

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

April 27, 2020

Beth Kidder
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Ms. Kidder:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for Florida's section 1115 demonstration entitled, "Managed Medical Assistance" (Project Number 11-W00206/4), and effective through June 30, 2022. We sincerely appreciate the state's commitment to a rigorous evaluation of your demonstration.

CMS has added the approved evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment D. A copy of the STCs, which includes the new attachment, is enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design is due to CMS one year prior to the expiration of the demonstration, or at the time of the renewal application if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period.

We look forward to our continued partnership with you and your staff on the Florida Managed Medical Assistance demonstration. If you have any questions, please contact your CMS project officer, Mr. Jack Nocito. Mr. Nocito may be reached by email at Jack.Nocito@cms.hhs.gov.

Sincerely,

**Danielle
Daly -S** Digitally signed by
Danielle Daly -S
Date: 2020.04.27
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Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

**Angela D.
Garner -S** Digitally signed by
Angela D. Garner -S
Date: 2020.05.21
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Angela D. Garner
Director
Division of System Reform
Demonstrations

cc: Tandra Hodges, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance

AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement—and not expressly waived in the title XIX waivers list below—shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (“the Act”) to enable the state to continue its Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled “Medicaid Reform”) consistent with the approved Special Terms and Conditions (STC). The state has acknowledged that it has not asked for, nor has it received, a waiver of Section 1902(a)(2).

These waivers are effective beginning the date of the amendment approval through June 30, 2022, unless otherwise specified.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider service networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers. This does not authorize restricting freedom of choice of family planning providers.

4. Retroactive Eligibility

Section 1902(a)(34)

Effective February 1, 2019, to enable Florida to only provide medical assistance beginning the month in which a beneficiary's Medicaid application is filed, for adult beneficiaries who are not pregnant or within the 60-day period after the last day of the pregnancy, and are aged 21 and older. The waiver of retroactive eligibility does not apply to pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21. The state currently has state legislative authority for this waiver through June 30, 2019. The state must submit a letter to CMS by May 17, 2019, if it receives State Legislative authority to continue the waiver past June 30, 2019. In the event the state does not receive Legislative authority to continue this waiver past June 30, 2019 and timely submit a letter to CMS to this effect, this waiver authority ends June 30, 2019.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITIES

NUMBER: 11-W-00206/4
TITLE: Florida Managed Medical Assistance Program
AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from the date of the amendment approval through June 30, 2022, be regarded as expenditures under the state’s title XIX plan, unless otherwise specified.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration.

1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.
2. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured and/or underinsured.
3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.
4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 18, effective January 1, 2018.
5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 19, effective January 1, 2018.
6. Expenditures for behavioral health and supportive housing assistance services to individuals in MMA, as described in STC 55, effective as of the approval date of the amendment (March 26, 2019). The state will implement this pilot less than statewide and institute annual enrollment limits to 50,000 member months each demonstration year.
 - a. **REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 6.**
All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the behavioral health and supportive housing assistance services. In addition, the following Medicaid requirement is not applicable:

i. Statewide Operation

Section 1902(a)(1)

To the extent necessary to enable the state to operate on less than a statewide basis for behavioral health and supportive housing assistance services.

ii. Amount, Duration and Scope

Section 1902(a)(10)(B)

To the extent necessary to enable Florida to limit the amount, duration, and scope of behavioral health and supportive housing assistance pilot services to restrict this benefit to those individuals diagnosed with a serious mental illness (SMI), substance use disorder (SUD), or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability, as described in the STC 55.

iii. Reasonable Promptness

Section 1902(a)(8)

To the extent necessary to enable the state not to provide behavioral health and supportive housing assistance pilot services when the enrollment cap for this benefit is reached, as specified in the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

I. PREFACE

The following are the Special Terms and Conditions (STC) for the Florida Managed Medical Assistance Program (MMA) section 1115(a) demonstration (hereinafter “demonstration”) to enable Florida to operate the demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (“the Act”), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable (CNOM) under section 1903 of the Act, which are separately enumerated. The parties to this agreement are the Agency for Health Care Administration (Florida) and CMS. The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by those set forth below and in the foregoing waivers and expenditure authorities. The effective date of the demonstration amendment is no earlier than the date of the amendment approval through June 30, 2022.

These STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility Derived from the Demonstration
- V. Enrollment For the Managed Medical Assistance Program
- VI. Enrollment
- VII. Benefit Packages and Plans in Managed Medical Assistance Program
- VIII. Cost-sharing
- IX. Delivery Systems
- X. Consumer Protections
- XI. Choice Counseling
- XII. Healthy Behaviors Program Under the MMA Program
- XIII. Additional Programs
- XIV. Low Income Pool
- XV. Low Income Pool Participation Requirements and Deliverables
- XVI. General Reporting Requirements
- XVII. General Financial Requirements
- XVIII. Monitoring Budget Neutrality

- XIX. Evaluation of the Demonstration
- XX. Measurement of Quality of Care and Access to Care Improvement
- XXI. Schedule of State Deliverables

Attachment A: Comprehensive Program Description

Attachment B: Developing the Evaluation Design

Attachment C: Preparing the Evaluation Report

II. PROGRAM DESCRIPTION AND OBJECTIVES

Florida’s current 1115 demonstration allows the state to operate a comprehensive Medicaid managed care program and a Prepaid Ambulatory Health Plan (PAHP). Under the demonstration, most Medicaid-eligibles are required to enroll in one of the MMA managed care plans (MMA plans) contracted with the state under the MMA Program. MMA plans are MCOs as defined under 42 CFR 438.2. Several populations may also voluntarily enroll in the MMA program. Applicants for Medicaid are given the opportunity to select a MMA plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are auto-assigned into a MMA plan upon an affirmative eligibility determination and subsequently provided with information about their choice of plans with the auto-assignment. MMA plans are able to provide customized benefits to their members that differ from, but are not less than, the State Plan benefits—and participating Medicaid-eligibles have access to Healthy Behaviors Programs that provide incentives for healthy behaviors.

Additionally, upon implementation of the prepaid dental health program (PDHP), dental managed care plans (dental plans) will provide State Plan dental services and provide services statewide to recipients required to enroll in a dental plan. The dental plans are PAHPs as defined under 42 CFR 438.2.

The demonstration also establishes a Low Income Pool (LIP) to ensure continuing support for the safety net providers that furnish uncompensated care (UC) to the Medicaid, uninsured, and underinsured populations.¹

The renewal approved in August 2017 allowed the state to continue operating the MMA program while increasing the LIP to \$1.5 billion annually. This prior renewal also removed historical information about implementation of the MMA program from the STCs and modified the frequency of state-reported demonstration activities—based on the long-standing nature of the demonstration, the consistency in its operations, and the lack of significant issues or corrective actions needed. All reporting modifications continue to provide CMS and the public with the information necessary to effectively monitor and evaluate the MMA demonstration.

On November 30, 2018, an amendment was approved to the demonstration that, allows the state to operate a statewide Prepaid Dental Health Program, modifies the LIP to add Regional Perinatal Intensive Care Centers (RPICCs) as an eligible hospital ownership subgroup and community behavioral health providers as a participating provider group, and waives retroactive eligibility for all beneficiaries under the demonstration, except for pregnant women, women 60 days or less

¹ 1 For the “Comprehensive Program Description and Objectives,” see Attachment B.

post-partum, and beneficiaries under age 21 (non-pregnant adults). The approval of the waiver of retroactive eligibility will encourage Medicaid beneficiaries to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (if eligibility depends on a finding of disability or a certain diagnosis).

On March 26, 2019, an amendment was approved to the demonstration to implement a pilot program that provides additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The pilot program will be operated in two regions of the State, Regions 5 (Pasco and Pinellas counties) and Region 7 (Brevard, Orange, Osceola and Seminole counties).

On April 7, 2020, an amendment was approved to the demonstration that enables Florida to increase the behavioral health and supportive housing assistance services annual enrollment limit, modify the Low Income Pool's (LIP) permissible expenditures related to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), and memorializes some budget neutrality-related edits to the Supportive Housing Pilot table.

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

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner, except those specifically exempted.
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals and federally qualified health care centers (FQHC) and rural health clinics (RHC) that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.²
- Improving continuity of coverage and care and encouraging uptake of preventive services, or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable, as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.

