Brevard, and Polk counties account for the largest concentrations of members with SMI and SED. Miami-Dage continued to have the highest number of affected members, although its percentage of identified population declined for both conditions, for SMI, Miami-Date decreased from 4,230 members in 2024 to 3,279 in 2025. While Orange, Hillsborough, Brevard, and Polk experienced increases. For SED, Miami-Dade remained nearly unchanged at approximately 2,00 members from 2024 to 2025, while Orange, Hillsborough, Polk and Osceola continued to increase. This Pattern indicates that behavioral health needs remain concentrated in Miami-Dade but are becoming more broadly distributed across other high-volume counties.

The race/ethnicity findings further demonstrate the importance of culturally and linguistically appropriate behavioral health services. In 2025, Caucasian/White members represented the largest reported SMI group followed by Hispanic and African American/Black members. For SED, the highest members counts were also reported among Caucasian/White and Hispanic members, followed by African American/Black members. SED prevalence increased across each reported racial and ethnic category from 2024 to 2025. The number of members with an Unknown/Not reported race or ethnicity also remains a limitation. In 2025, this category included 1,763 members with SMI and 1,558 members with SED. Missing demographic information reduces e ABHFL's ability to accurately compare outcomes, identify disparities, and design targeted interventions. Continued efforts to improve race, ethnicity, and language data collection and validation may strengthen future analyses and allow resources to be directed more precisely.

Overall, continued collaboration among Behavioral Health, Care Management, Quality Management, and the provider network is important to support timely access to culturally responsive behavioral health services. Ongoing monitoring of SMI and SED trends by geography and race/ethnicity can help identify barriers, guide resource allocation, and support targeted interventions for populations with the greatest behavioral health needs.

Disabilities

1. Members with Disabilities

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Members with Disability			
	2025	**2024**	**2023**
# Members	9,703	8,321	9,972
% of Total Membership	4.61%	3.95%	4.74%

2. Top 10 Conditions with Disability Prevalence

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Disability Condition Prevalence 2025						
Condition	**2025**		**2024**		**2023**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
Hyperlipidemia	3,692	38.05%	2,463	29.60%	2,608	26.15%
HTN	3,635	37.46%	2,622	31.51%	2,757	27.65%
Obesity	2,322	23.93%	1,669	20.06%	1,428	14.32%
Anxiety Disorders	1,674	17.25%	868	10.43%	889	8.91%
Gastro-Duodenal Ulcer and Inflammation	1,610	16.59%	987	11.86%	1,073	10.76%
Conduction Disorders	1,566	16.14%	1,003	12.05%	1,135	11.38%
Overweight	1,524	15.71%	1,160	13.94%	611	6.13%
Diabetes	1,515	15.61%	1,007	12.10%	1,099	11.02%
Spondylosis, Intervertebral Disc. Disorders, Other Back Problems	1,510	15.56%	930	11.18%	1,093	10.96%
Depression	1,504	14.52%	421	5.06%	403	4.04%
Total	***20,552***		***13,130***		***18,496***	

Disability Condition Prevalence Quantitative Analysis

The three-year disability condition prevalence data demonstrates an overall increase across the leading condition from 2023 through 2025. Hyperlipidemia was the most prevalent condition in 2025, increasing from 2,608 members in 2023 to 2,463 in 2024 and 3,692 in 2025. HTN (hypertensions) increased from 2,767 members in 2023 to 2,622 in 2024 and 3,635 in 2025. obesity increased from 1,428 members in 2023 to 1,669 in 2024 and 2,322 in 2025, while anxiety disorder increased from 889, members in 2023 to868 members in 2024 and 1,674 in 2025. Gastro-duodenal ulcer and inflammation increased from 1,073 members in 2023 to 987 in 2024 and 1,610 in 2025, Additional conditions also demonstrated notable increases. Conduction disorders increased from 1,135 members in 2023 to 1,003 in 2024 and 1,566 in 2025. Overweight showed substantial growth increasing from 611 members in 2023 to 1,160 in 2024 and 1,524 in 2025. Diabetes increased from 1,099 members in 2023 to 1,007 in 2024 and 1,515 in 2025. spondylosis, intervertebral disc disorder and other back problems increased from 1,093 members in 2023 to 930 in 2024 and 1,510 in 2025. Depression demonstrated one of the highest pronounce increases, rising from 403 members in 2023 to 421 in 2024 and 1,504 in 2025.

Overall, the data shows that although several conditions experienced slight decreases in member counts between 2023 to 2024. Prevalence percentages generally increased, followed by substantial increases across all listed conditions in 2025. Hyperlipidemia and hypertension remained the leading conditions, while the

significant growth in obesity, overweight, anxiety disorders, and depression highlights an increasing burden of both physical and behavioral health conditions within the disability population.

