DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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State Demonstrations Group

JAN 0 5 2016

Mr. Justin Senior
Deputy Secretary for Medicaid
State of Florida, Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

Thank you to you and your staff for your work on the 2014-17 Draft Evaluation Design ("Evaluation") for Florida's section 1115 demonstration, entitled "Florida Managed Medical Assistance Program" (MMA). We are writing to approve the state's latest revision of the Evaluation with only one change which was discussed during the Florida/CMS call on November 3, 2015—that the Evaluation retains the section entitled, "New Domain 16" on p. 53 of the October 14, 2015 revision. A copy of the approved Evaluation is enclosed with this letter.

If you have additional questions or concerns, please contact your assigned project officer, Mr. Adam Goldman. His contact information is as follows:

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Official communications regarding program matters should also be sent simultaneously to Ms. Jackie Glaze, Associate Regional Administrator for our Atlanta Regional Office. Her contact information is as follows:

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We look forward to continuing to work together to ensure that the Florida MMA Evaluation remains focused on its objectives and the results are both meaningful and demonstrable.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc:
Jackie Glaze, ARA, Region IV, CMS Atlanta Regional Office

Florida Medicaid 1115(a) Demonstration Waiver Evaluation Design Update

2014 – 2017

(Revised January 5, 2016)

I. Background

A. Synopsis of the Waiver

The Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" on October 19, 2005. Florida designed Medicaid Reform as a comprehensive demonstration that sought to improve the value of the Medicaid delivery system through several key components: comprehensive choice counseling, customized benefit packages, enhanced benefits for engaging in healthy behaviors, risk-adjusted premiums based on enrollee health status, and a Low Income Pool. Florida initially implemented the program in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay, and Nassau counties on July 1, 2007.

On June 30, 2010, the Agency for Health Care Administration (Agency) submitted a 3-year waiver extension request to maintain and continue operations of Medicaid Reform for the period July 1, 2011 through July 31, 2014. Federal CMS approved the 3-year waiver extension request on December 15, 2011. The waiver extension period is December 16, 2011 through June 30, 2014 with a temporary extension to July 31, 2014. The renewal included several improvements to the demonstration, including enhanced managed care requirements to ensure increased stability across managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans. The renewal included the continuation of the Low Income Pool (LIP) of $1 billion annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations.

On August 1, 2011, Florida submitted an amendment request to Federal CMS to implement the Managed Medical Assistance program as specified in Part IV of Chapter 409, Florida Statutes (F.S.). On June 14, 2013, Federal CMS approved the amendment, along with amended Special Terms and Conditions (STCs), waiver and expenditure authorities. The approved amendment and STCs allowed the state to implement a new statewide managed care delivery system without increasing costs and to continue the Low Income Pool program. The program builds upon the successful elements of the previous demonstration while incorporating stronger protections for consumers, as well as higher standards and more significant accountability measures for plans. The amendment changes the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. MMA program implementation began May 1, 2014 and was completed January 1, 2015. The Medicaid Reform demonstration remained in effect in the five Medicaid Reform counties until the MMA program was implemented. Florida phased out the existing Medicaid Reform program as it implemented the MMA program

in each region of the state, as approved by Federal CMS. The state authority to operate and sunset the Medicaid Reform program is located in Section (s.) 409.91211, F.S.

The MMA program requires most Medicaid eligible individuals to enroll in a capitated managed care plan as a condition for receiving Medicaid. Participation is mandatory for TANF-related populations and the aged and disabled with some exceptions. The MMA program continues to allow plans to offer customized benefit packages and reduced cost-sharing, although each plan is required to cover all mandatory services and all state plan services for children and pregnant women.

On November 27, 2013, Florida submitted a request for a three-year extension to the MMA 1115 waiver demonstration. On July 31, 2014, Federal CMS approved the request, along with newly amended STCs, waiver and expenditure authorities. All future references to the STCs in this document relate to the July 31, 2014 STCs unless otherwise indicated.

B. Key Components and Objectives of the MMA Program

Federal approval of the MMA amendment and the subsequent three-year extension allows Florida Medicaid to move from a fee-for-service system to the MMA program. The MMA program uses market principles to increase quality and control costs. The key components of the program include:

- Choice Counseling, where Medicaid recipients choose plans based upon the strength of their networks, their benefit packages, and their quality scores;
- Competitive procurement of managed care plans, where plans compete with one another on quality and price for the right to serve Medicaid enrollees throughout the state;
- Customized benefit packages;
- Healthy Behaviors programs, that reward and incentivize Medicaid enrollees to engage in healthy behaviors;
- Risk-adjusted premiums based on enrollee health status; and
- The Low Income Pool.

As described in STCs #54-#58 of the MMA Program Demonstration, Choice Counseling services provide MMA program enrollees with full, complete, and impartial information about managed care plan choices, including information on benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. Choice counseling and enrollment information are available on the Agency website and by phone. Choice counseling materials and information may also be provided face-to-face.

Special Terms and Conditions #26-#31 describe the requirements and standards for customized benefit packages. Although capitated plans may provide customized benefit packages for Demonstration enrollees, none of the plans chose to do so. Customized benefit packages are required to include all mandatory services specified in the State

plan for all populations but may alter the amount, duration, and scope of optional services to reflect the needs of the plan's target population. Plans may also offer additional services and benefits not available under the State plan. Customized benefit packages are required to include all State plan services available under the State plan for pregnant women and children, including all EPSDT services for children under age 21.

Prior to the Healthy Behaviors programs being implemented under the MMA program, Medicaid Reform featured an Enhanced Benefits Account Program. As described in the June 14, 2013 STCs #61-#64, the Enhanced Benefits Account Program provides incentives to Medicaid Reform enrollees for participating in particular activities that promote healthy behaviors, such as health screenings, preventive care services, disease or weight management, and smoking cessation programs. Enrollees may have earned up to $125.00 in credits per state fiscal year and may have used those credits to purchase approved health-related products and supplies at Medicaid-participating pharmacies. Individuals who lost Medicaid eligibility or transitioned to an MMA program plan retained access to any accrued funds in an individual enhanced benefit account for a maximum of one year.

Special Terms and Conditions #59-#62 describe the Healthy Behaviors programs under the MMA program. Through its procurement process, the state required the managed care plans operating in the MMA program to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For dually eligible Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, MMA plans are required to coordinate their Healthy Behaviors programs with the Medicare Advantage plan. Florida requires plans to have, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan that meet all state requirements.

The Low Income Pool (LIP), described in the June 14, 2013 STCs #74-#85, is a pool of funds that supports safety net providers that furnish uncompensated care to the Medicaid, underinsured, and uninsured populations. This definition applies through demonstration year 10 (SFY 2015-2016). In demonstration year 11 (2016-2017) the LIP will provide support for safety net providers for the costs of uncompensated care and charity care for low income individuals that are uninsured.

The LIP has a maximum annual allotment of $1 billion total computable for each year of the Demonstration in years 1-8. In DY 9 (SFY 2014-2015), CMS approved a total computable annual allotment of $2.16 billion. For DY 10 (SFY 2015-2016), the approved total computable annual allotment is $1 billion and for DY 11 (SFY 2016-2017) the approved total computable annual allotment is $607,825,452.00 million.

Federal CMS established Tier-One and Tier-Two Milestones for the LIP during the Demonstration, which were outlined in the June 14, 2013 STCs #83-#85. Please note that the Tier-Two Milestones expired June 30, 2014 and therefore have been removed from the evaluation from this date forward. Additionally, the LIP Tier-One Milestones expired June 30, 2015 and have been removed from the evaluation from this date forward. Both Tier-One and Tier-Two Milestones were to be aligned with the overarching goals of CMS' Three-Part Aim: better care for individuals including safety,

effectiveness, patient centeredness, timeliness, efficiency, and equity; better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and reducing per-capita costs.

- Tier-One Milestones included the development and implementation of a State initiative that required Florida to allocate $50 million in total LIP funding in Demonstration Years 7 and 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Other Tier-One Milestones included the State's timely submission of LIP reconciliations and Demonstration deliverables, as well as the development and annual submission of a "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report."
- Tier-Two Milestones applied to the 15 hospitals that were allocated the largest annual amounts in LIP funding. Each of the 15 hospitals was required to select and participate in three initiatives focusing specifically on: infrastructure development; innovation and redesign; and population-focused improvement. In order to receive 100 percent of allocated LIP funding, participating hospitals were required to implement new, or enhance existing, health care initiatives, investments, or activities aimed at meaningfully improving the quality of care and the health of populations served (including low income populations) and meet hospital-specific targets. If a facility did not meet its tier-two milestones or components of its tier-two milestones, the State was required to assess a penalty of 3.5 percent of the facility's annual LIP allocation.

The MMA program will increase consumer protections as well as quality of care and access for Floridians in many ways, including:

- Increasing recipient participation on Florida's Medical Care Advisory Committee and convening smaller advisory committees to focus on key special needs populations;
- Ensuring the continuation of services until the primary care or behavioral health provider reviews the enrollee's treatment plan (no more than 60 calendar days after the effective date of enrollment);
- Ensuring recipient complaints, grievances and appeals are reviewed immediately for resolution as part of a rapid cycle response system;
- Establishing Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requiring plans to offer a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan;
- Requiring Florida's External Quality Review Organization to validate each plan's encounter data every three years;
- Enhancing consumer report cards to ensure recipients have access to understandable summaries of quality, access, and timeliness of care regarding the performance of each participating managed care plan;

- Enhancing the impact of the plans' performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health, and reducing per capita Medicaid expenditures;
- Enhancing metrics on plan quality and access to care to improve plan accountability; and
- Creating a comprehensive state quality strategy to implement a comprehensive continuous quality improvement strategy to focus on all aspects of quality improvement in Medicaid.

Under the MMA demonstration, Florida seeks to continue building upon the following objectives:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost;
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program;
- Improve health outcomes and reduce inappropriate utilization;
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve;
- Serve as an effective deterrent against fraud and abuse by moving from a fee-for-service to a managed care delivery system;
- Maintain strict oversight of managed care plans including adapting fraud efforts to surveillance of fraud and abuse within the managed care system;
- Provide managed care plans with flexibility in creating benefit packages to meet the needs of specific groups; and
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

C. Populations Covered in the MMA Program

Participation in the MMA program, the statewide program which was implemented in calendar year 2014, is mandatory for the following eligibility groups currently covered by Florida Medicaid and as defined in STC #20 of the waiver.

The MMA program participants are individuals eligible under the approved state plan who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a capitated plan as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a plan to receive Medicaid benefits.

On November 24, 2014, the Agency submitted an amendment to Federal CMS to allow certain populations that were previously excluded from the MMA population, to enroll as Voluntary Participants. As the Agency anticipates this amendment will be approved, these populations are included in this draft evaluation design update.

All MMA program participants, whether voluntary or mandatory, are included in the study population for the MMA evaluation as described below.

1. Mandatory Participants - Individuals who reside in one of the 11 MMA regions, who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation are required to be MMA program participants.

Mandatory Managed Care Enrollees			
Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
Infants under age 1 Population 2	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & related grp
Children 1-5 Population 2	No more than 140% of the FPL.	Title XIX	TANF & related grp
Children 6-18 Population 2	No more than 133% of the FPL.	Title XIX	TANF & related grp
Blind/Disabled Children Population 1	Children eligible under SSI, or deemed to be receiving SSI.	Title XIX	Aged/Disabled
IV-E Foster Care and Adoption Subsidy Population 2	Children for whom IV-E foster care maintenance payments s or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & related grp
Pregnant women Population 2	Income not exceeding 191% of FPL.	Title XIX	TANF & related grp
Section 1931parents or other caretaker relatives Population 2	No more than AFDC Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.)	Title XIX	TANF & related grp
Aged/Disabled Adults Population 1	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by SSA.	Title XIX	Aged/Disabled

Mandatory Managed Care Enrollees			
Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & related grp
Optional State Plan Groups			
State-funded Foster Care or Adoption assistance under age 18 Population 2	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & related grp
Individuals eligible under a hospice-related eligibility group Population 1	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236 Population 1	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217 Population 1	This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled

2. Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid will be required to participate in the MMA program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-

Medicaid recipients will be afforded the opportunity to choose a plan. However, to facilitate enrollment, if the individual does not elect a plan, then the individual will be assigned to a plan by the state using the criteria outlined in STC #19 of the waiver.

3. Voluntary Participants – The following individuals are excluded from mandatory participation but may choose to be voluntary participants in MMA program:

   i. Individuals who have other creditable health care coverage, excluding Medicare;
   ii. Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;
   iii. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
   iv. Individuals with developmental disabilities enrolled in the developmentally disabled home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;
   v. Children receiving services in a prescribed pediatric extended care facility; and,
   vi. Medicaid-eligible recipients residing in group home facilities licensed under Section (s.) 393.067, Florida Statutes (F.S).

4. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from participation in the MMA program.

   i. Individuals eligible for emergency services only due to immigration status;
   ii. Family planning waiver eligibles; and,
   iii. Individuals eligible as women with breast or cervical cancer.

II. Evaluation of Medicaid Reform and the MMA Program

A. Evaluation of the initial Reform Demonstration period (2006-2011)

During the initial waiver period, the Agency contracted with an independent entity, the University of Florida (UF), to conduct the evaluation. The three primary components of the evaluation were: Organizational Analysis; Utilization and Payment Analysis; and Quality of Care, Outcomes, and Patient Satisfaction Assessment. The evaluation research questions were in five key areas: Patient Involvement; Access to Care; Quality of Care; Coverage; and Costs.

Florida submitted UF's Final Evaluation Report, *Evaluating Florida's Medicaid Reform Demonstration Pilot: 2006 – 2011* to Federal CMS on December 15, 2011. This report summarized evaluation findings across the five years of the initial waiver. It included a description of the managed care organizations participating in the demonstration, enrollee experiences with the demonstration, and the fiscal impact of the

demonstration, the Low Income Pool, and mental health services under the demonstration. A few key findings of the evaluation included:

- The percentage of enrollees reporting that they do have a personal doctor and that they did not have a problem finding a personal doctor/health care provider with whom they were happy increased significantly from the benchmark year to Demonstration Year 1 and was maintained in Demonstration Years 2 and 3.
- There were statistically significant improvements from the benchmark year to Demonstration Years 1, 2, and 3 regarding rating of communication with a personal doctor.
- There were statistically significant improvements from the benchmark year to the Demonstration Years regarding ratings of always getting care right away, in terms of both urgent care and routine care.
- The demonstration resulted in reductions in Per Member Per Month expenditures for SSI and TANF enrollees. A multivariate analysis controlling for age, gender, and race also included a variable capturing change over time and confirmed a downward trend in expenditures over time in the demonstration counties compared to the control counties.
- The shift from the Special Medicaid Payments program to the Low Income Pool (LIP) program resulted in increased funding for safety-net providers and the extension of this funding to non-hospital providers, in addition to hospitals.
- Analyses of mental health-related services found that implementation of the demonstration was not associated with significant changes in rates of Baker Act examinations, arrests, or juvenile justice encounters.

B. Goals of the Evaluation of the Reform Demonstration renewal period (July 2011-June 2014)

As noted in the Background, in December 2011, Federal CMS approved a renewal of the 1115 Medicaid Reform Waiver through June 30, 2014. The Agency for Health Care Administration submitted a draft evaluation design for the renewal period to CMS on April 12, 2012, as specified in the June 14, 2013 STC #80. In June 2012, the Agency discussed the draft evaluation design with, and received written comments from Federal CMS. Florida submitted a revised evaluation design in August 2012 and Federal CMS approved it on October 31, 2012. After receiving approval of the evaluation design, the Agency executed contracts with two state universities to conduct different parts of the evaluation. The broad goals of the evaluation are to:

- Measure the extent to which the Medicaid Reform Demonstration achieves its objectives;

- Capture lessons learned as a result of the Demonstration;
- Determine in what ways, and to what extent, experiences and outcomes for enrollees, providers, and payers changed as a result of the Demonstration; and
- Determine whether the reallocation of resources in the demonstration provided greater "value" than under traditional state Medicaid expenditures.