² Available at <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589>

- Improving integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality (BN) agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the BN agreement are not subject to change.
 - b. If mandated changes in the federal law, regulation, or policy require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit a title XIX State Plan amendment for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid State Plan governs.
6. **Changes Subject to the Demonstration Amendment Process.** Changes related to

demonstration features, such as, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, LIP, sources of non-federal share of funding, BN, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services (“Secretary”) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

- a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- b) A data analysis, which identifies the specific “with waiver”, impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) An explanation of the public process used by the state consistent with the requirements of STC 15; and,
- d) The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase- out plan consistent with the requirements of STC 9.

9. Demonstration Transition and Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30)-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan amendment. Once the thirty (30)-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

- a. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.
- b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan, the process by which it will notify affected beneficiaries (including those on any applicable wait lists), the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or on a wait list, determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
- c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d. Exemption from Public Notice Procedures 42 CFR 431.416(g): CMS may expedite or waive the federal and state public notice requirements under circumstances described in 42 CFR §431.416(g).
- e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- c. **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. **Federal Financial Participation:** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.

11. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

13. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date.

If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

14. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost-sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, and/or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

16. Federal Financial Participation. No federal matching for administrative or service expenditures for this demonstration will take effect until the approval date identified in the demonstration approval letter.

17. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR 438, except as explicitly provided to the contrary in this STC 17. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.4. The capitation rates shall be developed according to 42 CFR 438.5 and 438.6, and the certification submitted pursuant to 42 CFR 438.7.

The state must maintain:

- a. Policies to ensure an increased stability among capitated managed care plans and fee-for-service (FFS) PSNs and minimize plan turnover. This could include a limit on the number of participating plans in the MMA program. Plan selection and oversight criteria must include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the state; and financial penalties for not completing a contract term.
- b. These STCs provide additional refinements and detail on the state's existing obligations under 42 CFR Part 438 and are intended to be consistent with the requirements of 42 CFR Part 438; except where expressly noted otherwise, these STCs are not wholly new and distinct requirements on the state. The state must

maintain policies to ensure network adequacy and access requirements which address travel time and distance, which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations.

- c. The state must ensure that each managed care entity calculates and reports a Medical Loss Ratio (MLR) for each contract and rating year. Such MLR calculation and reporting must be consistent with the standards specified in 42 CFR 438.8.

The state shall monitor each plan's financial solvency, appropriateness of capitation rates, and provision of Medicaid services. As an addition to the requirements in the underlying regulations in 42 CFR Part 438, the state shall submit to CMS annual MLR reports with notation of concerns and actions taken by the state for each managed care plan or PSN that has a MLR above 95 percent or below 75 percent.

- i. For plans with a MLR above 95 percent, the state shall report any concerns about the plans' financial viability, plan performance, and continuation with the MMA program.
 - ii. For plans with a MLR below 75 percent, the state shall report any concerns with beneficiary access to care and utilization, capitation rates, or MCO reporting.
- d. Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and beneficiary requests to seek out of network care.
- e. Policies to ensure adequate choice of providers when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services, consistent with 42 CFR 438.52.
- f. Policies that result in a network of appropriate dental providers sufficient to provide adequate access to all covered dental services, consistent with 42 CFR 438.68, 438.206 and 438.207.

IV. ELIGIBILITY DERIVED FROM THE DEMONSTRATION

This section governs the state's exercise of the expenditure authorities 4 and 5 listed on page 4 of these STCs. These groups derive their eligibility by virtue of the expenditure authorities expressly granted in this demonstration—eligibility and coverage for these groups are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted herein.

18. MEDS AD Eligibility Group. The MEDS AD eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

- a. Aged or disabled individuals
 - i. Income at or below 88% FPL
 - ii. Assets that do not exceed \$5,000 (individual) or \$6,000 (couple)
 - iii. Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services
- b. Aged or disabled individuals
 - i. Income at or below 88% FPL
 - ii. Assets that do not exceed \$5,000 (individual) or \$6,000 (couple)
 - iii. Medicaid-only eligibles receiving hospice, HCBS, or institutional care services
- c. Aged or disabled individuals
 - i. Income at or below 88% FPL
 - ii. Assets that do not exceed \$5,000 (individual) or \$6,000 (couple)
 - iii. Medicare Eligible receiving hospice, HCBS, or institutional care services

19. AIDS CNOM Eligibility Group. The AIDS CNOM eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

- a. Have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS); and
- b. Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate);
- c. Have assets that do not exceed \$2,000 (individual) or \$3,000 (couple); and
- d. Meet hospital level of care, as determined by the State of Florida.