3. Top Disability Conditions by Race / Ethnicity

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

Disability by Race / Ethnicity 2025			
Race	**HTN**	**Hyperlipidemia**	**Obesity**
African American/Black	593	593	327
Caucasian/ White	597	523	276
Asian/Pacific Islander	53	61	32
American Indian or Alaskan Native	2	3	3
Other Race	597	523	276
Hispanic	645	655	320
Unknown/Not Reported	1,255	1,188	738
Total Members	3,742	3,546	1,972

Disability by Race / Ethnicity 2025						
	HTN		**Hyperlipidemia**		**Obesity**	
	# of Members	**% of Membership**	**# of Members**	**% of Membership**	**# of Members**	**% of Membership**
African American/Black	593	30.03%	593	30.03%	327	16.56%
Caucasian/ White	597	34.95%	523	30.23%	276	16.16%
Asian/Pacific Islander	53	37.86%	61	43.57%	32	22.86%
American Indian or Alaskan Native	2	14.29%	3	21.43%	3	21.43%
Other Race	597	34.95%	523	30.62%	276	16.16%
Hispanic	645	33.33%	655	33.85%	320	16.54%
Unknown/Not Reported	1,255	22.71%	1,188	21.49%	738	13.35%
Total Members	3,742		3,546		1,972	

Top Disability Conditions by Race/Ethnicity Quantitative Analysis

The 2025 disability population demonstrated variation in the prevalence of the three leading conditions across race/ethnicity groups. HTN (Hypertension) was the most prevalent condition overall affecting 3,742 members, followed by hyperlipidemia with 3,546 members and obesity with 1,972 members. For HTN, the largest number

of members were classified as Unknown/Not reported (1,255), followed by Hispanic member (645), Caucasian/White and other race members (597 each) and African American/Black members (593). For hyperlipidemia, Unknown/Not Reported members represented the largest group (1,188), followed by Hispanic members (655), African American/Black members (593), and Caucasian/Whie and Other Race members (523). Obesity affected 1,972 members, with the highest number again among Unknown/Not Reported members (738). Among members with a reported race/ethnicity, African American/Black member had the highest obesity count (327), followed closely by Hispanic member (320). Caucasian/White and Other Race members each accounted for 276 members. Overall, HTN represented the highest-volume disability condition in 2025, while the substantial proportion of member categorized as Unknown/Not Reported across all three conditions limits the ability to fully assess differences by race and ethnicity.

Overall Disability Qualitative Analysis

Review of the disability population data indicates that chronic conditions continue to represent a significant health burden with the disability population, with hyperlipidemia, HTN (Hypertension, obesity, anxiety disorders, and gastrointestinal conditions among the most prevalent diagnoses. The three-year trend demonstrates increases in several leading conditions in 2025, particularly hyperlipidemia, HTN, obesity, and anxiety disorders. These findings suggest an ongoing need for chronic condition management, preventive care, behavioral health support and member education, focused on modifiable risk factors.

The race and ethnicity analysis identified differences in the distribution of the leading disability conditions. Hispanic, African American/Black and Caucasian/White members were represented across hypertension, hyperlipidemia and obesity, supporting the continued importances of culturally and linguistically appropriate outreach and interventions. However, a substantial number of members with these conditions were categorized as Unknown/Not Reported race or ethnicity, which limits the ability to fully evaluate potential disparities and identify populations that may benefit from targeted interventions.

Overall, the finding support continued monitoring of disability condition prevalence and utilization trends, with emphasis on early identification, care coordination, medication adherence, lifestyle and weight management, and behavioral health integration. Continued efforts to improve the completeness of race and ethnicity data may also strengthen future disparity analyses and help the health plan better identify opportunities for targeted equitable interventions with the disability population.

Inpatient Utilization

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/InpatientAuths

Readmission Rates 2025			
	2025	**2024**	**2023**
# of Admissions	8,553	7,654	8,428
# of Readmissions	946	760	1,015
Readmission Rate	11.06%	9.93%	12.04%

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/InpatientAuths

Top Ten Diagnoses for Inpatient Admissions 2025						
Diagnosis	**2025**		**2024**		**2023**	
	Admission Count	**Auths / 1000 mbrs**	**Admission Count**	**Auths / 1000 mbrs**	**Admission Count**	**Auths / 1000 mbrs**
Encounter for Full-Term Uncomplicated Delivery	1,369	7.7	1,337	7.7	1,446	7.9
Encounter for CD without Indication	734	4.1	670	3.8	794	4.4
Major Depressive Disorder Recurrent	425	2.4	301	1.7	340	1.9
Major Depressive Disorder Single Episode	386	2.2	334	1.9	309	1.7
Persistent Mood Affective Disorders	249	1.4	203	1.2	214	1.2
Encounter for Supervision of Normal Pregnancy	172	1.0	129	0.7	-N/A	N/A
Weeks of Gestation	145	0.8	153	0.9	-N/A	N/A
D/O Newborn Rel Shor Gest & LW Birth Weight NEC	151	0.9	126	0.7	147	0.8
Abdominal and pelvic Pain	136	0.8	N/A	N/A	164	0.9
Bipolar Disorder	134	0.8	N/A	N/A	N/A	N/A
Total	***3,901***		***3,253***		***3,414***	