Special Term and Condition (STC) #80 of the waiver extension specified that, in the evaluation design, the state must propose at least one research question that it will investigate within nine Domains of Focus. With respect to the last three domains, the state must propose two research questions under each domain, one related to LIP Tier-One milestones and one related to LIP Tier-Two milestones.

The Domains of Focus for the extension were:

1) The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
2) The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
3) Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
4) The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;
5) The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
6) The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups;
7) The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
8) The impact of Tier-One and Tier-Two milestone initiatives on population health; and
9) The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

In late October 2012, the Agency contracted with a research team at the University of Florida to conduct the evaluation of domains 1-3 and 5-9. In February 2013, the Agency contracted with a research team at Florida International University to evaluate domain 4.

On October 28, 2014, the Agency submitted the draft evaluation report of Domains 1-9 to Federal CMS.

C. Evaluation of the MMA Program (2014-2017)

As noted in the Background, Federal CMS approved Florida's amendment to the 1115(a) demonstration on June 14, 2013, changing the title of the waiver to the MMA Program and amending the Special Terms and Conditions (STCs) for the waiver. Per the June 14,

2013 STC #110, the state was required to submit a Draft Evaluation Design Update, which included an adjustment to Domain iii and added Domains x through xiii to the Domains of Focus. The amended and new domains are:

3) Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status;
10) The effect of having separate managed care programs for acute care and Long-term care (LTC) services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
11) The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
12) The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs; and
13) The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals.

This Evaluation Design Update was approved on December 31, 2014 and included preliminary research questions, data sources, and methodologies for the amended and new domains. While the Agency will be collecting data and information on the MMA program (e.g., enrollment and capitation payment data, encounter data, managed care plan reporting) that will serve as evaluation data sources from the start of program implementation, evaluation activities and reporting for the MMA program will not begin until the program is fully implemented.

In October 2015 CMS approved three amendments to the demonstration. The first amendment added two populations as voluntary managed care participants. The second amendment changed the process for beneficiary enrollment in managed care plans and the timing and procedure for auto-assignments. The third amendment extended the Low Income Pool through June 30, 2017 and modified the definition and structure of the Low Income Pool. The amendment also modified the evaluation design update process to become part of an amendment or extension approval process, rather than the previous post-approval deliverable process.

These amendments seek to achieve several objectives:

- Expanding access to coordinated care by extending the opportunity to enroll in managed care on a voluntary basis to two populations: children receiving services in a prescribed pediatric extended care facility and Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 Florida Statutes (F.S.)
- Improving access to care and health outcomes for Medicaid recipients with Express Enrollment, an auto-assignment of recipients to a managed care plan at the point of eligibility if a plan is not selected by the recipient. Promote a stable and usual source of care by permitting recipients to change managed care plans within 120 days of

eligibility determination but requiring that they remain with the plan after that point until the next enrollment period.

- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse uncompensated care costs for services provided to low-income uninsured patients at hospitals with charity care programs as described in STC #78.

As a result of these amendments to the demonstration, in addition to certain aspects of the demonstration sunsetting after SFY 2014-2015 and 2015-2016, the Domains of Focus for the evaluation have been further modified and now (as of October2015) encompass 18 unique Domains of Focus as follows:

1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
2. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
3. Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status;
4. The impact of the demonstration as a deterrent against Medicaid fraud and abuse;

Sunsetting Domain of Focus June 30, 2015	New Domain of Focus effective July 1, 2015	Sunsetting Domain of Focus June 30, 2016	New Domain of Focus effective July 1, 2016
Old #6. The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups. Old #7: The impact of LIP funding and Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity). Old #8: The impact of LIP funding and Tier-One milestone	New 14: The effectiveness of the Express Enrollment process in connecting beneficiaries with care, including expanded benefits, in a timely manner New #15: The benefits and outcomes associated with participation in the Event Notification Service New #16: The effect of Choice on Plan enrollment and disenrollment.	Old #5: The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance.	New #5: The impact of LIP funding requirements on hospital charity care programs; New #7: The impact of LIP funding on per-capita costs for uninsured populations.

initiatives on population health. Old #9: The impact of LIP funding and Tier-One milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.			

10. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
11. The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
12. The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs; and,
13. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals.

The Agency has received project proposals from state universities to conduct an independent evaluation of the MMA program. In its solicitation for proposals, the Agency provided universities with a description of the objectives of the MMA program and the December 31, 2014 approved evaluation design. The Agency required that respondents describe how they will ensure that the evaluation meets all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. The selected evaluator(s) will be required to use the best available data for the evaluation; to control for and report on any limitations of the data and their effects on results; and to report on how generalizable the evaluation results may be. At present, the state has a total of $430,000 available per state fiscal year for the evaluation of the 1115 demonstration waiver. If universities propose a scope of work that requires funding above and beyond this amount, they may provide in-kind, non-federal funding to draw down additional funds for evaluation activities. Necessary revisions will need to be made to incorporate the evaluation plan changes.

III. Methodologies for Evaluation of the MMA Program for July 31, 2014-June 30-2017

This section presents the research questions, hypotheses, data sources, and methods of evaluation for the 2014-2017 demonstration period. As noted above, the state's solicitation

of evaluation proposals from state universities may result in changes to the data sources and methods. For the Domains of Focus that have not been amended for the MMA program evaluation, the research questions will remain the same, though the demonstration period of interest will shift to the period in which the MMA program is operational.

It should be noted that the Florida Medicaid program has utilized managed care as a service delivery system for the past two decades. Managed care was initially implemented through a 1915(b) MC waiver authority and was one of several service delivery options available to eligible Florida Medicaid recipients. In 2006, the Agency implemented managed care through the current 1115(a) Demonstration waiver in select areas of the state. The managed care plans that served recipients under the two separate managed care service delivery systems are referred to as Non-Reform plans (those that operated under 1915(b) MC waiver authority) and Reform plans (those plans that operated under the Medicaid Reform 1115 Demonstration waiver authority). Collectively these plans are now referred to as pre-MMA plans. Post MMA plans are managed care plans authorized under the 1115(a) Demonstration Waiver amended on June 14, 2013. MMA plans replaced both the Reform and Non-Reform plans and include standard MMA plans and specialty MMA plans. The MMA plans began operating on May 1, 2014.

This section is organized into five proposed projects that encompass 18 unique Domains of Focus. Due to Domains sunsetting during DY9 or DY10 and other Domains added in DY10 and DY 11, the Domains of Focus are numbered 1-16 for ease of numbering purposes. There are no more than fourteen (14) active Domains at a given time. Each project area includes the research questions by domain, the hypotheses to be tested, the methods of evaluation and the data sources. The final analysis of the research questions will, where appropriate, draw comparisons regarding the impact on different population groups covered by the demonstration stratified by age, sex, income level, eligibility category, and other appropriate factors. The analysis will also describe how the effects of the demonstration are isolated from other initiatives ongoing in the State. A table that aligns the hypotheses, analyses and data sources to each research question may be found in Appendix I.

Proposed Research Projects, Questions, Hypotheses, Methods and Data Sources

A. <u>Domains 1, 2, 10, New 14 (DYs 10 and 11), and New 15 (DYs 10 and 11), and New 16 (DYs 10 and 11): Studying the effect of managed care, customized benefit plans, express enrollment (DYs 10 and 11), the Event Notification System (DYs 10 and 11), and having separate managed care programs for MMA and LTC services on beneficiaries' choice of plans, access to care, quality of care, and cost of care.</u>

1) The effect of managed care on access to care, quality and efficiency of care, and the cost of care.

Research Questions:

- 1. A. What barriers do enrollees encounter when accessing services?

- 1. B. What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre- MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans (MMA plans as a whole)? 1. C. What changes in the accessibility of services occur with MMA implementation, comparing the accessibility of specialty services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to specialty MMA plans? 1. D. What changes in the accessibility of services occur with MMA implementation, comparing the accessibility of specialty services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to standard MMA plans? 1. E. What changes in the accessibility of services occur with MMA implementation, comparing accessibility of services in specialty MMA plans to standard MMA plans and to the degree possible, comparing the accessibility of services in specialty MMA plans to accessibility of services for recipients in standard MMA plans eligible for enrollment in the specialty MMA plan (e.g., recipients with COPD enrolled in standard MMA plans compared to recipients with COPD enrolled in the COPD specialty plan)?
- 1. F. What changes in the utilization of services for recipients are evident post MMA implementation, comparing: 1) utilization of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to utilization of services in post MMA implementation plans (MMA plans as a whole); 2) utilization of services in specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those recipients in the standard MMA plans with the specialty plan condition; e.g., COPD)? 1. G. What changes in quality of care for recipients are evident post MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in post MMA implementation plans (MMA plans as a whole); 2) quality of care in specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD)? 1. H. What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?
- 1. I. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans (MMA plans as a whole) and 2) specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD)?
- I. J. What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per enrollee costs post-MMA implementation (MMA plans as a whole, standard MMA plans and specialty MMA plans)?

2) The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care.

Research Questions:

- 2. A. What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the type of expanded benefit to particular populations? To what extent do enrollees use these expanded benefits?
- 2. B. What differences in enrollee satisfaction with their health plan occur over the course of the demonstration based on how many types of expanded benefits are offered by a plan?
- 2. C. What differences in the accessibility of services occurs over the course of the demonstration in standard MMA or specialty MMA plans based on how many types of expanded benefits are offered by the plan?

10) The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014.

Research Questions:

- 10. A. How many recipients are enrolled in separate Medicaid managed care programs for acute care and LTC services? 10. B. How many recipients are enrolled in comprehensive plans that provide both acute care and LTC services?
- 10. C. What are the differences in service utilization and costs between enrollees who are in comprehensive plans vs. those who are enrolled in separate MMA and LTC plans?
- 10. D. What strategies are LTC plans using for benefit coordination for enrollees who are also enrolled in a MMA plan or a Medicare plan? Which of these strategies are most effective in improving benefit coordination and why?

New 14) The effectiveness of the Express Enrollment process in connecting beneficiaries with care, including expanded benefits, in a timely manner.

Research Questions:

- 14.A. What difference is evident in how quickly recipients access services, including expanded benefits in excess of state plan covered benefits, after becoming Medicaid eligible if they are enrolled in a health plan immediately upon becoming Medicaid eligible compared to those recipients who experienced a period of fee-for-service enrollment prior to health plan enrollment?

New 15) The benefits and outcomes associated with participation in the Event Notification Service.

Research Questions:

- 15.A. How many providers/managed care organizations are participating in the Event Notification Service and for what duration?
- 15.B. How do managed care plans follow-up with recipients after an event notification?
- 15.C. What do managed care organizations report are the perceived benefits of utilizing the Event Notification Service?

New 16) The effect of Choice on Plan enrollment and disenrollment.

- 16 New A. How many recipients select a plan versus are auto-enrolled upon eligibility determination?
- 16 New B. How many recipients elect to change plans within the 120 day change period?
- 16 New C. What difference in length of plan enrollment over time is evident from recipients who initially select a plan versus those who are auto-enrolled in a plan?

Hypotheses: It should be noted that several sets of research questions are included to provide descriptive information about the program as context for the other research questions, and thus do not have specific hypotheses to be tested. See Appendix I for more details.

- 1. A. The MMA program will result in improved access to appropriate use of services (preventive care services (PCP and specialty services) versus preventable ER visits and hospitalizations) compared to Reform and 1915 (b) waiver plans. 1. B. The accessibility of services will be statistically significantly greater in MMA plans as a whole than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. C. The accessibility of specialty services will be statistically significantly greater in specialty MMA plans, than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. D. The accessibility of specialty services will be statistically significantly greater in standard MMA plans, than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. E. Accessibility of services will not be statistically significantly different in specialty MMA plans and standard MMA plans as a whole. However, accessibility of specialty services will be statistically significantly greater in specialty MMA plans than for specialty population recipients served by standard MMA plans (e.g., recipients with COPD enrolled in standard MMA plans compared to recipients with COPD enrolled in the COPD specialty plan).

- 1. F. It is expected that: 1) the demonstration will result in a statistically significant improvement in the appropriate use of services for recipients post versus pre-MMA implementation. That is, appropriate utilization of services will be significantly greater in MMA plans as a whole than in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); 2) the demonstration will not result in significantly different utilization of services overall for specialty MMA plans compared to standard MMA plans.; and 3) Specialty MMA plans will provide enrollees with improved access to specialty services related to the specialty condition (~~i.e.~~ e.g., COPD specialty plan and access to pulmonary specialists) compared to standard MMA plans.
- 1. G. Quality of care for enrollees will: 1) be statistically significantly higher in MMA plans as a whole compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); 2) not be statistically significantly different for enrollees in specialty versus standard MMA plans (whole standard MMA population); and 3) be statistically significantly higher in specialty MMA plans compared to enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD, if such comparison is feasible.
- 1. H. The quality of care strategies targeting specific sub-populations or services will be more successful than strategies which do not target specific sub-populations or services.
- 1. I. The demonstration will result in: 1) a statistically significant improvement in timeliness of services in post-MMA implementation plans compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); 2) no statistically significant differences in timeliness of services for enrollees in specialty versus standard MMA plans (whole standard MMA population); and 3) statistically significant improvement in timeliness of services in specialty MMA plans compared to enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD, if such comparison is feasible.
- 1. J. The per-enrollee cost by eligibility group within the MMA demonstration will be less than the estimated costs by a statistically significant amount had the MMA demonstration not been in place.
- 2. A. Descriptive research question – no hypothesis.
- 2. B. Enrollees of standard MMA or specialty MMA plans that offer more types of expanded benefits will report greater satisfaction with their plan than enrollees of standard MMA and specialty MMA plans that offer fewer types of expanded benefits.
- 2. C. Enrollees of standard MMA or specialty MMA plans that offer more types of expanded benefits will have statistically significantly higher accessibility and quality of care measures than enrollees of standard MMA

and specialty plans that offer fewer types of expanded benefits. 10. A. Descriptive research question – no hypothesis.

- 10. B. Plans that provide both acute and LTC services will enroll more enrollees who need both types of services than plans that only provide one type of services.
- 10. C. Enrollees receiving acute and LTC services from comprehensive plans will have statistically significantly lower service utilization and costs than enrollees who receive acute and LTC services from separate MMA and LTC plans. 10. D. Descriptive research question – no hypothesis.
- New 14.A. It is expected that recipients will access services sooner if they are enrolled in a health plan immediately upon becoming Medicaid eligible. This includes both State Plan benefits and expanded benefits in excess of State Plan coverage.
- New 15.A. Descriptive research question – no hypothesis.
- New 15.B. Descriptive research question – no hypothesis.
- New 15.C. Descriptive research question – no hypothesis.
- New 16.A. Descriptive research question – no hypothesis.
- New 16.B. Descriptive research question – no hypothesis
- New 16.C. Recipients who select a plan will have statistically significant longer duration of plan enrollment than recipients who are auto-enrolled in a plan.