V. ELIGIBILITY FOR THE MANAGED MEDICAL ASSISTANCE PROGRAM

20. Waiver of Retroactive Eligibility Population. The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), or a beneficiary under age 21. The waiver of retroactive eligibility applies to all recipients aged 21 and older who are not pregnant or in the 60-day period after the last day of the pregnancy (non-pregnant adults), effective February 1, 2019. The waiver applies to non-pregnant adults who are eligible for Medicaid under the State Plan (including all modified adjusted gross income (MAGI) and Non-MAGI related groups), as well as the MEDS AD Eligibility Group defined in STC 18 and the AIDS CNOM Eligibility Group defined in STC 19.

- a. The state assures that it will provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver.

- b. The state currently has state legislative authority for this waiver through June 30, 2019. The state must submit a letter to CMS by May 17, 2019, if it receives state legislative authority to continue the waiver past June 30, 2019. In the event the State Legislature does not authorize the state to continue the waiver of retroactive eligibility or the state does not timely submit a letter to CMS, the authority for the waiver of retroactive eligibility will end.

21. Consistency with State Plan Eligibility Criteria. There is no change to Medicaid eligibility. Standards for eligibility remain set forth under the State Plan. There is no expansion or reduction of eligibility under the State Plan as a result of this demonstration, with the exception of the waiver of retroactive eligibility as specified in STC 20.

22. Enrollment in MMA Plans. MMA program enrollees are individuals eligible under the approved State Plan or as a demonstration-only group, and who are described below as “mandatory enrollees” or as “voluntary enrollees.” Mandatory enrollees are required to enroll in a MMA plan as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have the option to enroll in a demonstration MMA plan to receive Medicaid benefits.

- a. Mandatory Managed Care Enrollees – Individuals who belong to the categories of Medicaid-eligibles listed in the following table, and who are not listed elsewhere in this section V as excluded from mandatory participation, are required to be MMA program enrollees.

Table 1. Mandatory and Optional State Plan Eligibility Groups

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Infants under age 1	No more than 206% of the FPL.	Title XIX	TANF & Related Grp
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & Related Grp
Children 6-18	No more than 133% of the FPL.	Title XIX	TANF & Related Grp
Blind/Disabled Children	Children eligible under Supplemental Security Income (SSI) or deemed to be receiving SSI.	Title XIX	Aged/Disabled
IV-E Foster Care and Adoption Subsidy	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & Related Grp

Pregnant women	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Grp
Section 1931 parents or other caretaker relatives	No more than Aid to Families with Dependent Children (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	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
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	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	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	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 STC 22(c).	Title XIX	Aged/Disabled

Institutionalized individuals eligible under the special home and community-based waiver group specified at 42 CFR 435.217	This group includes non-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 STC 22(c).	Title XIX	Aged/Disabled
Demonstration Only Groups			
Aged or disabled Individuals	<ul style="list-style-type: none"> • Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services 	Title XIX	MEDS AD
Aged or disabled Individuals	<ul style="list-style-type: none"> • Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • Medicaid-only eligibles receiving hospice, HCBS, or institutional care services 	Title XIX	MEDS AD
Aged or disabled Individuals	<ul style="list-style-type: none"> • Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • Medicare Eligible receiving hospice, HCBS, or institutional care services 	Title XIX	MEDS AD

Individuals diagnosed with AIDS	<ul style="list-style-type: none"> • Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate), • Have assets that do not exceed \$2,000 (individual) or \$3,000 (couple), and • Meet hospital level of care, as determined by the State of Florida 	Title XIX	AIDS CNOM
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- b. Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan 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 beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 25.
- c. Voluntary enrollees – The following individuals are excluded from mandatory enrollment into the MMA program under subparagraph (a) but may choose to voluntarily enroll under the demonstration, in which case the individual would be a voluntary participant in an MMA plan and would receive its benefits:
- 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 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 (PPEC) facility; and
 - vi. Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

- d. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from enrollment in managed care plans.
 - i. Individuals eligible for emergency services only due to immigration status;
 - ii. Family planning waiver eligibles;
 - iii. Individuals eligible as women with breast or cervical cancer; and,
 - iv. Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the State Plan, except as inpatients in a medical institution).