**Certain fields are blank (N/A) because there were no cases or data to report for the specific diagnosis during that timeframe.*

Inpatient Quantitative Analysis

Inpatient utilization data for calendar years 2023 through 2025 demonstrates changes in both the volume and composition of inpatient admissions. Among the top diagnoses, Encounter for full-term uncomplicated delivery remained the leading inpatient diagnosis across all three years, with 1,446 admissions in 2023, decreasing to 1,337 in 2024 and increasing slightly to 1,369 in 2025. Encounter for cesarean deliver (CD) without Indication was the second-highest diagnosis, decreasing from 794 admissions in 2023 to 670 in 2024 before increasing to 734 in 2025. Behavioral health diagnoses also represented a notable portion of inpatient utilization. Major depressive disorder, recurrent increased from 340 admissions in 2023 to 301 in 2024 and then rose substantially to 425 in 2025. Major depressive disorders, single episodes increased consistently from 309 admissions in 2023 to 334 in 2024 and 386 in 2025, while persistent mood affective disorders increased from 214 in 2023 to 203 in 2024 and 249 in 2025. In 2025, bipolar disorder also entered the top diagnoses with 134 admissions. These results indicate an increasing contribution of behavioral health condition to inpatient utilization in 2025. Other leading 2025 diagnoses included encounter for supervision of normal pregnancy with 172 admissions, disorders of newborn related to short gestation and low birth weight with 151 admissions, weeks of gestation with 145 admissions and abdominal and pelvic pain with 136 admissions. Overall, the top diagnoses accounted for 3,414 admissions in 2023, 3,253 in 2024 and 3,901 in 2025, representing a 4.7% decrease from 2023 to 2024 followed by a 19.9% increase from 2024 to 2025.

Overall inpatient admissions, however, declined across the three-year period, from 8,446 in 2023 to 7,643 in 2024 and 7,248 in 2025. The 2025 admission rates remained below the 2023 level, the increase from 2024 to 2025 indicates an opportunity for continued monitoring of transition of care, discharge planning, and conditions contributing to repeat inpatient utilization. Overall, the data demonstrate declining total inpatient admissions over the three-year period while showing increased utilization among the top diagnoses in 2025, particularly maternity-related and behavioral health conditions.

Inpatient Qualitative Analysis

Overall inpatient admissions declined from 2023 through 2025, suggesting a positive trend in reducing inpatient utilization. However, the continued presence of maternity-related conditions among the leading diagnoses indicates that pregnancy, delivery and postpartum care remain significant drivers of inpatient admissions. This highlights the importance of early and consistent prenatal care, identification and management of high-risk pregnancies, postpartum follow-up, and coordination between maternity providers, primary care providers and care management. The increase in behavioral health diagnoses in 2025 represents an area requiring continued monitoring a targeted intervention. This trend may indicate a growing need for timely behavioral health screening, improved access to outpatient treatment, medication management, crisis support, and coordination between behavioral and physical health providers. Strengthening these services may help members manage their conditions in outpatient settings and reduce preventable emergency department visits and inpatient admissions.

Although readmissions remained below the 2023 level, the increase from 2024 to 2025 identifies an opportunity to strengthen transition of care. Key areas of focus include timely discharge planning, medication management, member education, communication of discharge plan to outpatient providers, and follow-up appointments within recommended time frames. Additional outreach to members with Behavioral health conditions, high-risk pregnancies, complex medical needs, or barriers to care may help identify unmet needs following discharge. Continued monitoring of behavioral health and maternity admissions, readmission patterns, and post-discharge follow-up will help identify opportunities for targeted interventions. Enhancing care management engagement and coordination across inpatient, outpatient, behavioral health, and maternity services may improve continuity of care, support better health outcomes, and reduce potentially avoidable inpatient utilization.

Subpopulations

Defined Subpopulations 2025			
Subpopulations	**2025**	**2024**	**2023**
	# of Members	**# of Members**	**# of Members**
Diabetes	5,498	4,940	5,177
Pregnancy	6,114	6,545	6,342

1. **Diabetes**

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/PopulationAssessment/ConditionPrevalence

2025 Diabetes by Age Band 2025			
Age Bands	**# Members**	**% of Diabetic Population**	**% of Age Group**
Age <1	2	0.04%	0.01%
Age 1-4	13	0.24%	0.06%
Age 5-14	274	4.98%	0.98%

Age 15-24	297	5.40%	2.69%
Age 25-44	722	13.13%	18.97%
Age 45-64	1,648	29.97%	51.46%
Age >=65	2,542	46.23%	25.83%
Total Subpopulation	5,542		