Analyses:

- Descriptive statistics of plans selected and related enrollment data;
- Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing the MMA program as a whole to Reform and 1915 (b) waiver plans, comparing standard MMA and specialty MMA plans to one another, and comparing standard MMA and specialty MMA plans that offer more types of expanded benefits to standard MMA and specialty MMA plans that offer fewer types of expanded benefits;
- Comparison of MMA program weighted means to Medicaid National Means and Percentiles for HEDIS measures. MMA program weighted means will also be compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of the MMA program, when available;
- Descriptions of Performance Improvement Projects, including their objectives, interventions, and outcomes;
- Descriptive statistics of plan benefits over time, including the number of expanded benefits offered per plan, as well as the average number of expanded benefits offered across plans; including specialty and standard MMA plans;
- Descriptive statistics and tests of significance for measures in the Timely Access PCP Wait Times Report comparing standard MMA and specialty MMA plans to one another;

- Multivariate regression and interrupted time series analyses (as appropriate) to assess utilization and expenditures before and after implementation of the MMA program as well as across standard MMA and specialty MMA plans. Evaluators will examine trends in utilization and expenditures over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity;
- Evaluators will make comparisons of care coordination policies and procedures for plans that provide LTC services. Additionally, evaluators will analyze effectiveness of procedures utilized;
- Evaluators will conduct interviews with LTC plan staff regarding their care coordination activities and which strategies they consider effective;
- Analysis of barriers to care will be descriptive, focusing on frequencies of complaints, grievances, and appeals that are related to access to care. Comparisons across plans, between specialty MMA plans and standard MMA plans, and pre and post MMA program implementation will be made (to the extent possible);
- Accessibility, utilization of services, and quality of care will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate;
- Comparison of timing of use of services by enrollees who were enrolled in fee-for-service Medicaid prior to enrolling in an MMA health plan to those enrollees who were enrolled in a MMA health plan immediately after eligibility determination;
- Descriptive statistics of providers/managed care plans participating in the Event Notification System and duration of participation;
- Descriptive analysis of types and content of follow-up contact with recipient;

Data Sources: To answer the research questions related to domains 1, 2, 10, New 14, and New 15, and New 16, specific data elements (identified in Appendix I) obtained from the following data sources will be used.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data: The Agency will be contractually requiring MMA plans to contract with an NCQA-certified CAHPS survey vendor for a CAHPS health plan survey to be conducted each year. The Agency will require that MMA plans report the survey results to the Agency annually. To answer questions related to access, quality, satisfaction and efficiency of care, evaluators will analyze overall ratings variables related to health care, health plan, personal doctor, and specialists. The evaluation team will conduct analyses of survey results related to getting needed care, ease in getting care, and getting care quickly as well.
- HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures: The Agency will require MMA plans to submit performance measures to the Agency annually. The Agency requires plans to certify, through independent audit, that the data have been "fairly and accurately

reported" and plans must attest to the accuracy of their performance measure data. The Agency currently has six years of performance measure data (calendar years 2007-2012) that may be used as baseline data prior to the MMA program. To answer questions related to access and quality of care, the evaluators will analyze measures related to use of preventive services and management of chronic conditions.

- Enrollee Complaint, Grievance, and Appeals Report: Managed care plans will be required to submit this report monthly. (E.g., Number of grievance and appeals by type.)
- Agency Complaints, Issues, Resolutions & Tracking System (CIRTS). The Agency maintains the above data system to track recipient complaints. Data elements include recipient identifier information, type of complaint (e.g., access, quality of care, etc.) and plan enrollment. The Agency currently has four years of data to that may be used as baseline data prior to the MMA program. Some of the elements in and processes around the CIRTS system have changed with the transition to the MMA program, so comparisons may be made to the extent possible, understanding that they will not always be apples-to-apples. To answer questions related to access to care, barriers to care and quality of care, the evaluators will analyze measures related to the frequency and type of complaints.
- Performance Improvement Projects (PIPs): The Agency will contractually require MMA plans to conduct a set number of PIPs and to have two of them validated by the State's External Quality Review Organization each year. Plans must report on their PIPs according to Federal CMS protocols, and the External Quality Review Organization provides technical assistance to the plans as well as preparing an annual report on the status of the health plans' PIPs. Evaluators will review health plan PIP submissions to look at what steps the health plans have taken to improve quality of care for enrollees during the demonstration. The evaluation team may analyze External Quality Review reports on the status of health plan PIPs as well.
- Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to look at enrollment, plan selection, service utilization, and expenditures during the demonstration.
- Health plan policies and procedures related to care coordination, choice materials and Agency quarterly and annual reports to Federal CMS: evaluators will use these data sources to examine plan operations and to identify any expanded/additional services they cover.
- Timely Access PCP Wait Times Report. This report provides PCP Access data (average appointment wait times through a statistically valid sample). The evaluation team will utilize this data to complete comparative analyses across MMA and specialty MMA plans.
- LTC Case Management Monitoring and Evaluation Report: The Agency requires plans that provide LTC services to report on a quarterly and annual basis data related to the plan: case file audit reviews to determine the timeliness of enrollee assessments performed by case managers, reviews of the consistency of enrollee service authorizations performed by case

managers, and the development and implementation of continuous improvement strategies to address identified deficiencies.

- State data source of event Notification tracking data regarding the number of events, type of events, recipients involved (for the purposes of matching with claims data for tracking service utilization), and timeframe for notification.
- State data source on managed care plans meeting requirements of managed care provider network capacity; recipient previous enrollment; and primary care provider location.
- Florida Center data regarding participating and enrolled ENS providers.

B. Domains 3 and 12: Studying the transition of the EBAP program to the MMA plans' Healthy Behaviors programs, participation in the Healthy Behaviors programs and its effect on participant behavior or health status.

3) Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status. Please note that the following research questions focus on the Healthy Behaviors programs under MMA, while the questions related to EBAP are provided in the December 2014 approved evaluation design under the Reform evaluation. Also note that the following questions may change based on the types of Healthy Behaviors programs offered by MMA plans.

Research Questions:

- 3. A. What Healthy Behaviors programs do MMA plans offer? What types of programs and how many are offered in addition to the three required programs (medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)?
- 3. B. What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs?
- 3. C. How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behavior programs attract higher numbers of participants?
- 3. D. How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity, and health status of enrollee?
- 3. E. What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating?

12) The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs.

Research Questions:

- 12. A. How many enrollees that participated and earned credits in the EBAP program participate in MMA plan Healthy Behaviors programs? How many enrollees that did not participate in the EBAP program (including those previously in Reform plans and those in 1915 (b) waiver plans) participate in Healthy Behaviors programs?
- 12. B. What Healthy Behaviors programs do MMA plans offer that were not part of the EBAP program?
- 12. C. What is the difference in enrollees earning, accessing, and using the Healthy Behaviors incentives and rewards programs compared to the prior EBAP program?
- 12. D. What is the difference in utilization of inpatient, outpatient and physician specialist services for ambulatory care sensitive conditions for enrollees in EBAP versus after they: 1) transition into a Healthy Behaviors program or 2) do not transition into a Healthy Behaviors program?

Hypotheses: It should be noted that several sets of research questions are included to provide descriptive information about the program as context for the other research questions, and thus do not have specific hypotheses to be tested. See Appendix I for more details.

- 3. A., 3. B., 3. C., 3. D., 12. A., 12. B. Descriptive research questions – no hypotheses.
- 3. E. Enrollees participating in Healthy Behaviors programs will have a statistically significant higher utilization of preventive services and outpatient services (e.g. Primary Care Physician (PCP) visits and smoking cessation counseling sessions) compared to enrollees not participating in Healthy Behaviors programs. Furthermore, service utilization of ER, inpatient and outpatient hospital and physician specialty services for treatment of conditions that these programs are designed to prevent will be lower by a statistically significant amount for enrollees after enrolling in the Healthy Behaviors program than before enrollment.
- 12. C. Enrollees will earn, access and utilize the Healthy Behaviors program incentives and rewards offered at a statistically significant higher rate than the EBAP program.
- 12. D. The transition into Healthy Behaviors will result in no statistically significant difference in utilization of inpatient, outpatient or physician specialist services for ambulatory care sensitive conditions for an enrollee as compared to when they were enrolled in EBAP for the same type of program. EBAP enrollees that do not transition into a Healthy Behaviors program will experience a statistically significant increase in inpatient, outpatient and physician specialist service use for ambulatory care sensitive conditions.

Analyses:

- This study will describe what Healthy Behaviors programs are offered by MMA plans, what incentives and rewards are offered to enrollees for

participating in the programs, how many enrollees participate in the programs, how many complete the programs, and if certain types of programs attract higher numbers of participants It will also look at how many enrollees that participated and earned credits in the EBAP program participate in the MMA plans' Healthy Behaviors programs, and how many Healthy Behaviors program participants did not previously participate in the EBAP program. Additionally, demographic characteristics of program participants will be analyzed. Evaluators will compare the incentives and rewards offered by the MMA Healthy Behaviors programs to the credits that Reform enrollees earned accessed and utilized through the EBAP program.

- Evaluators will use Medicaid claims, eligibility, and encounter data to compare the likelihood of receiving particular services between program participants before and after program participation, and between program participants and enrollees who do not participate in Healthy Behaviors programs. Evaluators will use claims, eligibility, and Healthy Behaviors reports to compare demographic and health status characteristics of program participants and those who do not participate. Utilization of services will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate.
- Evaluators will also compare service utilization of enrollees who participated in the EBAP program to those who participate in Healthy Behaviors programs. Evaluators will conduct bivariate and multivariate analyses that control for factors such as age, gender, eligibility category, race/ethnicity, and length of time in Medicaid. Specifically, the evaluation team will assess general descriptive statistics and Healthy Behaviors program participation rates using the MMA plan reports on Healthy Behaviors programs. Evaluators will use Medicaid claims, eligibility, and encounter data to compare the likelihood of receiving particular services between program participants before and after program participation, and between program participants and enrollees who do not participate in Healthy Behaviors programs. Evaluators will use claims, eligibility, and Healthy Behaviors reports to compare demographic and health status characteristics of program participants and those who do not participate. These data will be linked to encounter data to compare the likelihood of avoidable hospitalizations for ambulatory care sensitive conditions (using Prevention Quality Indicators) for program participants vs. those who do not participate. Ambulatory care sensitive conditions will be assessed consistent with the Prevention Quality Indicators (PQIs), including PQIs in the CMS Medicaid Adult Core Set.

Data Sources: To answer the research questions related to Domain 3 and 12, the following data sources will be used:

- MMA Managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount

and type of rewards/incentives provided for each Healthy Behaviors program.

- Enhanced Benefits Information System (EBIS): This database includes information on the healthy behavior activities in which enrollees participated during the Medicaid Reform demonstration (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits.
- Medicaid claims, eligibility, and encounter data: evaluators will use these data to look at service utilization and costs during the demonstration.

C. Domains 4 and 11: Studying the impact of the demonstration as a deterrent against Medicaid fraud and abuse, including the effect of having separate managed care programs for MMA and LTC services.

4) The impact of the Demonstration as a deterrent against Medicaid fraud and abuse.

Research Questions:

- 4. A. What are the program integrity-related measures employed by the MMA managed care plans related to: deterring fraud and abuse by network and non-network providers; deterring fraud and abuse by recipients; detecting fraud and abuse by network and non-network providers; and detecting fraud and abuse by recipients?
- 4. B. How often do managed care plan compliance officers/teams interact with providers in the plan networks? What types of contact and interactions do the compliance officers/teams have with providers? How do plans document and track their efforts to deter fraud and abuse?
- 4. C. How does the State collect and track Medicaid fraud and abuse data reported by the MMA plans? How does the State coordinate and/or assist the MMA plans with fraud and abuse efforts?
- 4. D. How do health plan compliance officers/teams measure the effectiveness of the health plan policies and procedures related to program integrity?

11) The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014.

Research Questions:

- 11. A. To what extent is there overlap in services between LTC and MMA programs?

Hypotheses: It should be noted that several sets of research questions are included to provide descriptive information about the program as context for the other

research questions, and thus do not have specific hypotheses to be tested. See Appendix I for more details.

- 4. A. It is expected that MMA managed care plans in the Demonstration will use a variety of strategies to deter Medicaid fraud and abuse and to improve detection of fraud and abuse by providers and recipients.
- 4. B. It is expected that MMA managed care plans will use a variety of strategies to work with their providers to prevent fraud and abuse.
- 4. C. and 4. D. Descriptive research questions – no hypotheses.
- 11. A. There are seven services which are covered by both the LTC plans and MMA plans. These services are: Home health, Hospice, DME (durable medical equipment), Transportation, Care Coordination, Assistive Care and Therapy services (physical, occupational, respiratory, and speech). It is expected that duplication of services may be greater for people receiving both LTC and acute care services from separate LTC and MMA plans than for people receiving both LTC and acute care services from a (comprehensive) single plan.

Analyses:

- This study will review the program integrity-related measures health plans in the MMA program take to deter and detect fraud and abuse, by both providers and recipients. Analyses will include comparisons of efforts across MMA managed care plans. Evaluators will use descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors to assess the impact of the demonstration as a deterrent against Medicaid fraud and abuse.
- Evaluators will complete content analyses of interviews with health plan and with Agency staff.
- Evaluators will review the Agency's efforts to assist the health plans in their program integrity-related activities.
- Evaluators will use claims and encounter data to compare utilization of services between the two populations (people receiving LTC and acute care services from separate LTC and MMA plans versus people receiving both LTC and acute care services from a (comprehensive) single plan).

Data Sources: To answer the research questions related to Domain 4 and 11, the following data sources will be used:

- Health plan policies and procedures (including manuals) related to compliance and to fraud and abuse.
- Health plan anti-fraud plans and fraud and abuse reports that are submitted to the Agency.
- Interviews of Agency staff, health plan executive leadership and compliance/fraud and abuse directors at health plans.
- Medicaid claims and encounter data.

D. Domains 5-9: Due to the October 2015 Amendment and the extension of the LIP, some Domains expired at the end of DY9, others will expire at the end of DY10, and New Domains will be added beginning DY11.

For DY9, Domains 5-9: Studying the effect of the Low Income Pool (LIP) on funding on the provision of health care services to the uninsured and the impact of Tier-One initiatives on (a) access to and quality of care, (b) population health, and (c) per capita costs and the cost-effectiveness of care.

For DY 10: Domain 5 will be evaluated.

For DY 11, New Domains 5 and 7: Studying the effect of the LIP on uncompensated care provided through hospital charity care programs; effect on access to care, quality of care, timeliness of care, and emergency department (ED) usage for the uninsured; and impact on costs for treating uninsured patients.

LIP Domains to be evaluated by DY		
DY9 (SFY 2014-2015)	DY10 (SFY 2015-2016)	DY11 (SFY 2016-2017)
Domain 5: The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance.	Domain 5: The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance.	Domain New 5: The impact of LIP funding requirements on hospital charity care programs.
Domain 6: The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups.		
Domain 7: The impact of LIP funding and Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness,		Domain New 7: The impact of LIP funding on per-capita costs for uninsured populations.

efficiency, and equity).		
Domain 8: The impact of LIP funding and Tier-One milestone initiatives on population health.		
Domain 9: The impact of LIP funding and Tier-One milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.		

Domains 5-9 for DY 9 (2014-2015)

5) The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance. (This domain will sunset after DY 10)

Research Questions:

- 5. A. How has the LIP program changed between DYs 9 and 10?
- 5.B. How has LIP funding continued to provide access to care for uninsured/underinsured recipients? That is, how many uninsured and underinsured recipients receive services through LIP funding? What types of services are being provided?

6) The effect of LIP funding on disparities in the provision of health care services, both geographically and by population groups. (This domain expired at the end of DY 9).

Research Questions:

- 6. A. What changes in the accessibility of services, occurs over the course of the demonstration in care for populations funded by LIP? What differences in accessibility of services is evident based on sex, age, race/ethnicity, and geographic location of enrollees?
- 6. B. How many programs funded by LIP, including Tier-One initiatives, are focused on reducing disparities in the provision of health care services or

health outcomes? What are these programs doing to reduce disparities and how successful are they?

7) The impact of LIP funding and Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity). (This Domain expired at the end of DY 9).

Research Questions:

- 7. A. What are the goals of the Tier-One Milestone programs? What interventions/activities are they using to enhance quality of care and the health of low-income populations?
- 7. B. How successful are Tier-One Milestone programs in meeting their stated objectives related to access and quality of care consistent with the Three-Part Aim? What is the difference in hospital AHCA quality measure rates for hospitals participating in Tier-One Milestone programs versus those that do not participate?

8) The impact of LIP funding and Tier-One milestone initiatives on population health. (This Domain expired at the end of DY 9).

Research Questions:

- 8. A. What strategies are Tier-One Milestone initiatives adopting to improve population health consistent with the Three-Part Aim? What are the age, sex, race/ethnicity, and health conditions of target populations?
- 8. B. How successful are Tier-One Milestone programs in meeting their stated objectives related to improving population health consistent with the Three-Part Aim?