23. Indian Health Care Providers and Managed Care Protections.

- a. The state will assure compliance by the state with the requirements of section 1911 of the Social Security Act and 25 USC §1647a(a)(1), to accept an entity that is operated by the Indian Health Service (IHS) an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program, if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.
- b. The state will assure compliance by the state with 42 CFR 431.110(b), which specifies that an IHS facility meeting state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider, and also specifies that when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, the state may not take into account an absence of licensure of any staff member of the facility.

VI. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid-eligible individuals in Medicaid managed care plans. All Medicaid recipients, except those specified in STC 56, must enroll in the Prepaid Dental Health Program (PDHP) in order to receive dental services covered under the Florida Medicaid program. The state will implement the PDHP in three phases by region, beginning December 1, 2018, with completion by March 1, 2019.

- 24. New Enrollees.** 42 CFR § 438.71 requires choice counseling as part of the beneficiary support system. At the time of their application for Medicaid, individuals who are mandated to enroll in an MMA or dental plan must receive information about MMA and

dental plan choices in their area. They must be informed of their options in selecting an authorized MMA/dental plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice, and to indicate a plan choice selection if they are prepared to do so. Eligible individuals will be enrolled in a MMA and dental plan upon eligibility determination. If the individual has not selected a plan at the time of the approval of eligibility, the state may auto-assign the individual into a MMA/dental plan. Upon enrollment, individuals will receive information on their MMA and dental plan assignments or selection and information about all plans in their area. Individuals may actively select a plan or change their plan selection during a 120-day change/disenrollment- period without cause post-enrollment. All individuals will be provided with information regarding their rights to change plans. Once the plan selection is registered and takes effect, the plan must communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, and how to access those benefits.

25. Auto-Enrollment Criteria. Each enrollee must have an opportunity to select a MMA and dental plan before or upon being determined eligible. Individuals must be provided information to encourage an active selection electronically or in print. Enrollees who fail to choose a plan by the time their eligibility is determined will be auto-assigned to a MMA and/or dental plan. At a minimum, the state must use the criteria listed below when assigning an enrollee to a MMA or dental plan, in addition to criteria identified in 42 CFR 438.54. When more than one plan meets the assignment criteria, the state will make enrollee assignments consecutively by family unit.

MMA criteria include but are not limited to:

- a. Whether the plan has sufficient provider network capacity to meet the needs of the enrollee;
- b. Whether the recipient has previously received services from one of the plan's primary care providers; and
- c. Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

PDHP criteria include but are not limited to:

- a. Whether the plan has sufficient network capacity to meet the needs of the recipients such as geographic accessibility based on beneficiary's residence;
- b. Whether the recipient has a family member enrolled in one of the PDHP plans.
- c. A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the dental plan, regardless of the administrative enrollment procedures, and the dental plan is responsible for providing Medicaid services to the newborn. The mother may choose another dental plan for the newborn within 120 days after the

child's birth.

26. Auto Enrollment for Special Populations. For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to auto-assigning the SSI beneficiary to an MMA plan, the state must determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so in addition to complying with § 438.54(d), the state must assign the SSI recipient to that managed care plan whenever feasible. Assignment based on an ongoing relationship with a provider or managed care plan is the first priority in assigning enrollees pursuant to this STC. Those SSI recipients who do not have such a provider relationship must be assigned to a managed care plan using the assignment criteria previously outlined. In addition to complying with § 438.54(d), the state must use the following parameters when auto-assigning recipients who are members of the indicated special populations to a plan. The analogous requirements for auto enrollment into both MMA and PDHP plans are mentioned above in STC 25.