2025 Diabetes by Race / Ethnicity 2025			
Race/Ethnicity	**# of Diabetics**	**% of Diabetic Population**	**% of Group**
American Indian/ Alaska Native	**6**	**0.11%**	**1.80%**
Asian/Pacific Islander	**120**	**2.18%**	**3.70%**
Black African American	**1,092**	**19.86%**	**2.91%**
White	**1,381**	**25.12%**	**2.22%**
Hispanic	**400**	**7.28%**	**0.78%**
Unknown	**2,499**	**45.45%**	**6.68%**
Total	**5,498**		

Quantitative Analysis

The diabetes subpopulation demonstrated variation across the three-year period. In 2023, 5,177 members were identified with diabetes. This decreased to 4,940 members in 2024, a reduction of 237 members (4.6%). In 2025, the diabetic population increased to 5,498 members, an increase of 558 members (11.3%) from 2024 and 321 (6.2%) members compared with 2023. This upward trend demonstrates the continued relevance of diabetes to overall ABH FL population.

Diabetes is an important chronic condition because it requires ongoing monitoring and treatment and may lead to costly complication when it is not effectively managed. The increase in members with diabetes may contribute to a greater demand for primary care, medication management, laboratory testing specialist services, and care-management support.

In 2025, diabetes was most prevalent among older members. Members age 65 and older accounted for 46.23% of the diabetic population, followed by members ages 45-64 at 29.97% and ages 25-44 at 13.13%. Together, members age 45 and older represented approximately 76.2% of the diabetic population, indicating that diabetes prevention and management efforts should place particular emphasis on middle-aged and older members.

By race/ethnicity in 2025, Unknown represented the largest proportion at 45.45% followed by White members at 25.12% and Black/African American members at 19.86%. Hispanic members accounted for 7.28%, Asian/Pacific islander members 2.18% and American Indian/Alaska Native members 0.11%. The large percentage of members with unknown race may limit the ability to identify disparities accurately and highlights and opportunity to improve demographic data collection.

2. Pregnancy

Data Location:
https://tableau.aetna.com/#/site/MedicaidInformatics/views/MaternityReport/ChildbirthDelivery

2025 Pregnancy: Delivered 2025					
Age	**# FCBA**	**% of All FCBA**	**# Deliveries**	**% of All Deliveries**	**% FCBA with a Delivery**
<20	25,480	12%	191	4.48%	0.31%
20-24	4,500	64%	850	19.95%	1.38%
25-29	6,813	81%	1,299	30.49%	2.11%
30-34	8,242	79%	1,131	26.55%	1.84%
35-39	7,691	74%	644	15.12%	1.05%
40+	8,815	20%	145	3.40%	0.24%
Total	**61,541**		**4,260**		**6.92%**

2025 Pregnancy by Race / Ethnicity 2025					
Race/Ethnicity	**# Deliveries**	**% of Deliveries**	**# High-Risk Deliveries**	**% of Deliveries that were High-Risk**	**% of All High-Risk Deliveries**
American Indian/ Alaska Native	7	0.16%	5	71.4%	0.20%
Asian/Pacific Islander	33	0.78%	19	57.6%	0.75%
Black African American	1,189	27.96%	786	66.1%	30.96%
Hispanic (Ethnicity)	1,171	27.54%	673	57.5%	26.49%
White	1,457	34.27%	832	57.1%	32.74%
Unknown	21	0.49%	15	71.4%	0.59%

Total	**3,878**		**2,330**		

Quantitative Analysis

In Calendar year 2025, ABH FL reported 3,878 deliveries among members with available race and ethnicity data. Of these, 2,330 were classified as High-risk, resulting in an overall high-risk delivery rate of 60.1%. This indicates that approximately three out of every five deliveries required an elevated level of clinical monitoring, care coordination, or specialized maternity services.

White members accounted for the largest number of deliveries, with 1,457 deliveries, representing 34.27% of all deliveries. Of these, 832 were high-risk, resulting in a high-risk rate of 57.1%. White members accounted for 32.74% of all high-risk deliveries.

Black African American members accounted for 1,189 deliveries of 27.96% of all deliveries. Among these deliveries, 786 were classified as high-risk, producing a high-risk rate of 66.1%. This was 9.0 percentage points higher than the rate among White members and 8.6 percentage points higher than the rate among Hispanic members. Black/African American members represented 30.96% of all high-risk deliveries, which was 3.0 percentage points higher than their share of total deliveries. This disproportionate representation indicates an area for continued monitoring and targeted intervention to address potential maternal health disparities.

Hispanic members accounted for 1,171 deliveries, representing 27.54% of all deliveries. Of these, 673. Were High-risk, resulting in a high-risk, resulting in high-risk rate of 57.5%. Hispanic members accounted for 26.49% of all high-risk deliveries.

Asian/Pacific Islander members accounted for 33 deliveries, including 19 high-risk deliveries, resulting in a high-risk rate of 57.6%. American Indian/Alaska Native members accounted for seven deliveries, five of which were high-risk, resulting in a rate of 71.4%. members of an unknown race or ethnicity accounted for 21 deliveries, including 15 high-risk deliveries, also resulting in a rate of 71.4%.