9) The impact of LIP funding and Tier-One milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care. (This Domain expired at the end of DY 9).

Research Questions:

- 9. A. How do expenditures for services funded through the Tier-One Milestone initiatives differ from other LIP expenditures? How do the services provided under Tier-One milestone initiatives differ from those provided under other LIP funding?
- 9. B. What is the difference in use of preventive and outpatient care versus emergency department and inpatient visits by uninsured and underinsured individuals for hospitals participating in Tier-One Milestone programs versus those that do not participate?
- 9. C. What is the difference in expenditures on services for uninsured and underinsured individuals, for hospitals participating in Tier-One Milestone programs versus those that do not participate?

Hypotheses: It should be noted that several sets of research questions are included to provide descriptive information about the program as context for the other research questions, and thus do not have specific hypotheses to be tested. See Appendix I for more details.

- 5. A. Descriptive research question – no hypothesis.
- 5.B. Descriptive research question- no hypothesis.
- 6. A. The availability of LIP funding will sustain accessibility of services for populations funded by LIP over the course of the demonstration, in the absence of Medicaid expansion.
- 6. B. It is expected that those programs and quality initiatives that focus on specific disparities in the provision of health care services or health outcomes will achieve their goals by reducing disparities compared to their baseline.
- 7. A., 8. A., and 9. A. Descriptive research questions – no hypotheses.
- 7. B. Tier-One Milestone programs will achieve all of their goals related to access and quality of care consistent with the Three-Part Aim. Hospitals with Tier-One Milestone programs initiatives will report greater improvements in quality measure rates (statistically significant) than hospitals not participating in Tier-One Milestone programs.7. D. It is expected that Tier-Two milestone initiative programs will achieve all of their stated goals related to access to and quality of care, and consistent with the Three-Part Aim.
- 8. B. Tier-One Milestone programs will achieve all of their stated goals related to improving population health consistent with the Three-Part Aim.
- 9. B. Hospitals participating in Tier-One Milestone programs will have statistically significant higher utilization of preventive and outpatient care and statistically significantly lower utilization of emergency department and inpatient visits compared to uninsured and underinsured individuals that do not receive services through Tier-One Milestone programs or initiatives.
- 9. C. Hospitals participating in Tier-One Milestone programs will have statistically significantly lower expenditures for services provided to uninsured and underinsured individuals compared to those without Tier-One Milestone programs.

Analyses: The analytic strategy of this study is a review of the innovative programs and services funded by the LIP. The final evaluation report will include a summary of lessons learned through the LIP projects.

- The evaluation team will conduct descriptive analyses of the LIP program to compare the changes from DY 9 to DY 10.
- The evaluation team will conduct descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained, and any changes over time.
- The evaluation team will provide a brief description of which hospitals and managed care plans participate in the Event Notification Service.

- The evaluation team will conduct surveys and/or interviews with managed care plan staff and hospital staff.
- Analyses of the LIP funding and Tier-One initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes.
- Evaluators will individually review the entities conducting Tier-One initiatives, though if there are several entities conducting similar initiatives, the evaluators will analyze differences and similarities between those projects and their levels of success.
- The evaluation team will conduct comparative analyses of quality measures reported by hospitals participating in Tier-One initiatives and hospitals not participating in Tier One initiatives.

Data Sources: To answer the research questions related to Domains 5-9, the following data sources will being used:

- Annual Milestone Statistics and Findings Report: This report includes information on the numbers and types of services that are provided by hospital and non-hospital providers, the number of recipients served, and encounters.
- Report on Medicaid Provider Payment required under STC #69a. This report will include a review of the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. Additionally, this report will provide information about how many recipients receiving care through LIP funds, would qualify for Medicaid under Medicaid expansion.
- Information on innovative programs funded under Tier-One Milestones (STC #69 b.): This information includes descriptions, goals, and progress reports of programs that are established (and funded through the $50 million allocation) to meaningfully enhance the quality of care and the health of low income populations.*
- The Special Terms and Conditions will be utilized to describe the provider participation requirements.
- Hospital quality measure scores used to distribute the Quality Add-on ($15 Million) Tier One Milestone funding.*
- Primary Care and Alternative Delivery System Report: This report includes descriptions of primary care and alternative delivery systems operating with LIP funds. The report will include descriptions of each program, including the services provided, the populations served, goals of the program, expenditures, and results of the program.*

*Applies to DY 9 only.

New Domains 5 and 7 Replacements for DY 11 (2016-2017): Studying the effect of the LIP on uncompensated care provided through hospital charity care programs; effect on access to care, quality of care, timeliness of care, and emergency department (ED) usage for the uninsured; and impact on costs for treating uninsured patients.

New 5) The impact of LIP funding requirements on hospital charity care programs;

Research Questions:

- New 5.A. What effect on the number of uninsured patients served results from a hospital accessing LIP funding through a charity care program? How does this compare among the hospitals in different tiers of LIP funding?
- New 5.B. What is the difference in scope of services offered to uninsured patients in hospitals accessing LIP funding?

New 7) The impact of LIP funding on per-capita costs for uninsured populations;

Research Questions:

- New 7. A. What is the difference in expenditures on services for uninsured individuals for hospitals receiving different amounts of LIP funding through the LIP distribution tiers?

Hypotheses:

- New 5.A. There will be a statistically significant greater number of uninsured patients served or a greater amount of expenditures on services by hospitals with higher levels of LIP funding.
- New 5.B. There will be a broader scope of services offered to uninsured patients in hospitals with LIP higher levels of LIP funding.
- New 7. A. There will be statistically significant higher expenditures on services for uninsured individuals in hospitals receiving higher amounts of LIP funding.

Analyses:

- Descriptive statistics and tests of significance (where appropriate) of the number of patients served at LIP funded facilities by tier.
- Descriptive statistics of the scope of services provided at LIP participating facilities by tier.
- Cost analysis and tests of significance (if possible) of service expenditures on the uninsured in hospitals with LIP funding in each tier.

Data Sources: To answer the research questions related to New Domains 5 and 7, the following data sources will be used:

- Medicare Cost Reports: This report includes descriptive, financial, and statistical data on hospitals (among other providers) and may be helpful with identifying facility characteristics, costs, and assessing charity care.
- Florida Hospital Uniform Reporting System (FHURS): This report collects financial and utilization statistics each year from Florida hospitals.
- Florida Hospital Uniform Reporting System (FHURS): This report collects financial and utilization statistics each year from Florida hospitals.
- DSH Reporting Data as needed for uninsured and uncompensated care analyses.
- Survey of LIP hospitals.
- Medicare Cost Reports: This report includes descriptive, financial, and statistical data on hospitals (among other providers) and may be helpful with identifying facility characteristics, costs, and assessing charity care.

E. Domain 13: Studying the impact of efforts to align with Medicare and improve experiences and outcomes for dual-eligible individuals.

Research Questions:

- 13. A. How many dual-eligible recipients are enrolled in MMA plans that are operated by the same parent organization as the recipient's Medicare Advantage Organization?
- 13. B. How are MMA plans coordinating care for their enrollees who are enrolled in Medicare Advantage plans that are not operated by the same parent organization?
- 13. C. What is the difference in enrollee satisfaction for individuals dually eligible for Medicare and Medicaid who are enrolled in MMA plans that are operated by the same parent organization as the recipient's Medicare Advantage Organization versus those enrolled in a plan that does not share a parent organization?

Hypotheses: It should be noted that several research questions are included to provide descriptive information about the program as context for the other research questions, and thus do not have specific hypotheses to be tested. See Appendix I for more details.

- 13. A. and 13. B. Descriptive research questions – no hypotheses.
- 13. C. Individuals dually eligible for Medicare and Medicaid who are enrolled in MMA plans operated by the same parent organization as the recipient's Medicare Advantage Organization will report statistically significant greater satisfaction with care than enrollees in MMA plans and Medicare Advantage Organizations that do not share a parent organization.

Analyses:

- This study will describe how many dual-eligible enrollees are in MMA plans, how many of those enrollees are also in Medicare Advantage plans, and

how many of those enrollees are in plans operated by the same parent organization. It will examine how MMA plans coordinate care for dual-eligible enrollees who are in Medicare Advantage plans.

- To the extent possible, this study will also look at dual-eligible enrollees' satisfaction with care, and will compare those in plans with the same parent organization to those in plans that do not have the same parent organization.

Data Sources: To answer the research questions related to Domain 13, the following data sources may be used:

- A patient satisfaction and experience with care survey may be needed to specifically address the experiences and needs of the dual-eligible population, and specific samples of dual eligibles, including those who are in two plans with the same parent organization and those who are in two separate plans, may need to be surveyed to address this domain. In its solicitation of proposals for the MMA evaluation, the state will ask respondents to propose how they would answer these research questions.
- Evaluators will use eligibility and enrollment files to identify how many dual-eligible recipients are enrolled in MMA plans and in Medicare Advantage plans, and which ones are enrolled in plans operated by the same parent organization.
- MMA plan policies and procedures related to coordinating care for enrollees who are also enrolled in Medicare Advantage plans that are not operated by the same parent organization.
- Interviews with MMA plan staff regarding coordination of care for dual eligible in Medicare Advantage plans.

IV. Performance Measures for the MMA Program

Over the course of the Medicaid Reform demonstration, the Agency phased in a set of performance measures that the demonstration plans and non-demonstration plans submitted to the Agency annually. The Agency made several changes to the list of performance measures over time, due to modifications to HEDIS by NCQA, and due to the release of the Core Set of Children's Health Care Quality Measures (Child Core Set) and the corresponding Core Set of Quality Measures for Medicaid Eligible Adults (Adult Core Set) by CMS. The Agency has sought out standardized national measures as much as possible, but has retained several Agency-defined measures, keeping them as HEDIS-like as possible. The Agency has dropped several Agency-defined measures due to the availability of similar standardized measures (e.g., Adult BMI Assessment, Use of Appropriate Medications for People with Asthma), and has adapted two HEDIS measures (Follow-up after Hospitalization for Mental Illness and Frequency of Ongoing Prenatal Care) to better reflect care parameters within the state of Florida. As noted above, managed care plans submit their performance measure results to the state annually and must certify, through independent audit by an NCQA-certified HEDIS auditor, that the data have been fairly and accurately reported. Managed care plans' performance measure data are also validated by the EQRO on an annual basis.

In addition to performance measures reported by the plans, CAHPS survey data on recipients' experiences and satisfaction with care are important for assessing managed care plan performance and opportunities for improvement. During the Reform demonstration, the Agency contracted with the University of Florida to conduct CAHPS surveys for the managed care population. Under MMA, managed care plans will contract with an NCQA-certified CAHPS survey vendor for a CAHPS health plan survey conducted each year. The plans will report survey results to the Agency annually.

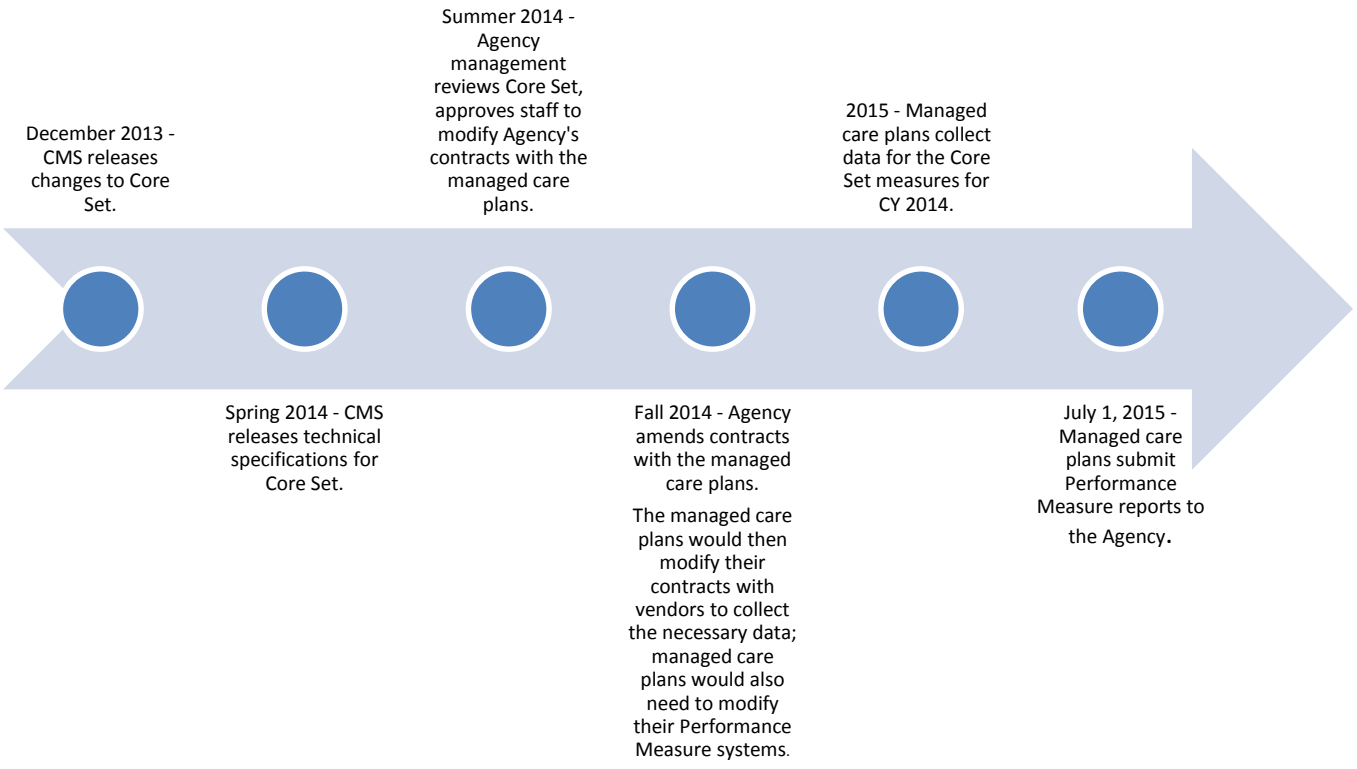
The Agency will use performance measures and CAHPS survey results to assess MMA program performance by managed care plan and for the program as a whole. Agency staff will use these data to identify areas in need of improvement and to look at improvement over time. For many of the measures, the Agency will have seven years of data (calendar years (CY) 2006-2013) for Reform and 1915 (b) managed care waiver health plans, which will serve as a baseline against which to compare MMA plan performance. In addition to performance measures that are being reported by current managed care plans, the state has added several of the CMS Medicaid Adult Core Set measures to the reporting requirements for MMA plans. While the state will not have its own baseline data for these measures, the state will use the National Means and Percentiles published by NCQA as a comparison/benchmark for the HEDIS measures, and will use national benchmark data for other measures as it becomes available. Plans that perform highly on HEDIS performance measures compared to the NCQA National Means and Percentiles will have the opportunity to earn financial incentives through an add-on to an Achieved Savings Rebate, while plans that perform poorly may face liquidated damages and/or sanctions. In addition to internal review and analysis of performance measures and CAHPS survey results, these data will be used as part of the evaluation analyses.

On an annual basis, the state will continue to review the performance measures reported by the managed care plans, considering whether any measures should be removed and whether there are additional measures from the Child and Adult Core Sets that should be added to reporting requirements. As national, standardized measures are developed that can replace Agency-defined measures in particular areas (e.g., a Mental Health Readmission Rate measure), the state will adopt those measures in order to collect data that are more comparable to other states and national benchmarks. As measures are added and removed from the Child and Adult Core Sets, and as technical specifications for these measures become available, the state will work on including these measures in required reporting. The state is also exploring the use of encounter data to generate rates for Adult Core Set measures like the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators. The timing considerations regarding incorporating Core Set changes into the MMA Plan contract reporting are as follows:

- Plans are required to submit performance measure reports to the Agency by July 1 each year, for the previous calendar year measurement period. For example, the plans submitted performance measures for CY 2014 by July 1, 2015.
- Changes to Performance Measures (adding or deleting) would require a contract amendment with each MMA health plan. The Agency would need to execute the contract prior to the year in which the health plans report the Performance Measures. For example, if the plans are required to submit a new Performance Measure for calendar year 2015, the Agency

would have needed the technical specifications for the Performance Measure in the spring of 2015. Therefore, any technical specifications received in spring of one year would be able to be reported by the plans by July 1 of the next year.