- a. To promote alignment between Medicaid and Medicare, each beneficiary who is enrolled with a Medicare Advantage Organization, must first be assigned to any MMA plan in the beneficiary's region that is operated by the same parent organization as the beneficiary's Medicare Advantage Organization. If there is no match of parent organization or plan within the organization, then the beneficiary should be assigned as in sub-STC 25 above.
- b. If an applicable specialty plan is available, as described in STC 38, the recipient should be assigned to the specialty plan.
- c. Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan, unless it is a specialty plan; however, the mother may choose another plan for the newborn within 120 days after the child's birth.
- d. Foster care children will be assigned/re-assigned to the same plan to which the child was most recently assigned in the last 12 months, if applicable.
- e. Lock-In/Disenrollment. Once a mandatory enrollee has selected or been assigned an MMA or dental plan, the enrollee shall be enrolled for a total of 12 months, until the next open enrollment period, unless the individual is determined ineligible for Medicaid. The 12-month period includes a 120-day period to change or voluntarily disenroll from a plan without cause and select another plan. If an individual chooses to remain in a plan past 120 days, the individual will be permitted no further changes in enrollment until the next open enrollment period, except for cause. Good cause reasons for disenrollment from a plan are defined in Rule 59-G-8.600, Florida Administrative Code. Voluntary enrollees may disenroll from the MMA plan at any time and enroll in another managed care plan or receive their services through Florida FFS Medicaid. This Florida rule is compliant with § 438.56(c) and (d)(2).

- f. The choice counselor or state will record the plan change/disenrollment reason for all recipients who request such a change. The state or the state's designee will be responsible for processing all enrollments and disenrollments.

27. Re-enrollment. In instances of a temporary loss of Medicaid eligibility, which the state is defining as 6 months or less, the state will re-enroll demonstration enrollees in the same MMA or dental plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended due to plan requested or Agency-imposed enrollment freeze. The individual will have the same change/disenrollment period without cause as upon initial enrollment.

VII. BENEFIT PACKAGES AND PLANS IN THE MMA PROGRAM

28. Customized Benefit Packages. MMA plans have the flexibility to provide customized benefit packages for demonstration enrollees as long as the benefit package meets certain minimum standards described in this STC, and actuarial benefit equivalency requirements and benefit sufficiency requirements described in STCs 29 through 32, in accordance with section 409.973 F.S. For other plans, customized benefit packages must include all State Plan services otherwise available under the State Plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the state plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population as defined by the plan and approved by the Agency for Health Care Administration (AHCA). These plans can also offer additional services and benefits not available under the State Plan. The plans contracted with the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and emergency services.

Policies for determining medical necessity for children covered under the EPSDT benefit must be consistent with Federal statute at §1905(r) of the Act in authorizing vision, dental, hearing services, and other necessary health care, diagnostic services, treatment and other measures described in §1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered in the State Plan. EPSDT provisions apply as well to the PDHPs.

29. Overall Standards for Customized Benefit Packages for MMA Plans. All benefit packages must be prior-approved by the state and CMS and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition, the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population. Consistent with 42 CFR 438.3, customized benefit packages, as analyzed through the Plan Evaluation Tool (PET) discussed below, must be submitted to CMS for approval as part of the standard CMS contract review process.

30. Plan Evaluation Tool. The state will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for, or has been awarded, an MMA plan contract meets state

requirements. The PET measures actuarial equivalency and sufficiency. Specifically, the PET: (1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current State Plan package for the average member of the population; and (2) ensures the sufficiency of benefits consistent with 42 CFR 438.210(a)(3) and STC 31. The state will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

- 31. Plan Evaluation Tool: Sufficiency.** In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target-population's historic use of the applicable Medicaid State Plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the state as sufficiency-tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to meet the needs of 98.5 percent of enrollees.
- 32. Evaluation of Plan Benefits.** The state will review and update the PET for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the given service area. At a minimum, the state must conduct the review and update on an annual basis. The state will provide CMS with 60-days advance notice and a copy of any proposed changes to the PET.

VIII. COST-SHARING

- 33. Premiums and Co-Payments.** The state must pre-approve all cost sharing allowed by MMA or dental plans. Cost-sharing must be consistent with the State Plan except that managed care plans may elect to assess cost-sharing that is less than what is allowed under the State Plan.
- 34. American Indians.** Indians who receive services directly by an Indian Health Care Provider (IHCP) or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge. No deduction, copayment, cost sharing or similar charges shall be imposed against any such Indian. Payments due to an IHCP or to a health care provider through referral under Purchased/Referred Care services for services provided to an eligible Indian shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing or similar charges, that would be due from the Indian but for the prohibition on charging the Indian.