Pregnancy is highly relevant to ABH FL's overall population because maternity care affects maternal and infant health outcome, health care utilization and total cost of care. With 60.1% of the reported deliveries identified as high-risk, pregnancy represents a significant opportunity for early identification and care management. High-risk pregnancies may require more frequent prenatal visits, specialist care, diagnostic testing, hospitalization, neonatal intensive care, and postpartum follow-up, making them more cultically complex and potentially more costly than lower-risk pregnancies. The higher high-risk rate among Black/African American members further supports the need for culturally responsive outreach, early prenatal care, identification of social barriers, maternal care management, and focused efforts on reduce racial and ethnic disparities. Continued monitoring can help ABH FL direct resources toward population with the greatest needs and improve maternal and infant outcomes.

Overall Subpopulations Qualitative Analysis

Overall, the subpopulation analysis demonstrates opportunities to continue targeted monitoring and interventions for members with higher health risks and potential disparities. Chronic conditions, including diabetes, remain an important area of focus, with variations across racial and ethnic populations indicating the need for continued culturally responsive education, preventive care, and chronic disease management.

The pregnancy analysis also identified differences in maternal risk. While deliveries were primarily concentrated among members ages 25-34, Black/African American members had the highest high-risk delivery rate among the major racial /ethnic groups at 66.1%, compared with 57.5% for Hispanic members and 57.1% for White members. This finding supports continued evaluation of maternal health outcomes and potential disparities.

Overall, the finding support continued monitoring of subpopulation trends and targeted strategies to improve access to preventive service, strengthen care management, address identified disparities, and promote equitable health outcomes across the membership.

Risk Stratification / Segmentation

1. Consolidated Outreach and Risk Evaluation (CORE 2.0)

Data Location: QNXT / Analytical Services Database (ASDB) Risk Stratification 2025				
	2024		**2025**	
Risk Category	**# of Members**	**% of Membership** (n =221,592)	**# of Members**	**% of Membership** (n =210,436)
Low	319,370	96.0%	281,557	94.8%
Medium	10,940	3.3%	12,918	4.4%
High	2,248	0.7%	2,458	0.8%
Total Core	**332,558**	**100%**	**296,933**	**100%**
Not Stratified	**335,605**	-	**308,431**	-

2. Program Segmentation

Aetna Better Health currently administers a Population Health Management Strategy to manage the needs of members. Current health plan programs and their eligibility are contained within the table below. The focused areas of each program are:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety and Outcomes across Settings
4. Managing Multiple Chronic Conditions

Data Location: QNXT / Analytical Services Database (ASDB)

Focus Area	Program services	Subpopulation Managed	2025 Program Eligibility	% of Total Health Plan Enrollment (n=210,436)
1	Healthy Kids	Members between 1 month and 20 Years of age	230,954	74.9%
1	Maternal Care	Pregnant women and newborns through age 1 year	4,771	1.5%
1	Neonatal Abstinence	Pregnant females who use or are addicted to opiates.	60	0.02%
1	Healthy Behaviors: Tobacco Cessation	Members who smoke, use smokeless tobacco, or use electronic cigarettes	6,924	2.1%
1	Healthy Behaviors: Weight Management	Members with =>25 BMI for adults or =>85th percentile for	53,526	17.4%

		children & adolescents		
1	Healthy Behaviors: Substance Use	Members who misuse drugs or alcohol	4,811	1.6%
2	Living with Diabetes	Members with a diagnosis of Diabetes Mellitus	7,614	2.5%
2	Hepatitis C	Members with Hepatitis C	426	0.1%
3	Pharmacy Restriction Access	Members at high risk for overuse or abuse of opioid medications	851	0.3%
3	Appropriate Use of Acute Care	Members who transition from acute settings	1,129	0.4%
4	Intensive Care Management	Members at high CORE 2.0 status and eligible for ICM program	4,932	2.34%
4	Readmission Prevention	All members with a RAP score of 0.5 or higher and subsequently eligible for RAP	168	0.08%
Total Members Eligible for Programs			***308,431***	
***Some members may be represented multiple times if eligible for or enrolled in >1 of these programs.**				

Social Determinants of Health

Data Location: *Socially Determined, US Census, United for ALICE, CDC*

	Economic Climate	Housing	Health Literacy	Social Connectedness	Food Landscape	Digital Landscape	Transportation
USA	39% Median Income $80,734	26.4%	37%	22.3%	30%	13.1%	10.01%
Florida	44.9% Median Income $74,568	17.2%	49.2%	35.1%	32.8%	12.6%	3.8%
County							
Miami-Dade	63%	37%	82%	8%	38%	21%	2%
Orange	41%	18%	33%	10%	34%	14%	4%
Hillsborough	35%	22%	33%	11%	30%	10%	8%
Polk	39%	32%	33%	58%	32%	28%	46%
Osceola	53%	9%	48%	24%	24%	33%	29%

Brevard	23%	16%	13%	31%	33%	10%	22%
Seminole	24%	6%	8%	8%	24%	11%	4%

***** *Percentages in the table are representative of individuals at elevated risk per each domain listed (for example: 63% of Miami-Dade population is at an elevated economic climate risk)*

Source: *Socially Determined*

Quantitative Analysis

The 2026 Key Social Determinants of Health results show measurable variation across the seven assessed counties when compared against the USA and Florida benchmarks. The results reflect county-level risk percentages across Economic Climate, Housing, Health Literacy, Social Connectedness, Food Landscape, Digital Landscape, and Transportation.