Timeline Example



The table below includes the MMA performance measures, the Steward/Source of the measure, whether the measure is in the CMS Adult and/or Child Core Set, and the measure's National Quality Forum (NQF) number, if the measure is endorsed by NQF. It also notes the years of baseline data that the state has for the measure or whether the measure

is being newly reported under the MMA program. Specifications for the Agency-defined measures are in Appendix II.

MMA Program Performance Measures				
Measure	**Steward/ Source**	**CMS Adult/Child Core Measure?**	**NQF #**	**Baseline Years of Data (CYs)**
Adolescent Well Care Visits	NCQA HEDIS	Child	1332	2007-2013
Adults' Access to Preventive/ Ambulatory Health Services	NCQA HEDIS			2008-2013
Ambulatory Care – ED Visits	NCQA HEDIS	Child		2007-2013
Annual Dental Visits	NCQA HEDIS		1334	2007-2013
Annual Monitoring for Patients on Persistent Medications	NCQA HEDIS	Adult	2371	None, new measure
Antenatal Steroids	Joint Commission	Adult	0476	None, new measure
Antidepressant Medication Management	NCQA HEDIS	Adult	0105	2008-2013
BMI Assessment	NCQA HEDIS	Adult	0421	2009-2013
Breast Cancer Screening	NCQA HEDIS	Adult	2372	2008-2013
Call Abandonment	Prev. HEDIS/ Agency- defined			2011-2013
Call Answer Timeliness	HEDIS			2011-2013
Cervical Cancer Screening	NCQA HEDIS	Adult	0032	2007-2013
Childhood Immunization Status (Combos 2 and 3)	NCQA HEDIS	Child	0038	2008-2013
Children and Adolescents' Access to Primary Care	NCQA HEDIS	Child		2011-2013
Chlamydia Screening for Women	NCQA HEDIS	Child and Adult	0033	2010-2013
Comprehensive Diabetes Care (CDC)	NCQA HEDIS			2007-2013
CDC-HbA1c testing	NCQA HEDIS	Adult	0057	2007-2013
CDC-HbA1c poor control	NCQA HEDIS	Adult	0059	2007-2013
CDC-HbA1c control (<9%)	NCQA HEDIS		0575	2007-2013
CDC-Eye exam performed	NCQA HEDIS		0055	2007-2013
CDC-LDL-C screening	NCQA HEDIS			2007-2013
CDC-LDL-C control (<100 mg/dL)	NCQA HEDIS			2007-2013
CDC-Medical attention for nephropathy	NCQA HEDIS		0062	2007-2013
Controlling Blood Pressure	NCQA HEDIS	Adult	0018	2007-2013
Dental Treatment Services	CMS-416			None, new measure
Follow-up after Hospitalization for Mental Illness	HEDIS/Agency-defined	Child and Adult	0576	2007-2013
Follow-up Care for Children Prescribed ADHD Medication	NCQA HEDIS	Child	0108	2009-2013
Highly Active Anti-Retroviral Treatment (HAART)	Agency-defined			2010-2013
HIV-related Medical Visits	Agency-defined			2010-2013
Immunizations for Adolescents	NCQA HEDIS	Child	1407	2009-2013

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA HEDIS	Adult	0004	None, new measure
Lead Screening in Children	NCQA HEDIS			2008-2013
Mental Health Readmission Rate	Agency-defined			2008-2013
Plan All-Cause Readmissions	NCQA HEDIS	Adult	1768	None, new measure
Prenatal and Postpartum Care	NCQA HEDIS	Child and Adult	1517	2007-2013
Prenatal Care Frequency	HEDIS/Agency-defined	Child	1391	2007-2013
Preventive Dental Services for Children	CMS-416	Child		None, new measure
Sealants	CMS-416			None, new measure
Transportation Availability	Agency-defined			2011-2013
Transportation Timeliness	Agency-defined			2011-2013
Use of Appropriate Medications for People with Asthma	NCQA HEDIS		0036	2008-2013
Viral Load Suppression	Health Resources and Services Administration	Adult	2082	None, new measure
Well-Child Visits in the First 15 Months of Life	NCQA HEDIS	Child	1392	2007-2013
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA HEDIS	Child	1516	2007-2013

The most recent available baseline year weighted means for Reform and Non-Reform plans on HEDIS measures are presented in the table below. These measures were reported in 2014 and represent calendar year 2013.

Calendar Year 2013 HEDIS Measures – Non-Reform and Reform Plan Weighted Means		
Performance Measure	**Non-Reform**	**Reform**
Annual Dental Visit***	30.5%	42.3%
Adolescent Well-Care	50.3%	49.5%
Controlling Blood Pressure	53.7%	49.0%
Cervical Cancer Screening	56.8%	56.4%
Diabetes - HbA1c Testing	80.1%	81.9%
Diabetes - HbA1c Poor Control (INVERSE)	48.1%	47.8%
Diabetes - HbA1c Good Control	43.2%	44.5%
Diabetes - Eye Exam	49.5%	48.2%
Diabetes - LDL Screening	79.2%	82.4%
Diabetes - LDL Control	32.7%	32.8%
Diabetes - Nephropathy	79.6%	83.7%
Follow-up after Hospitalization for Mental Illness - 7 day	28.5%	22.4%
Follow-up after Hospitalization for Mental Illness - 30 day	46.8%	39.3%
Prenatal Care	71.6%	67.2%

Postpartum Care	50.7%	52.3%
Well-Child First 15 Mos. - 0 Visits (INVERSE)	2.4%	2.2%
Well-Child First 15 Mos. - 6(+) Visits	54.4%	54.2%
Well-Child 3-6 Years	74.4%	75.0%
Adults' Access to Preventive Care - 20-44 Yrs	66.7%	75.9%
Adults' Access to Preventive Care - 45-64 Yrs	82.2%	86.6%
Adults' Access to Preventive Care - 65+ Yrs	71.9%	78.4%
Adults' Access to Preventive Care - total	71.6%	76.1%
Antidepressant Medication Mgmt - Acute	52.1%	54.6%
Antidepressant Medication Mgmt - Continuation	37.2%	40.7%
Appropriate Medications for Asthma****	80.9%	81.3%
Breast Cancer Screening	54.2%	56.0%
Childhood Immunization Combo 2	76.8%	74.9%
Childhood Immunization Combo 3	71.6%	70.5%
Frequency of Prenatal Care	61.5%	53.7%
Lead Screening in Children	59.6%	63.2%
Adult BMI Assessment	83.3%	77.0%
Follow-up Care for Children Prescribed ADHD Medication - Initiation*****	48.6%	44.1%
Immunizations for Adolescents Combo 1	63.3%	63.0%
Chlamydia Screening - 16-20 years	58.2%	57.4%
Chlamydia Screening - 21-24 years	69.8%	69.6%
Chlamydia Screening - total	62.7%	61.8%
Appropriate Testing for Children with Pharyngitis	62.5%	69.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95.3%	95.8%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	88.2%	89.0%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	86.6%	87.3%
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	83.6%	84.1%
Call Answer Timeliness	94.9%	95.7%

MMA Evaluation Design
Appendix I

Domain 1, 2, 10, New 14 (DYs 10 and 11), New 15 (DYs 10 and 11) and New 16 (DYs 10 and 11): Studying the effect of managed care, customized benefit plans, and having separate managed care programs for MMA and LTC services on beneficiaries' choice of plans, access to care, quality of care, and cost of care.

Domain	Research Questions	Hypotheses	Analyses	Data Sources
Domain 1 The effect of managed care on access to care, quality and efficiency of care, and the cost of care.	1. A. What barriers do enrollees encounter when accessing services? 1. B. What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans (MMA plans as a whole)? 1. C. What changes in the accessibility of services occur with MMA implementation, comparing the accessibility of specialty services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to specialty MMA plans? 1. D.	1. A. The MMA program will result in improved access to appropriate use of services (preventive care services (PCP and specialty services) versus preventable ER visits and hospitalizations) compared to Reform and 1915(b) managed care waiver plans. 1. B. The accessibility of services will be statistically significantly greater in MMA plans as a whole than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. C. The accessibility of specialty services will be statistically significantly greater in specialty MMA plans, than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. D.	Multivariate regression and interrupted time series analyses (as appropriate) to assess utilization before and after implementation of the MMA program as well as across standard MMA and specialty MMA plans. Evaluators will examine trends in utilization over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity. Analysis of barriers to care will be descriptive, focusing on frequencies of complaints, grievances, and appeals that are related to access to care. Comparisons across plans, between specialty MMA plans and standard MMA plans, and pre and post MMA program implementation will be made (to the extent possible). Accessibility and utilization of services will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate.	Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to look at service utilization during the demonstration. (E.g., utilization of PCP, Specialists non-emergency hospitalizations and ER visits). Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data: The Agency will be contractually requiring MMA plans to contract with an NCQA-certified CAHPS survey vendor for a CAHPS health plan survey to be conducted each year. The Agency will require that MMA plans report the survey results to the Agency annually. To answer questions related to access and appropriate care, evaluators will analyze overall ratings variables related to access to personal doctor and referrals, satisfaction with personal doctor and specialists. The evaluation team will conduct analyses of survey results related to getting needed care, ease in getting care, and getting care quickly as well. HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures: The Agency will require MMA plans to submit performance measures to the Agency annually.

	1. D. What changes in the accessibility of services occur with MMA implementation, comparing the accessibility of specialty services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to standard MMA plans? 1. E. What changes in the accessibility of services occur with MMA implementation, comparing accessibility of services in specialty MMA plans to standard MMA plans and to the degree possible, comparing the accessibility of services in specialty MMA plans to accessibility of services for recipients in standard MMA plans eligible for enrollment in the specialty MMA plan (e.g., recipients with COPD enrolled in standard MMA plans compared to recipients with COPD enrolled in the COPD specialty plan)? 1. F.	The accessibility of specialty services will be statistically significantly greater in standard MMA plans, than it was in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). 1. E. Accessibility of services will not be statistically significantly different in specialty MMA plans and standard MMA plans as a whole. However, accessibility of specialty services will be statistically significantly greater in specialty MMA plans than for specialty population recipients served by standard MMA plans (e.g., recipients with COPD enrolled in standard MMA plans compared to recipients with COPD enrolled in the COPD specialty plan). 1.F.	Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing the MMA program as a whole to Reform and1915 (b) waiver plans , as well as comparing standard MMA and specialty MMA plans to one another. Comparison of MMA program weighted means to Medicaid National Means and Percentiles for HEDIS measures. MMA program weighted means will also be compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of the MMA program, when available.	The Agency requires plans to certify, through independent audit, that the data have been "fairly and accurately reported" and plans must attest to the accuracy of their performance measure data. The Agency currently has six years of performance measure data (calendar years 2007-2012) that may be used as baseline data prior to the MMA program. To answer questions related to access and quality of care, the evaluators will analyze measures related to use of preventive services and management of chronic conditions. (E.g., Adult Access to Preventive Care, Well-Child Visits, & Follow up After Hospitalization for Mental Illness). Enrollee Complaint, Grievance, and Appeals Report: Managed care plans will be required to submit this report monthly. (E.g., Number of grievances and appeals by type). Agency Complaints, Issues, Resolutions & Tracking System (CIRTS). The Agency maintains the above data system to track recipient complaints. Data elements include recipient identifier information, type of complaint (e.g., access, quality of care, etc.) and plan enrollment. The Agency currently has four years of data to that may be used as baseline data prior to the MMA program. Some of the elements in and processes around the CIRTS system have changed with the transition to the MMA program, so comparisons may be made to the extent possible, understanding that they will not always be apples-to-apples.

	What changes in the utilization of services for recipients are evident post MMA implementation, comparing: 1) utilization of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to utilization of services in post MMA implementation plans (MMA plans as a whole); 2) utilization of services in specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those recipients in the standard MMA plans with the specialty plan condition; e.g., COPD)?	It is expected that: 1) the demonstration will result in a statistically significant improvement in the appropriate use of services for recipients post versus pre-MMA implementation. That is, appropriate utilization of services will be significantly greater in MMA plans as a whole than in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); 2) the demonstration will not result in significantly different utilization of services overall for specialty MMA plans compared to standard MMA plans; and 3) Specialty MMA plans will provide enrollees with improved access to specialty services related to the specialty condition (e.g., COPD Specialty plan and access to pulmonary specialists) compared to standard MMA plans.		To answer questions related to access to care, barriers to care and quality of care, the evaluators will analyze measures related to the frequency and type of complaints.
	1. G. What changes in quality of care for recipients are evident post MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in post MMA implementation plans (MMA plans as a whole); 2) quality of	1. G. Quality of care for enrollees will: 1) be statistically significantly higher in MMA plans as a whole compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); 2) not be statistically significantly different for enrollees in specialty versus standard MMA plans (whole standard MMA population); and 3) be statistically significantly	Quality of care will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate. Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing the MMA program as a whole to Reform and 1915 (b) waiver plans, as well as comparing standard MMA and specialty MMA plans to one another.	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data. To answer questions related to quality of care, evaluators will analyze overall ratings variables related to satisfaction with health care, health plan, personal doctor, and specialists, getting needed care, ease in getting care, and getting care quickly. Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to look

	care in specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD)? 1. H. What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?	higher in specialty MMA plans compared to enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD, if such comparison is feasible. 1. H. The quality of care strategies targeting specific sub-populations or services will be more successful than strategies which do not target specific sub-populations or services.	Multivariate regression and interrupted time series (as appropriate) analyses with both bivariate and multivariate controls to assess utilization before and after implementation of the MMA program as well as across standard MMA and specialty MMA plans. Evaluators will examine trends in utilization and expenditures over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity. Comparison of MMA program weighted means to Medicaid National Means and Percentiles for HEDIS measures. MMA program weighted means will also be compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of the MMA program, when available. Descriptions of Performance Improvement Projects, including their objectives, interventions, and outcomes.	at service utilization and expenditures during the demonstration. (E.g., utilization of PCP, Specialists non-emergency hospitalizations and ER visits). HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures. (E.g., Comprehensive Diabetes care, Plan All-Cause Readmissions, and Controlling Blood Pressure). Performance Improvement Projects (PIPs): The Agency will contractually require MMA plans to conduct a set number of PIPs and to have two of them validated by the state's External Quality Review Organization each year. Plans must report on their PIPs according to Federal CMS protocols, and the External Quality Review Organization provides technical assistance to the plans as well as preparing an annual report on the status of the health plans' PIPs. Evaluators will review health plan PIP submissions to look at what steps the health plans have taken to improve quality of care for enrollees during the demonstration. The evaluation team may analyze External Quality Review reports on the status of health plan PIPs as well.
	1. I. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans	1. I. The demonstration will result in: 1) a statistically significant improvement in timeliness of services in post-MMA implementation plans compared to pre-MMA implementation plans	Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing the MMA program as a whole to Reform and 1915 (b) waiver plans, as well	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data. To answer questions related to timeliness of services, evaluators will analyze overall ratings variables related to recipient perceptions of access to

	(Reform plans and 1915(b) waiver plans) to post-MMA implementation plans (MMA plans as a whole) and 2) specialty MMA plans versus standard MMA plans (whole population and, to the extent possible, for those enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD)?	(Reform plans and 1915(b) waiver plans); 2) no statistically significant differences in timeliness of services for enrollees in specialty versus standard MMA plans (whole standard MMA population); and 3) statistically significant improvement in timeliness of services in specialty MMA plans compared to enrollees in the standard MMA plans with the specialty plan condition; e.g., COPD, if such comparison is feasible.	as comparing standard MMA and specialty MMA plans to one another. Descriptive statistics and tests of significance for measures for the Timely Access PCP Wait Times Report comparing standard MMA and specialty MMA plans to one another. Timeliness of services will be assessed based on CAHPS and HEDIS timeliness measures and PCP Wait Time Reporting, consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate.	PCP and Specialist, getting needed care, ease in getting care, and getting care quickly as well. Timely Access PCP Wait Times Report. To answer questions related to timeliness of services, evaluators will utilize PCP Access data (average appointment wait times through a statistically valid sample) to complete comparative analyses across MMA and specialty MMA plans. HEDIS measures related to timeliness of services (e.g., Timeliness of Prenatal Care, Postpartum Care). Agency defined measure related to Transportation Timeliness.
	1. J. What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per enrollee costs post-MMA implementation (MMA plans as a whole, standard MMA plans and specialty MMA plans)?	1. J. The per-enrollee cost by eligibility group within the MMA demonstration will be less than the estimated costs by a statistically significant amount had the MMA demonstration not been in place.	Multivariate and interrupted time series analyses with both bivariate and multivariate controls to assess utilization and expenditures before and after implementation of the MMA program. Evaluators will examine trends in utilization and expenditures over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.	Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to analyze service utilization and expenditures during the demonstration and compared to the Reform and 1915 (b) waiver plans and between standard MMA plans and specialty MMA plans.