Across the assessed domains, county-level results exceeding above the Florida benchmark in select areas, most notably Health Literacy, Social Connectedness, Digital Landscape, Transportation, Housing, and Food Landscape. Among the assessed counties, only Miami-Dade at 63% and Osceola at 53% exceeds Florida's benchmark for Economic Climate, with Miami-Dade also exceeding above the other counties for Economic Climate, Housing, Health, Literacy, and Food Landscape.

Trending results from 2025 to 2026 include the following:

- Housing risk increased in all five comparable counties.
- Digital Landscape risk increased in all five comparable counties.
    - Polk, Orange and Miami-Dade all trended upward with 8, 8, 6 percentage points, respectively.
- Transportation risk increased in all five comparable counties.
    - Polk County increased by 22 percentage points, followed by Brevard's 15 percentage points.
- Economic Climate risk increased in four of five comparable counties, with Polk showing a slight decrease.
- Social Connectedness risk increased in four of five comparable counties and remained unchanged in Hillsborough.
- Food Landscape risk increased in Miami-Dade, Orange and Brevard Counties, remained unchanged in Hillsborough, and decreased in one Polk County.
- Health Literacy showed the least year-over-year movement, with three counties unchanged- Miami-Dade, Orange and Brevard, increased in Polk County, and decreased in Hillsborough County.

Among all the counties listed in the above table, the social domain principal drivers are:

- Principal driver for Economic Climate risk: *Cost of living* (51%), *Income* (49%)
- Principal driver for Housing risk: *Affordability* (54%)
- Principal driver for Food Landscape risk: *Affordability* (83%)
- Principal driver for Transportation Network risk: *Access* (86%)
- Principal driver for Health literacy risk: *Demographics* (55%)
- Principal driver for Digital Landscape risk: *Accessibility* (46%)
- Principal driver for Social Connectedness risk: *Loneliness* (62%)

Collectively, 56.1% of individuals in the assessed counties reside in communities with elevated risk in two or more domains.

Qualitative Analysis

Across Florida, social determinants of health continue to be shaped by rising household costs, housing instability, transportation barriers, and uneven access to resources, despite relatively strong population and employment growth.

- ALICE data estimates that 47% of Florida households are below the ALICE survival threshold, illustrating that financial hardship extends well beyond households classified as living in poverty. ALICE data also reports that Miami-Dade County has the highest cost of living for a family of four in the state. Individuals in Florida spend about 38% of their income on rent, as reported by the US Census. Households that spend over 30% of their income towards rent are cost-burdened, which can impact their ability to afford necessities such as food, healthcare, or savings.

- As of 2024, 15% of the Florida population is food insecure (Feeding America). Hunger can be caused by various conditions, including income instability, environment and access, high cost of living, poverty, and health challenges. Given that 83% listed affordability as their principal driver indicates that the primary barrier is not necessarily food availability, but rather the ability of residents to purchase healthy and nutritious food.

- Digital access is relatively strong across the region, but access does not necessarily translate into digital or health literacy. According to the US Census, 89.7% of Miami-Dade households have a broadband subscription, leaving a meaningful minority without reliable connectivity. The elevated digital risk is Osceola, Polk, and Miami-Dade Counties which can create barriers to telehealth services, online benefits enrollment, patient portals, employment, health information, and social service applications.

- Transportation remains an important consideration across the assessed counties, particularly in larger metropolitan areas and communities with elevated transportation risk. For example, Miami-Dade workers report an average commute of 30.9 minutes, compared to 28 minutes in Orange County, which may contribute to transportation-related challenges for residents with limited flexibility or transportation options (US Census). County-level social risk data further indicates that Polk County demonstrated the highest transportation risk among evaluated counties, suggesting that barriers related to transportation access may affect the ability to reach healthcare appointments, pharmacies, employment opportunities, and social services.

- Social connectedness refers to the quality and diversity of relationships. Social isolation can negatively impact health outcomes by increasing risk for anxiety and depression, type 2 diabetes, heart disease, suicide, and self-harm and premature death (CDC). It can also reduce engagement with healthcare and community resources. According to Socially Determined, Polk County has a 46% elevated risk of social connectedness of the counties listed, followed by Osceola and Brevard counties at 29% and 22%, suggesting residents may experience greater level of social isolation compared to other assessed counties.

Implications

The results indicate that social risks continue to affect a significant portion of the population across multiple domains, particularly Economic Climate, Housing, Food Landscape, Health Literacy, Digital Landscape, Social Connectedness, and Transportation. As more than half of individuals reside in communities with elevated risk in two or more domains, ABHFL will continue to strengthen strategies that address both individual social needs and broader community-level factors that influence health outcomes.

Population Health Management and Care Coordination: ABHFL leverages Population Health Management, Quality Improvement, Behavioral Health, Care Management, Member REACH, Community Development and Community CARES programs, to identify and address social determinants of health impacting members. These programs support referrals, resource navigation, care coordination, and member engagement to help reduce barriers related to economic stability, housing, food security, transportation, health literacy, digital access, and social connectedness.

Community Resources and Partnerships: Aetna Better Health of Florida maintains the Community Resource Directory (CRD) as a centralized repository of community resources, including food assistance, housing and shelter services, transportation, financial assistance, utility support, employment services, and other social supports. In addition, the health plan collaborates with local health departments, community-based organizations, social service agencies, and community initiatives to connect members with resources that address identified social risks and support overall health and well-being.

Economic Self-Sufficiency and Hope Florida Initiatives: ABHFL actively supports economic self-sufficiency efforts through partnership with the Hope Florida initiative- now fully implemented- which focuses on helping individuals and families overcome social and economic barriers and achieve long-term stability. Through coordinated referrals, Care Management integration, Member REACH engagement, and collaboration with Hope Florida Navigators, eligible members are connected to community resources, workforce development opportunities, education support, and other services designed to promote self-sufficiency and improve social and economic outcomes.

Expanded Benefits and Support Services: Aetna Better Health of Florida offers eligible members access to value-added benefits and supportive services that help address identified social needs. Examples include transportation assistance, GED and job skills training, financial literacy resources, legal services related to housing concerns, workforce readiness supports, and other programs designed to enhance member independence, improve access to resources, and support overall well-being.

These results highlight the importance of maintaining a comprehensive approach to addressing social determinants of health through continued investment in community partnerships, social needs screening, care coordination, and resource referral strategies. Ongoing monitoring of county-level trends and principal drivers will help ABHFL refine targeted interventions, enhance existing programs, and ensure members have access to the resources necessary to support their health, well-being, and long-term self-sufficiency. Continued collaboration with community organizations, healthcare providers, and social service partners will further strengthen ABHFL's ability to address emerging needs, reduce barriers to care, and advance equitable health outcomes for the diverse populations it serves.

Analysis of Results

ABHFL assembled a workgroup to further review, discuss, and analyze the data and findings collected for the Population Assessment and the findings of this assessment. The multi-disciplinary team included directors and leaders from all functional areas including plan leadership, chief medical officer and medical directors, and staff from various functional areas, including Director, Medical Management (Care Management and Utilization Management), Senior Manager, Member Services, Senior Director, Quality Management, Lead Director, Behavioral Health, and Lead Director, Informatics. The findings of the work group were reviewed and discussed at the QM/UM Committee (and QMOC).
The workgroup identified key barriers to the adequacy of our PHM program, activities, and resources to meet the needs of our membership and prioritized opportunities and actions for improvement.
The following barriers were identified when analyzing the population characteristics and needs during the measurement period (CY 2025):

- Timeliness of utilization data (up to 3 months lag in claims)
- The overall physical and behavioral health of Medicaid recipients, employment information and other SDoH data are not included with the enrollment file from the state.
- Outdated or limited public data sources used to assess some SDoH factors impacting poverty, food security, transportation and adequate housing assess total community rather than plan membership.

- Availability of self-reported information from members (ethnicity, language, health status/health appraisal)
- Strong privacy laws and internal protocols limit when and how to collect member data related to social and behavioral health.
- Some individuals consider the collection of information such as race, ethnicity, gender identity, sexual orientation, employment information, and other SDoH data an invasion of privacy.
- Some individuals are reluctant to provide information about race, ethnicity, gender identity, sexual orientation or other personal data for fear it will negatively impact their benefits and limit their coverage.
- Availability of systems and processes to adequate to capture information about healthcare equity about our membership and identify how those factors impact the health care needs of our members and their access to care and service.

This Assessment will be repeated annually or when substantial changes are made to the service area or composition of the membership.

Conclusion

The population assessment provides ABHFL with a membership profile illustrating changes in demographics, geographic distribution, language preferences, cultural diversity trends, and changes in age and gender distribution within the health plan. The data is used to ensure that ABHFL programs, services and resources adequately meet members' needs. Based on the annual Population Assessment for CY2025 and the review of its PHM Programs, resources, and activities, and when comparing findings year-over-year, ABHFL found the PHM programs, resources, and activities are adequate and continue to meet the needs its population/membership.
At the present time, there is no need to:

- Modify or change the methods used to identify and categorize at-risk members.
- Add, remove, or modify existing PHM programs (identified in the PHM Strategy) or Care Management services.
- Make changes to the current population health management staffing.
- Change or modify the technology or software applications used for population health management.