Domain 2	2. A.	2. A.	Descriptive statistics of plan benefits over time, including the number of expanded	Health plan choice materials and Agency quarterly and annual reports to Federal CMS:

The Effect of Customized Benefit Plans on Beneficiaries' Choice of Plans, Access to Care and Quality of Care	What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the type of expanded benefit to particular populations? To what extent do enrollees use these expanded benefits?	These research questions were included to provide context (description of plans with expanded benefits) to analyses for this Domain. Therefore, there are no hypotheses to test for these research questions.	benefits offered per plan, as well as the average number of expanded benefits across plans, including specialty and standard MMA plans.	evaluators will use these data sources to identify any expanded/additional services plans cover.
	2. B. What differences in enrollee satisfaction with their health plan occur over the course of the demonstration based on how many types of expanded benefits are offered by a plan?	2. B. Enrollees of standard MMA or specialty MMA plans that offer more types of expanded benefits will report greater satisfaction with their plan than enrollees of standard MMA and specialty MMA plans that offer fewer types of expanded benefits.	Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing standard MMA and specialty MMA plans that offer more types of expanded benefits to standard MMA and specialty MMA plans that offer fewer types of expanded benefits.	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data. The evaluation team will conduct analyses of survey results related to enrollee satisfaction based on the number and types of expanded benefits offered. Evaluators will analyze overall ratings variables related to enrollee satisfaction with health plan, health care, getting needed care, ease in getting care, and getting care quickly as well.
	2. C. What differences in the accessibility of services occurs over the course of the demonstration in standard MMA or specialty MMA plans based on how many types of expanded benefits are offered by the plan?	2. C. Enrollees of standard MMA or specialty MMA plans that offer more types of expanded benefits will have statistically significantly higher accessibility and quality of care measures than enrollees of standard MMA and specialty plans that offer fewer types of expanded benefits.	Multivariate regression and interrupted time series analyses with both bivariate and multivariate controls to assess utilization before and after implementation of the MMA program with particular focus on use of expanded benefits**.** Evaluators will examine trends in utilization over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.	Medicaid claims, eligibility, enrollment, and encounter data: these data will be used to look at service utilization prior to and during the demonstration. (E.g., utilization of PCP, Specialists, non-emergency hospitalizations and ER visits). Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data. To answer questions related to accessibility of services, evaluators will analyze overall ratings variables related to recipient satisfaction with health

			Descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey and performance measures, comparing standard MMA and specialty MMA plans that offer expanded benefits to standard MMA and specialty MMA plans that do not offer expanded benefits. Accessibility of services will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate.	plan, getting needed care, ease in getting care, and getting care quickly as well. Performance Measures related to access to care (e.g., Adult Access to Preventive Care, Well-Child Visits, & Follow up After Hospitalization for Mental Illness) and quality of care (e.g., measures related to care of chronic conditions).
Domain 10 The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014.	10. A. How many recipients are enrolled in separate Medicaid managed care programs for acute care and LTC services? 10. B. How many recipients are enrolled in comprehensive plans that provide both acute care and LTC services?	10. A. This research question was included to provide context (description of selected managed care plans, services each provides and associated enrollment) to analyses for this Domain. Therefore, there are no hypotheses to test for this research question. 10. B. Plans that provide both acute and LTC services will enroll more enrollees who need both types of services than plans that only provide one type of services.	Descriptive statistics of plans selected and related enrollment data.	Medicaid enrollment data.
	10. C. What are the differences in service utilization and costs between enrollees who are in	10. C. Enrollees receiving acute and LTC services from comprehensive plans will have statistically significantly	Evaluators will make comparisons of service utilization and costs between enrollees who are in comprehensive plans and those who are enrolled in separate	Medicaid Eligibility, enrollment, claims, and encounter data.

	comprehensive plans vs. those who are enrolled in separate MMA and LTC plans?	lower service utilization and costs than enrollees who receive acute and LTC services from separate MMA and LTC plans.	MMA and LTC plans. Evaluators will examine trends in utilization and expenditures over time. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.	
	10. D. What strategies are LTC plans using for benefit coordination for enrollees who are also enrolled in a MMA plan or a Medicare plan? Which of these strategies are most effective in improving benefit coordination and why?	10. D. These research questions were included to provide context (description of how plans provide coordination of care) to analyses for this Domain. Therefore, there are no hypotheses to test for these research questions.	Evaluators will conduct interviews with LTC plan staff regarding their care coordination activities and which strategies they consider effective. Evaluators will make comparisons of care coordination policies and procedures for plans that provide LTC services. Additionally, evaluators will analyze effectiveness of procedures utilized.	Interview responses from LTC plan staff. Health plan policies and procedures related to care coordination. LTC Case Management and Monitoring Report: The Agency will require plans that provide LTC services to report on a quarterly and annual basis data related to the plan: case file audit reviews to determine the timeliness of enrollee assessments performed by case managers, reviews of the consistency of enrollee service authorizations performed by case managers, and the development and implementation of continuous improvement strategies to address identified deficiencies.

Domain New 14 The effectiveness of the Express Enrollment process in connecting beneficiaries with care, including expanded benefits, in a timely manner. **Effective DYs 10 and 11**	New 14.A How quickly do recipients access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible if they are enrolled in a health plan immediately upon becoming Medicaid eligible compared to those recipients who experienced a period of fee-for-service enrollment prior to health plan enrollment.	New 14.A. It is expected that recipients will access services sooner if they are enrolled in a health plan immediately upon becoming Medicaid eligible. This includes both State Plan benefits and expanded benefits in excess of State Plan coverage.	Comparison of timing of use of services pre and post expedited enrollment process by enrollees who were enrolled in fee-for-service Medicaid prior to enrolling in an MMA health plan to those enrollees who were enrolled in a MMA health plan immediately after eligibility determination.	Medicaid claims; eligibility, enrollment and encounter data: these data will be used to look at enrollment, plan selection, service utilization, and expenditures during the demonstration.
Domain New 15 The benefits and outcomes associated with participation in the Event Notification Service.	New 15.A. How many providers/managed care organizations are participating in the Event Notification Service and for what duration?	New 15.A. Descriptive research question – no hypothesis.	Descriptive statistics of providers/managed care plans participating in the Event Notification System and duration of participation.	Florida Center data regarding participating and enrolled ENS providers.

Effective DYs 10 and 11				
	New 15.B. How do managed care plans follow-up with recipients after an event notification?	New 15.B. Descriptive research question – no hypothesis.	Descriptive analysis of types and content of follow-up contact with recipient.	Data from evaluator-designed interviews and/or survey of managed care plans that participate in ENS.
	New 15.C. What do managed care organizations report are the perceived benefits of utilizing the Event Notification Service?	New 15.C. Descriptive research question – no hypothesis.	Analysis of interviews and/or survey of managed care staff comments regarding experiences with the Event Notification System.	Data from evaluator-designed interviews and/or survey of managed care plans.

Domain New 16 The effect of Choice on Plan enrollment and disenrollment. Effective DYs 10 and 11.	New 16.A. How many recipients select a plan versus are auto-enrolled upon eligibility determination?	New 16.A. Descriptive research question – no hypothesis.	Descriptive statistics of recipients selecting plans versus auto-assigned to plans as well as changing plan selections.	Medicaid eligibility and enrollment: these data will be used to look at enrollment, plan selection.
	New 16.B. How many recipients elect to change plans within the 120 day change period?	New 16.B. Descriptive research question – no hypothesis.	Descriptive statistics of recipients changing plans within 120 days.	Medicaid eligibility, enrollment, and Managed Care Span; data will be used to look at enrollment and plan selection during the demonstration.
	New 16.C. What difference in length of plan enrollment over time is evident from recipients who initially select a plan versus those who are auto-enrolled in a plan?	New 16.C. Recipients who select a plan will have statistically significant longer duration of plan enrollment than recipients who are auto-enrolled in a plan.	Descriptive statistics and tests of significance of differences in duration of enrollment comparing recipients selecting plans upon eligibility determination versus those auto-assigned.	Medicaid choice counseling data: this data will be used to look at auto-enrollment, plan selection, and length of plan enrollment.

Domains 3 and 12: Studying the transition of the EBAP program to the MMA plans' Healthy Behaviors programs, participation in the Healthy Behaviors programs and its effect on participant behavior or health status.

Domain	Research Questions	Hypotheses	Analyses	Data Sources
Domain 3	3. A. What Healthy Behaviors programs do MMA plans offer?	3. A., 3. B., 3. C. & 3. D. These research questions were included to provide context	Analyses will describe what Healthy Behaviors programs are offered by MMA plans, what incentives and rewards are	MMA managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors

Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status. Please note that the following research questions focus on the Healthy Behaviors programs under MMA, while the questions related to EBAP are provided on pages 15 and 16 under the Reform evaluation. Also note that the following questions may change based on the types of Healthy Behaviors programs offered by MMA plans.	What types of programs and how many are offered in addition to the three required programs (medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)? 3. B. What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs? 3. C. How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behavior programs attract higher numbers of participants? 3. D. How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity, and health status of enrollees?	(description and number of Healthy Behavior programs provided by plan as well as associated incentives and rewards) to analyses for this Domain. Therefore there are no hypotheses to be tested for these research questions.	offered to enrollees for participating in the programs, how many enrollees participate in the programs, how many complete the programs and if certain types of programs attract higher numbers of participants. Demographic characteristics of program participants will be analyzed as well.	program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives provided for each Healthy Behaviors program.
	3. E. What differences in service utilization occur over the course	3. E. Enrollees participating in Healthy Behaviors programs will have a	The evaluation team will compare the service utilization of enrollees who participate in Healthy Behaviors programs to the utilization	Managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors

	of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating?	statistically significant higher utilization of preventive services and outpatient services (e.g. Primary Care Physician (PCP) visits and smoking cessation counseling sessions) compared to enrollees not participating in Healthy Behaviors programs. Furthermore, service utilization of ER, inpatient and outpatient hospital and physician specialty services for treatment of conditions that these programs are designed to prevent will be lower by a statistically significant amount for enrollees after enrolling in the Healthy Behaviors program than before enrollment.	of enrollees who do not participate in the programs, and will compare the service utilization of program participants before and after participation. Evaluators will use Medicaid claims, eligibility, and encounter data to compare the likelihood of receiving particular services between program participants before and after program participation, and between program participants and enrollees who do not participate in Healthy Behaviors programs. Evaluators will use claims, eligibility, and Healthy Behaviors reports to compare demographic and health status characteristics of program participants and those who do not participate. These data will be linked to encounter data to compare the likelihood of physician visits, specialist visits, ER visits and avoidable hospitalizations for ambulatory sensitive conditions (using Prevention Quality Indicators) for program participants vs. those who do not participate. Utilization of services will be assessed consistent with CMS Child Core and Medicaid Adult Core Sets as appropriate.	program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives provided for each Healthy Behaviors program. Medicaid claims, eligibility, and encounter data: evaluators will use these data to look at service utilization during the demonstration.

Domain 12 The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs.	12. A. How many enrollees that participated and earned credits in the EBAP program participate in MMA plan Healthy Behaviors programs? How many enrollees that did not participate in the EBAP program (including those previously in Reform plans and those in 1915 (b) waiver plans) participate in Healthy Behaviors programs?	12. A. These research questions are descriptive rather than aimed at testing a hypothesis.	Analyses will look at how many enrollees that participated and earned credits in the EBAP program participate in the MMA plans' Healthy Behaviors programs, and how many Healthy Behaviors program participants did not previously participate in the EBAP program.	MMA managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives provided for each Healthy Behaviors program. Enhanced Benefits Information System (EBIS): This database includes the Enhanced Benefits Account Program information on the healthy behavior activities in which enrollees participated during the Medicaid Reform demonstration (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits.
	12. B. What Healthy Behaviors programs do MMA plans offer that were not part of the EBAP program?	12. B. This research question was included to provide context (changes between EBAP program and Healthy Behavior programs) to analyses for this Domain. Therefore, there are no hypotheses associated with this research question.	Analyses will identify the Healthy Behaviors programs available through the MMA plans that were not part of the EBAP program.	MMA managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives provided for each Healthy Behaviors program. Enhanced Benefits Information System (EBIS): This database includes the Enhanced Benefits Account Program information on the healthy behavior activities in which enrollees participated during the Medicaid Reform

				demonstration (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits.
	12. C. What is the difference in enrollees earning, accessing, and using the Healthy Behaviors incentives and rewards programs compared to the prior EBAP program?	12. C. Enrollees will earn, access and utilize the Healthy Behaviors program incentives and rewards offered at a statistically significant higher rate than the EBAP program.	Evaluators will compare the incentives and rewards earned, accessed and utilized by enrollees in the MMA Healthy Behaviors programs to the credits that Reform enrollees earned, accessed and utilized through the EBAP program.	MMA managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives provided for each Healthy Behaviors program. Enhanced Benefits Information System (EBIS): This database includes the Enhanced Benefits Account Program information on the healthy behavior activities in which enrollees participated during the Medicaid Reform demonstration (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits.
	12. D. What is the difference in utilization of inpatient, outpatient and physician specialist services for ambulatory care sensitive conditions for enrollees in EBAP	12. D. The transition into Healthy Behaviors will result in no statistically significant difference in utilization of inpatient, outpatient or physician specialist services for ambulatory care sensitive	Evaluators will compare service utilization of EBAP participants before and after implementation of the MMA program. Analyses will include comparisons between EBAP participants who also participate in Healthy Behaviors programs versus those who do not. Evaluators will conduct bivariate	MMA managed care plan reports on Healthy Behaviors programs: these reports include data related to each Healthy Behaviors program, caseloads (new and ongoing) for each Healthy Behaviors program, and the amount and type of rewards/incentives

	versus after they: 1) transition into a Healthy Behaviors program or 2) do not transition into a Healthy Behaviors program?	conditions for an enrollee as compared to when they were enrolled in EBAP for the same type of program. EBAP enrollees that do not transition into a Healthy Behaviors program will experience a statistically significant increase in inpatient, outpatient and physician specialist service use for ambulatory care sensitive conditions.	and multivariate analyses that control for factors such as age, gender, eligibility category, race/ethnicity, and length of time in Medicaid. The evaluation team will assess general descriptive statistics and Healthy Behaviors program participation rates using the MMA plan reports on Healthy Behaviors programs. Evaluators will use Medicaid claims, eligibility, and encounter data to compare the likelihood of EBAP participants receiving particular services prior to MMA and during the MMA program. These data will be linked to encounter data to compare the likelihood of avoidable hospitalizations for ambulatory care sensitive conditions (using Prevention Quality Indicators) for program participants vs. those who do not participate. Ambulatory care sensitive conditions will be assessed consistent with the Prevention Quality Indicators (PQIs), including PQIs in the CMS Medicaid Adult Core Set.	provided for each Healthy Behaviors program. Enhanced Benefits Information System (EBIS): This database includes information on the healthy behavior activities in which enrollees participated during the Medicaid Reform demonstration (submitted by the health plans), the amount of credits earned by enrollees for those activities, the amount of credits spent by enrollees, and the items purchased using credits. Medicaid claims, eligibility, and encounter data: evaluators will use these data to look at service utilization and costs during the demonstration.