ABHFL continues to look for effective and creative ways to train and educate its staff as well as its network practitioners and providers to effectively identify and respond to individuals' needs as well as address the changing health care needs of the entire membership/population. ABHFL continuously designs new training and education programs and venues to maximize the learning experience.

ABHFL continues its efforts to identify and link with the various national, state, and local community resources available to the Florida population and looks for ways to serve the membership in the community where they live.

ABHFL utilizes a variety of data elements to identify network gaps not limited to ratio, time, and distance for physical and behavioral health, both during initial network development and as part of network maintenance. The following core processes facilitate optimal identification of network deficiencies and barriers:

- Quarterly geographical access reports to identify network gaps or barriers.
- Review of enrollee complaints to identify expressed enrollee needs and address them as appropriate. This function is coordinated between Customer Service, Provider Engagement, and Network Management
- SCA and LOA trends
- Provider surveys to identify and report missing data elements.
- Real-time identification of network gaps during daily prior authorization
- Member Requests for assistance to schedule appointments
- Provider Nomination
- Competitor Directory
- Letter of intents (LOIs)

Study Contact

Clinical Health Services: Dominque Alessi-Storms, Director, Principal Clinical, DominqueAlessiStorms@aetna.com
Provider Network: Elba Tapanes, Director, Network Management, TapanesE@aetna.com
Quality Management: Sharon Hatch, Director, Quality Management, HatchS@aetna.com
Social Determinants of Health (SDoH): Tiffinie Bratcher, FL Community Cares Manager, BrratcherT@aetna.com
Utilization Management: Natasha Sealey, Manager Utilization Management, SealeyN@aetna.com

Committee Review

QM/UM Committee:	11/19/2026
QMOC Committee:	09/10/2026

Appendix A – Medicaid Definitions

Acronym	Definition
ABD	Aged Blind and Disabled; not eligible for Medicare/duals
AHCA	The Agency for Health Care Administration
Benchmark	An indicator or performance goal, the industry measure of best performance for a particular process or outcome.
BH	Specialized behavioral health services which include mental health and substance use treatment
CHIP	Children's Health Insurance Program
Cultural Competence	The ability of practitioners and systems to respect and respond to diverse member values, beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.
Culture	The shared values, ideals and beliefs of a group.
DD	Developmentally Disabled
D-SNP	Dual Special Needs Plans
Dual Eligible	Members eligible for both Medicare and Medicaid
Dual Elig LTSS	Members eligible for both Medicare and Medicaid receiving Long Term Services and Support
Duals Demo	Duals Demonstration, Members Eligible for and enrolled in both Medicare and Medicaid
Duals LTSS	Duals Demonstration, Members Eligible for both Medicare and Medicaid received Long Term Services and Supports
Eligible Members	NCQA defines members who meet the criteria for participation in a benefit program or a contracted service.
Equity	NCQA defines equity as developing, strengthening and supporting procedural and outcome fairness in systems, procedures and resource distribution mechanisms to create equitable opportunities for all individuals. Equity and "equitable" are distinct from equality or "equal," which refers to everyone having the same treatment but does not account for different needs or circumstances. Equity focuses on eliminating barriers that have prevented the full participation of historically and currently oppressed groups.
Ethnicity	NCQA defines ethnicity as a shared culture and way of life, especially reflected in language, religion and material culture products, distinct from OMB's use of the term to refer only to Hispanic ethnicity ("Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," IOM, 2003).
Exp	Medicaid Expansion of Traditional TANF coverage
LTSS	Members eligible for Medicaid coverage only receiving Long Term Services and Supports
MDR Only	Member Eligible for Medicare Only
Percentage	A number or ratio that can be expressed as a fraction of 100. Calculation: number divided by whole and multiply by 100
Percentage Rate Change	The value difference between two numbers. Calculation: new value minus old value divided by old value and multiply by 100
Percentage Point Change	The difference between the final and initial values. Calculation: new value minus old value
Qualitative Analysis	NCQA defines qualitative analysis as an examination of the underlying reason for or cause of results, including deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Qualitative analysis draws conclusions about why the results are

	what they are and involves staff responsible for executing a program or process. Also called a causal, root cause or barrier analysis.
Quantitative Analysis	NCQA defines quantitative analysis as a comparison of numeric results against a standard or benchmark, trended over time. Quantitative analysis draws conclusions about what results mean. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends. NCQA does not require that results be trended for First Surveys.
Race	NCQA defines as a biological categorization of genetically transferred physical characteristics (e.g., skin color, eye color, hair color, bone and jaw structure).
SDOH	Social Determinants of Health. Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Star Kids	Medicaid Managed care program that will provide benefits to children and adults 20 and younger who have disabilities
TANF	Temporary Assistance to Needy Families