Domains 4 and 11: Studying the impact of the demonstration as a deterrent against Medicaid fraud and abuse, including the effect of having separate managed care programs for MMA and LTC services.

Domain	Questions	Hypotheses	Analyses	Data Sources
Domain 4 The impact of the Demonstration as a deterrent against Medicaid fraud and abuse	4. A. What are the program integrity-related measures employed by the MMA managed care plans related to: deterring fraud and abuse by network and non-network providers; deterring fraud and abuse by recipients; detecting fraud and abuse by network and non-network providers; and detecting fraud and abuse by recipients?	4. A. It is expected that MMA managed care plans in the Demonstration will use a variety of strategies to deter Medicaid fraud and abuse and to improve detection of fraud and abuse by providers and recipients.	This study will review the program integrity-related measures health plans in the MMA program take to deter and detect fraud and abuse, by both providers and recipients. Analyses will include comparisons of efforts across MMA managed care plans. Evaluators will use descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors to assess the impact of the demonstration as a deterrent against Medicaid fraud and abuse. Evaluators will also review the Agency's efforts to assist the health plans in their program integrity-related activities.	Health plan policies and procedures (including manuals) related to compliance and to fraud and abuse. Health plan anti-fraud plans and fraud and abuse reports that are submitted to the Agency. Interviews of health plan executive leadership and compliance/fraud and abuse directors at health plans.
	4. B. How often do managed care plan compliance officers/teams interact with providers in the plan networks? What types of contact and interactions do the compliance officers/teams have with providers? How do plans document and track their efforts to deter fraud and abuse?	4. B. It is expected that MMA managed care plans will use a variety of strategies to work with their providers to prevent fraud and abuse.	Evaluators will use descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors to assess the impact of the demonstration as a deterrent against Medicaid fraud and abuse.	Data sources as described above.

	4. C. How does the State collect and track Medicaid fraud and abuse data reported by the MMA plans? How does the State coordinate and/or assist the MMA plans with fraud and abuse efforts?	4. C. These questions do not lend themselves to a hypothesis. The information reported from examining these questions will provide background and context to other analyses. The Agency will also request that the evaluator provide recommendations as appropriate.	Evaluators will review the Agency's efforts to assist the health plans in their program integrity-related activities. Evaluators will also complete content analyses of interviews with health plan and with Agency staff.	Interviews of Agency staff and compliance/fraud and abuse directors at health plans.
	4. D. How do health plan compliance officers/teams measure the effectiveness of the health plan policies and procedures related to program integrity?	4. D. These questions do not lend themselves to a hypothesis. The information reported from examining these questions will provide background and context to other analyses. The Agency will also request that the evaluator provide recommendations as applicable.	Evaluators will use descriptions of health plan policies and procedures and manuals related to fraud and abuse and compliance and content analyses of interviews with health plan compliance/fraud and abuse directors to identify how the plans measure the effectiveness of their fraud and abuse activities.	Interviews of health plan executive leadership and compliance/fraud and abuse directors at health plans.
Domain 11 The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014.	11. A. To what extent is there overlap in services between LTC and MMA programs?	11. A. There are seven services which are covered by both the LTC plans and MMA plans. These services are: Home health, Hospice, DME (durable medical equipment), Transportation, Care Coordination, Assistive Care and Therapy services (physical, occupational, respiratory, and speech). It is expected that duplication of services may be greater for people receiving LTC and acute care services from separate LTC and MMA plans than people receiving both LTC and	Evaluators will use claims and encounter data to compare utilization of the seven services between the two populations (people receiving both LTC and acute care services from separate LTC and MMA plans versus people receiving both LTC and acute care services from a (comprehensive) single plan).	Medicaid claims and encounter data.

		acute care services from a (comprehensive) single plan.		

Domains 5-9: Due to the October 2015 Amendment and the extension of the LIP, some Domains expired at the end of DY9 and others will expire at the end of DY10. For DY9, Domains 5-9: Studying the effect of the Low Income Pool (LIP) on funding on the provision of health care services to the uninsured and the impact of Tier-One initiatives on (a) access to and quality of care, (b) population health, and (c) per capita costs and the cost-effectiveness of care. For DY 10 Domain 5 will be evaluated. For DY 11,New Domains 5 and 7: Studying the effect of the LIP on uncompensated care provided through hospital charity care programs; effect on access to care, quality of care, timeliness of care, and emergency department (ED) usage for the uninsured; and impact on costs for treating uninsured patients.

Domain	Research Questions	Hypotheses	Analyses	Data Sources
Domain 5 The effect of LIP: 1) funding on the number of uninsured and underinsured, and rate of uninsurance.(This Domain will sunset after DY 10)	5.A. How has the LIP program changed between DYs 9 and 10?	This research question was included to provide context for analyses for this Domain. Therefore, there are no hypotheses to test for these research questions.	Descriptive analyses of the LIP program to compare the changes between DYs 9 and 10.	STCs.
	5. B. How has LIP funding continued to provide access to care for uninsured/underinsured recipients? That is, how many uninsured and underinsured recipients receive services through LIP funding? What types of services are being provided?	5. B. It is expected that LIP funds to hospital providers will continue to provide access to care for uninsured and underinsured individuals at the same or higher rates as during the period prior to MMA.	The evaluation team will conduct descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained, and any changes over time.	LIP provider reporting on services provide and number of recipients served.
Domain 6 The effect of LIP funding on disparities in the provision of health care services, both geographically	6. A. What changes in the accessibility of services, occurs over the course of the demonstration in care for populations funded by LIP? What differences in	6. A. The availability of LIP funding will sustain accessibility of services for populations funded by LIP over the course of the demonstration, in the absence of Medicaid expansion.	The evaluation team will conduct descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained, and any changes over time. The Agency and CMS discussed the possibility of looking at LIP funding's impact on services	Annual Milestone Statistics and Findings Report. Information on innovative programs funded under Tier-One Milestones.

and by population groups. (This domain will sunset after DY 9)	accessibility of services is evident based on sex, age, race/ethnicity, and geographic location of enrollees?		defined by CMS Child Core and Medicaid Adult Core sets. It was determined that the LIP providers do not collect or report data in a way that the requested measures would be able to be calculated for the uninsured and underinsured populations served by the LIP providers.	Primary Care and Alternative Delivery System Report.
	6. B. How many programs funded by LIP, including Tier-One, are focused on reducing disparities in the provision of health care services or health outcomes? What are these programs doing to reduce disparities and how successful are they?	6. B. It is expected that those programs and quality initiatives that focus on specific disparities in the provision of health care services or health outcomes will achieve their goals by reducing disparities compared to their baseline.	Analyses of Tier-One initiatives that are focused on reducing disparities in the provision of health services or health outcomes will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes. Evaluators will individually review the entities conducting Tier-One initiatives, though if there are several entities conducting similar initiatives, the evaluators will analyze differences and similarities between those projects and their levels of success. The State and CMS discussed the possibility of including the National Quality Forum's (NQF's) Disparities-Sensitive Measures, and NQF's endorsed Healthcare Disparities and Cultural Competency measures to assess health care disparities. As this data is not	Annual Milestone Statistics and Findings Report. Information on innovative programs funded under Tier-One Milestones. Primary Care and Alternative Delivery System Report.

			collected by providers or reported to the State these measures are unable to be used at this time. However, in the future the State will consider utilizing these measures to assess these outcomes.	
Domain 7 The impact of Tier-One milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity). (This Domain will sunset after DY 9).	7. A. What are the goals of the Tier-One Milestone programs? What interventions/activities are they using to enhance quality of care and the health of low-income populations?	7. A. These research questions were included to provide context (i.e., description of goals of the Tier-One Milestone programs) to analyses for this Domain. Therefore, there are no hypotheses associated with these research questions.	Analyses of Tier One initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes. Evaluators will individually review the entities conducting Tier-One initiatives, though if there are several entities conducting similar initiatives, the evaluators will analyze differences and similarities between those projects and their levels of success.	Annual Milestone Statistics and Findings Report. Information on innovative programs funded under Tier-One Milestones.
	7. B. How successful are Tier-One Milestone programs in meeting their stated objectives related to access and quality of care consistent with the Three-Part Aim? What is the difference in hospital AHCA quality measure rates for hospitals participating in Tier-One Milestone programs versus those that do not participate?	7. B. Tier-One milestone programs will achieve all of their stated goals related to access and quality of care consistent with the Three-Part Aim. Hospitals with Tier-One Milestone programs initiatives will report greater improvements in quality measure rates (statistically significant) than hospitals not participating in Tier-One Milestone programs.	The evaluation team will conduct comparative analyses of quality measures reported by hospitals participating in Tier-One initiatives and hospitals not participating in Tier One initiatives. Analyses of Tier-One initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes. Evaluators will individually review the entities conducting	Annual Milestone Statistics and Findings Report. Information on innovative programs funded under Tier-One Milestones. Hospital quality measure scores used to distribute the Quality Add-on ($15 Million) Tier One Milestone funding.

			Tier-One initiatives, though if there are several entities conducting similar initiatives, the evaluators will analyze differences and similarities between those projects and their levels of success.	
Domain 8 The impact of LIP funding and Tier-One milestone initiatives on population health. (This Domain will sunset after DY 9).	8. A. What strategies are Tier-One Milestone initiatives adopting to improve population health consistent with the Three-Part Aim? What are the age, sex, race/ethnicity, and health conditions of target populations?	8. A. These research questions were included to provide context (i.e., description of the goals of the Tier One Milestone initiatives) to analyses for this Domain. Therefore, there are no hypotheses associated with the first two research questions.	Analyses of Tier-One initiatives will include content analyses of proposals/plans and progress reports, identifying which prong or prongs of the Three-Part Aim are addressed by the initiatives, describing the strategies being implemented for each initiative, and whether those strategies result in the intended outcomes. Evaluators will individually review the entities conducting Tier-One initiatives, though if there are several entities conducting similar initiatives, the evaluators will analyze differences and similarities between those projects and their levels of success.	Information on innovative programs funded under Tier-One Milestones. Primary Care and Alternative Delivery System Report.
	8. B. How successful are Tier-One Milestone programs in meeting their stated objectives related to improving population health consistent with the Three-Part Aim?	8. B. Tier One Milestone programs will achieve all of their stated goals related improving population health consistent with the Three-Part Aim.		
Domain 9 The impact of LIP funding and Tier-One	9. A. How do expenditures for services funded through the Tier-One Milestone initiatives	9. A. These research questions were included to provide context to analyses for this Domain. Therefore,	The evaluation team will conduct descriptive analyses of the entities receiving LIP funds, the number of recipients served, and the	Information on innovative programs funded under Tier-One Milestones.

milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care. (This Domain will sunset after DY 9).	differ from other LIP expenditures? How do the services provided under Tier-One milestone initiatives differ from those provided under other LIP funding?	there are no hypotheses associated with these research questions.	types of services obtained through the Tier-One initiatives.	Primary Care and Alternative Delivery System Report.
	9. B. What is the difference in use of preventive and outpatient care versus emergency department and inpatient visits by uninsured and underinsured individuals for hospitals participating in Tier-One Milestone programs versus those that do not participate? 9. C. What is the difference in expenditures on services for uninsured and underinsured individuals, for hospitals participating in Tier-One Milestone programs versus those that do not participate?	9. B. Hospitals participating in Tier-One Milestone programs will have statistically significantly higher utilization of preventive and outpatient care and statistically significantly lower utilization of emergency department and inpatient visits by uninsured and underinsured individuals compared to those without Tier-One Milestone programs. 9. C. Hospitals participating in Tier-One Milestone programs will have statistically significantly lower expenditures for services provided to uninsured and underinsured individuals compared to those without Tier-One Milestone programs.	The evaluation team will conduct descriptive analyses of the entities receiving LIP funds, the number of recipients served, the types of services obtained, and any changes over time.	Annual Milestone Statistics and Findings Report. Information on innovative programs funded under Tier-One Milestones. Primary Care and Alternative Delivery System Report.

New 5. The impact of LIP funding on hospital charity care programs. Effective DY11.	5.A. What effect on the number of uninsured patients served results from a hospital accessing LIP funding for uncompensated care through a charity care program? How does this compare among hospitals in different tiers of LIP funding?	5.A. There will be a statistically significant greater number of uninsured patients served or a greater amount of expenditures on services by hospitals with higher levels of LIP funding.	Descriptive statistics and tests of significance (where appropriate) of the number of patients served at LIP participating facilities by tier.	Florida Hospital Uniform Reporting System (FHURS): This report collects financial and utilization statistics each year from Florida hospitals. DSH Reporting Data (as needed for uninsured and uncompensated care analyses). Survey of LIP hospitals.
	5.B. What is the difference in scope of services offered to uninsured patients in hospitals accessing LIP funding?	5.B. There will be a broader scope of services offered to uninsured patients in hospitals with higher levels of LIP funding.	Descriptive statistics of the scope of services provided at LIP participating facilities by tier.	
New 7. The impact of LIP funding on per-capita costs for uninsured populations. Effective DY11.	7.A. What is the difference in expenditures on services for uninsured individuals for hospitals receiving different amounts of LIP funding through the LIP distribution tiers?	7. A. There will be statistically significant higher expenditures on services for uninsured individuals through charity care programs in hospitals receiving higher amounts of LIP funding.	Cost analysis and tests of significance (if possible) of service expenditures on the uninsured through charity care programs in hospitals with LIP funding.	Medicare Cost Reports: This report includes descriptive, financial, and statistical data on hospitals (among other providers) and may be helpful with identifying facility characteristics, costs, charity care. Florida Hospital Uniform Reporting System (FHURS): This report collects financial and utilization statistics each year from Florida hospitals.

Domain 13: Studying the impact of efforts to align with Medicare and improve experiences and outcomes for dual-eligible individuals.

Domain	Questions	Hypothesis	Analyses	Data Sources
Domain 13 The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals	13. A. How many dual-eligible recipients are enrolled in MMA plans that are operated by the same parent organization as the recipient's Medicare Advantage Organization? 13. B. How are MMA plans coordinating care for their enrollees who are enrolled in Medicare Advantage plans that are not operated by the same parent organization?	13. A & B. These research questions were included to provide context (descriptive information about enrollment of this population and how plans coordinate care) to analyses for this Domain. Therefore, there are no hypotheses associated with these research questions.	This study will describe how many dual-eligible enrollees are in MMA plans, how many of those enrollees are also in Medicare Advantage plans, and how many of those enrollees are in plans operated by the same parent organization. It will examine how MMA plans coordinate care for dual-eligible enrollees who are in Medicare Advantage plans.	Evaluators will use eligibility and enrollment files to identify how many dual-eligible recipients are enrolled in MMA plans and in Medicare Advantage plans, and which ones are enrolled in plans operated by the same parent organization. MMA plan policies and procedures related to coordinating care for enrollees who are also enrolled in Medicare Advantage plans that are not operated by the same parent organization. Interviews with MMA plan staff regarding coordination of care for dual eligible in Medicare Advantage plans.
	13. C.	13. C.	To the extent possible, this study will look at dual-eligible enrollees' satisfaction with	A patient satisfaction and experience with care survey may be needed to specifically

	What is the difference in enrollee satisfaction for individuals dually eligible for Medicare and Medicaid who are enrolled in MMA plans that are operated by the same parent organization as the recipient's Medicare Advantage Organization versus those enrolled in a plan that does not share a parent organization?	Individuals dually eligible for Medicare and Medicaid who are enrolled in MMA plans operated by the same parent organization as the recipient's Medicare Advantage Organization will report statistically significant greater satisfaction with care than enrollees in MMA plans and Medicare Advantage Organizations that do not share a parent organization.	care, and will compare those in plans with the same parent organization to those in plans that do not have the same parent organization.	address the experiences and needs of the dual-eligible population, and specific samples of dual eligibles, including those who are in two plans with the same parent organization and those who are in two separate plans, may need to be surveyed to address this domain. In its solicitation of proposals for the MMA evaluation, the state will ask respondents to propose how they would answer these research questions.

Appendix II: Specifications for Agency-defined Measures

Follow-up after Hospitalization for a Mental Illness (FHM)

Description: The percent of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis and were discharged to the community and were seen on an outpatient basis by a mental health practitioner within seven days and within 30 days.

Age/Gender: 6 years and older as of the date of discharge.

Data Collection Method: Administrative Data. No sampling allowed.

Special Instruction: Outpatient follow-up visits within the 7-day and 30-day timeframes for discharges occurring at the end of the measurement year may occur in January and should be included in this measure. Note that an enrollee may have multiple discharges during the measurement year. Each discharge should be counted in the denominator unless the enrollee was readmitted during the 7-day or 30-day follow-up period, as described in the Exclusions section below. If a discharge is excluded because there was a readmission during the follow-up period, the final discharge without a readmission should be included in the denominator.

Administrative Specification

Numerator One: 7 Days:

FHM-7 Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.

Numerator: Discharges followed by an outpatient encounter with a mental health practitioner (see definition below) up to seven days after discharge.

Continuous Enrollment: Continuously enrolled for 7 days following discharge.

Exclusions:

Discharges for:

- Enrollees who died during the hospital stay or within 7 days of discharge
- Enrollees who were admitted to an inpatient setting within 7 days of discharge
- Enrollees who were not discharged to a community setting or who were admitted to a non-community setting within 7 days after discharge. Such non-community settings include the Statewide Inpatient Psychiatric Program (SIPP), Department of Juvenile Justice or Child Welfare Behavioral Health Overlay Service facility, hospice, nursing facilities, state mental health facilities, acute medical hospitals, and correctional institutions.
- Enrollees who receive Florida Assertive Community Treatment services

Numerator Two: 30 Days:

FHM-30 Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.00 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.

Numerator: Discharges followed by an outpatient follow-up encounter with a mental health practitioner (see definition below) up to 30 days after discharge.

Continuous Enrollment: Continuously enrolled for 30 days following discharge.

Exclusions:

Discharges for:

- Enrollees who died during the hospital stay or within 30 days of discharge
- Enrollees who were admitted to an inpatient setting within 30 days of discharge
- Enrollees who were not discharged to a community setting or who were admitted to a non-community setting within 30 days after discharge. Such non-community settings include the Statewide Inpatient Psychiatric Program (SIPP), Department of Juvenile Justice or Child Welfare Behavioral Health Overlay Service facility, hospice, nursing facilities, state mental health facilities, acute medical hospitals, and correctional institutions.
- Enrollees who receive Florida Assertive Community Treatment services

Allowable Encounter/Claim Codes

UB Revenue	CPT	HCPCS
0513, 0910, 0912, 0914, 0915	90772, 90801, 90802, 90804-90814, 90847, 90849, 90853, 90855, 90862, 99201, 99202, 99204, 99205, 99211-99215, 99241-99245	G0154 HE*, H0031 HO, H0031 HN, H0031 TS, H0035, H0046, H2000 HO, H2000 HP, H2010 HE, H2010 HO, H2010 HQ, H2012, H2017, H2019 HK, H2019 HQ, H2019 HR, H2019 HM, H2019 HN, H2019 HO, S9127, T1001*, T1015, T1015 HE, T1023 HE

*Must be provided by an RN who meets the definition of a mental health practitioner

Mental Health Practitioner:

A Florida licensed MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry.

A Florida Licensed Psychologist or a doctoral level psychologist practicing under the auspices of a community mental health center and being supervised by a licensed psychologist.

An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who is a Florida Licensed Clinical Social Worker; or who is a masters level social worker practicing under the auspices of a community mental health center and being supervised by a licensed clinical social worker.

A Florida-licensed registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and two years of supervised clinical experience.

A Florida-licensed Marriage and Family Therapist or a masters level marriage and family therapist practicing under the auspices of a community mental health center and being supervised by a Licensed Marriage and Family Therapist.

A Florida Licensed Mental Health Counselor or a masters level counselor practicing under the auspices of a community mental health center and being supervised by a Licensed Mental Health Counselor.

Mental Health Readmission Rate (RER)

Description: The percent of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days.

Age/Gender: 6 years and older as of the date of discharge.

Data Collection Method: Administrative Data. No sampling allowed.

Continuous Enrollment: Continuously enrolled for 30 days following discharge.

Special Instruction: Discharges occurring at the end of the measurement year may result in a readmission in January and should be included in the numerator.

Exclusions:

Discharges for:

- Enrollees who died during the hospital stay or within 30 days of discharge.
- Enrollees who were not discharged to a community setting or who were admitted to a non-community setting within 30 days after discharge. Such non-community settings include the Statewide Inpatient Psychiatric Program (SIPP), Department of Juvenile Justice or Child Welfare Behavioral Health Overlay Service facility, hospice, nursing facilities, state mental health facilities, acute medical hospitals, and correctional institutions.
- Enrollees who receive Florida Assertive Community Treatment services

Administrative Specification

Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) where the enrollee had a discharge diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.0 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9 and met continuous enrollment criteria.

Numerator: Discharges that result in a readmission to an acute care facility (inpatient or crisis stabilization unit) with a diagnosis of ICD-9-CM codes 290.0 through 290.43, 293.0 through 298.9, 300.0 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9 within 30 days following discharge.

Prenatal Care Frequency (PCF)

Description: The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than or equal to 81 percent of expected visits.

Age: None specified.

Data Collection Method: Administrative or Hybrid.

Continuous Enrollment: 43 days prior to delivery through 56 days after delivery. Anchor date is date of delivery.

Exclusions: Follow the Event/diagnosis instructions for the HEDIS measure, *Frequency of Ongoing Prenatal Care (FPC),* most recent edition.

Administrative/Hybrid Specifications: Follow the specifications for the HEDIS measure, *Frequency of Ongoing Prenatal Care (FPC),* most recent edition, with the following modification:

For those enrollees whose number of expected prenatal care visits is greater than 10, per Table FPC-A, the health plan should consider the enrollee having met the threshold for the greater than or equal to 81 percent of expected visits category if she received at least 10 visits. Report only the greater than or equal to 81 percent category.

Highly Active Anti-Retroviral Treatment – (HAART)

Description: The percentage of enrollees with an AIDS diagnosis that have been prescribed Highly Active Anti-Retroviral Treatment.

Eligible Population: Enrollees with AIDS as identified by at least one encounter with an ICD-9-CM diagnosis code 042 during the first six months of the measurement year.

Ages: No age limitations.

Data Collection Method: Administrative Data. No sampling allowed.

Enrollment: Enrolled in the health plan for the measurement year with no more than one month gap in enrollment.

Anchor Date: December 31 of the measurement year.

Administrative Specification

Denominator: Number of enrollees in the plan diagnosed with AIDS.

Numerator: Number of enrollees who were prescribed a HAART* regimen within the measurement year.

*HAART Regimen is defined by the following (see HIV/AIDS Attachment). Prescription fills should occur within 30 days of each other:

a) Three single-agent antiretroviral medications;
b) One two-agent combination medication with one other antiretroviral medication (from "a" or "b");
c) One three-agent combination medication.

Notes:

1) *Combinations of zidovudine (AZT) and stavudine (d4T) with either a PI or NNRTI are not considered HAART.*
2) *This specification is not intended to suggest appropriate medical practice. Instead, the specification is intended to capture appropriate treatment regimens in the most straightforward manner possible using administrative data. Certain combinations of medications should not be prescribed together. Clinicians should refer to treatment guidelines published by the Health Resources and Services Administration, available at http://hab.hrsa.gov/*

HIV-Related Outpatient Medical Visits – (HIVV)

Description: The percentage of enrollees who were seen on an outpatient basis with HIV/AIDS as the primary diagnosis by a physician, Physician Assistant or Advanced Registered Nurse Practitioner for an HIV-related medical visit within the measurement year.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with an ICD-9-CM diagnosis code 042, 079.53, 795.71, or V08 during the first six months of the measurement year.

Ages: No age limitations.

Data Collection Method: Administrative Data. No sampling allowed.

Enrollment: Enrolled in the health plan for the measurement year with no more than one month gap in enrollment.

Anchor Date: December 31 of the measurement year.

Exclusions: Medical visits provided in an emergency department or inpatient setting and claims from lab, radiology, or home health may not be included in calculating the numerator. However, such claims may be used in determining the eligible population.

Administrative Specification

Denominator: The eligible population.

Numerator: Four separate numerators are calculated:

a. Enrollees who were seen twice in measurement year, >= 182 days apart.
b. Enrollees who were seen twice or more in measurement year.
c. Enrollees who were seen exactly once in the measurement year.
d. Enrollees who were not seen during the measurement year.

*Note: Numerators a and b are not mutually exclusive.

Transportation Timeliness (TRT)

Description: The percentage of transports where the enrollee was delivered to the service provider prior to the scheduled appointment time.

Eligible Population: All enrollees who used the transportation service.

Ages: No age limitations.

Data Collection Method: Administrative Data. No sampling allowed.

Continuous Enrollment Criteria: None

Exclusions:

- Transports requested with less than 24 hours advance notice
- Medicaid service appointments that were cancelled or rescheduled not due to tardiness by the enrollee
- No shows

Denominator: The number of transports scheduled for an appointment for a Medicaid service.

Numerator: The number of transports where the enrollee was delivered to the service provider prior to or at the exact scheduled appointment time.

Note: Return trips following the appointment should not be counted as a second transport. Additionally, please note that the eligible population may not be equivalent to the denominator. This measure counts the number of transports, not the number of enrollees.

Transportation Availability (TRA)

Description: The percentage of requests for transport that resulted in a transport.

Eligible Population: All enrollees who requested a transportation service.

Ages: No age limitations.

Data Collection Method: Administrative Data. No sampling allowed.

Continuous Enrollment Criteria: None

Exclusions:

- Transports requested with less than 24 hours advance notice
- Transports requested to a location other than a Medicaid service
- No shows
- Medicaid appointments that were cancelled or rescheduled.

Denominator: The number of requests for a transport to a Medicaid service made within the required time frames.

Numerator: The number of transports delivered.

Note: Return trips following the appointment should not be counted as a second transport. Additionally, please note that the eligible population may not be equivalent to the denominator. This measure counts the number of transports, not the number of enrollees.

Appendix III: Updated Reform Evaluation Project Time Lines

Delivery dates and other key activities are identified in ranges. Please note that details of the MMA Evaluation timeline will be dependent upon the evaluator's proposal of evaluation activities and interim deliverables and thus, cannot be projected at this time. The state is soliciting evaluation proposals from universities in early 2015.

November 2012 – June 2013

- Obtain university IRB approval
- Prepare and submit comprehensive evaluation work plan for each project for the evaluation
- Receive and analyze EBIS, claims, eligibility, and encounter data for dates of service through June 30, 2011
- Receive and analyze CAHPS survey data – Benchmark year through Year 4 follow-up
- Receive and analyze HEDIS and Agency-defined performance measure data submissions 2008-2012
- Receive and analyze Performance Measure Action Plans and Performance Improvement Projects for 2011 and 2012
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 6 (State Fiscal Year 2011-12)
- Review information on Tier-One and Tier-Two Milestone initiative proposals submitted in Year 6
- Review Agency quarterly and annual reports
- Receive and analyze Year 6 LIP Milestone data from the Agency for the Milestone Statistics and Findings report
- Receive and analyze claim, eligibility, and encounter data through June 30, 2012
- Submit preliminary and final reports of LIP Milestone Statistics and Findings Report for DY 6 to the Agency
- Submit preliminary annual reports of analyses related to all Domains of Focus
- Submit final annual report of analyses related to domains v-ix to the Agency
- Submit final annual report of domain iv to the Agency

July – December 2013

- Receive and analyze the most recent EBIS data
- Receive and analyze the most recent CAHPS survey data
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 7 (State Fiscal Year 2012-13)
- Review information and quarterly progress reports for Tier-One and Tier-Two initiatives for Year 7
- Conduct and analyze interviews with health plan compliance/fraud and abuse directors
- Review Agency quarterly and annual reports
- Receive and analyze HEDIS and Agency-defined performance measure data submitted in 2013
- Receive and analyze data for the Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 (SFY 2012-13)
- Submit preliminary Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 to the Agency
- Complete final annual reports of analyses related to domains 1 and 2 and domain 3

- Receive and analyze LIP Milestone data for the Milestone Statistics and Findings report for Year 7
- Submit final Primary Care and Alternative Delivery Systems Expenditure Report for Year 7 (SFY 2012-13)

January – June 2014

- Receive and analyze claims, eligibility, and encounter data through June 30, 2013
- Submit preliminary LIP Milestone Statistics and Findings Report for Year 7 to the Agency
- Submit preliminary reports of analyses related to domains 1-4
- Submit final LIP Milestone Statistics and Findings Report for Year 7 to the Agency
- Submit preliminary annual report of analyses related to domains v-ix to the Agency
- Receive and analyze CAHPS survey data through Year 6
- Receive and analyze PMAPs and PIPs for 2013
- Submit final annual reports of analyses related to all Domains of Focus to the Agency

July – December 2014

- Review Agency quarterly and annual reports
- Receive and analyze EBIS data through June 30, 2013
- Review health plan policies, procedures, and manuals related to compliance and fraud and abuse for Year 8 (State Fiscal Year 2013-14)
- Submit draft of overall evaluation report to the Agency
- Receive and analyze HEDIS and Agency-defined performance measure data submitted in 2014 (if possible for Agency to send to the evaluation team by the end of August 2014)
- Submit preliminary annual reports of analyses related to domains 1-4
- Receive and analyze data for the Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 (SFY 2013-14)
- Submit Draft Evaluation Report to CMS (no later than October 28)
- Submit preliminary Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 to the Agency
- Submit final annual reports of analyses related to domains 1-4
- Submit final Primary Care and Alternative Delivery Systems Expenditure Report for Year 8 to the Agency

January –June 2015

- Solicit evaluation proposals for MMA from state universities, anticipating a November1, 2015 contract start date
- Develop contract with a state university for the MMA evaluation
- Submit final Primary Care and Alternative Delivery System Expenditure Report for Year 8 to CMS
- Submit final Milestone Statistics and Findings Report for Year 8 to the Agency
- Submit final Milestone Statistics and Findings Report for Year 8 to CMS

July – December 2015

- Execute contract with a state university for the MMA evaluation
- Receive and analyze data for the Primary Care and Alternative Delivery Systems Expenditure Report for Year 9 (SFY 2014-15)
- Provide data for the Primary Care and Alternative Delivery Systems Expenditure to the evaluator

- Provide non-LIP data and information to the evaluator
- Receive and analyze data for the Milestone Statistics and Findings Report for Year 9 (SFY 2014-15)
- Provide data for the Milestone Statistics and Findings Report to the evaluator

January – June 2016

- Submit preliminary Primary Care and Alternative Delivery Systems Expenditure Report for Year 9 to the Agency
- Submit final Primary Care and Alternative Delivery Systems Expenditure Report for Year 9 to the Agency
- Submit preliminary Milestone Statistics and Findings Report for Year 9 to the Agency
- Submit final Milestone Statistics and Findings Report for Year 9 to the Agency
- Submit final Primary Care and Alternative Delivery System Expenditure Report for Year 9 to CMS
- Submit final Milestone Statistics and Findings Report for Year 9 to CMS

October 2017

- Final report due to CMS