IX. DELIVERY SYSTEMS

- 35. Health Plans.** The final contracts and, as applicable, capitation rates developed to implement selective contracting by the state with any MCO, provider group, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) shall be subject to CMS Regional Office approval prior to implementation. The state may enter into

contracts for Medicaid managed care plans with the following entities:

- a. Managed Care Organization (MCO) – An entity (such as Health Maintenance Organization, Accountable Care Organization, capitated Provider Service Network, or Exclusive Provider Organization) that meets the definition of MCO as described in 42 CFR 438.2, and which must conform to all of the requirements in 42 CFR 438 that apply to MCOs.
- b. Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of FS 409.912. A PSN may be reimbursed on a FFS or capitated basis as specified in state statute. Capitated PSNs are categorized as MCOs, and must meet the requirements as described in 42 CFR 438.
- c. Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) – Entities that meet the definition of PIHP or PAHP as described in 42 CFR 438.2 and which must conform to all requirements in 42 CFR 438 that apply to PIHPs and PAHPs.

36. Eligible Plan Selection. The state will procure a specified number of MMA plans per region in accordance with section 409.974, Florida Statutes. A minimum and maximum number of plans are specified by region, with a minimum of two plans choices in each region. Issuance and award of the procurements will provide for a choice of plans, as well as market stability.

Should the state not be able to contract with at least two MMA plans in a region that is not rural, the state will issue another procurement to obtain a second plan and meet the federal requirements in 42 CFR §438.52(a). Until two MMA plans are available in the impacted region, beneficiaries may voluntarily choose to enroll in the available MMA plan or to access services through a FFS delivery system.

In addition to regional plans, the state will also seek to contract with specialty plans, as discussed in STC 38. Participation of specialty plans will be subject to competitive procurement requirements but will not be considered in assessing regional plan availability. Specialty plans are subject to 42 CFR 438.52 choice requirement. However, the state may not enter into contracts with additional specialty plans in a region if total enrollment in all specialty plans in the region is greater than ten percent of demonstration enrollees in the region.

The state will procure at least two statewide dental plans for the PDHP in accordance with section 409.973(5), Florida Statutes. To qualify for a contract under the PDHP, an entity must be licensed as a prepaid limited health service organization under Part I of Chapter 636, Florida Statutes, or as a health maintenance organization under Part I of Chapter 641, Florida Statutes.

Should the state undergo another Medicaid managed care procurement for MMA or dental plans during the demonstration period, the state must submit a report to CMS no later than

30 days after the selection of new managed care plans that will include the following, as applicable in addition to 42 CFR 438.66(d):

- a. The name of the managed care plans selected for each region;
- b. For the selected plans, please identify those plans that also provide LTSS under the 1915(b)/(c) waivers;
- c. The names of any managed care plans that will not be continuing by region; and,
- d. The number of enrolled beneficiaries in each plan that will not be continuing.

37. MMA Plan Selection when beneficiary also has Medicare Advantage.

- a. While beneficiaries are encouraged to select the same MMA plan as their Medicare Advantage or Long-term Care (LTC) Plan, if applicable, it is not a requirement.
- b. Should a beneficiary choose an MMA plan that is different from their Medicare Advantage or LTC plan, if applicable, the two entities must coordinate the beneficiary's care to ensure that all needs are met. The state must monitor such care coordination through its contract with the MCO and with the MAO under 42 CFR 422.107.

38. Specialty Plans. A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the state as a specialty plan to provide medical services. Specialty plans are designed for a target population, for example, children with chronic conditions, or recipients who have been diagnosed with HIV/AIDS. Participation of specialty plans will be subject to competitive procurement and the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the demonstration enrollees of that region. The state will freeze enrollment for specialty plans if the aforementioned enrollment limit is reached in a region. The Children's Medical Services Plan, a specialty plan operated by the Florida Department of Health, is not subject to competitive procurement.

39. The state may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the presence of clinical programs and/or providers with special expertise to serve that target population in the specialty plan's provider network. The state may not approve plans that discriminate against members of the target population with greater health care needs.

The state may also contract with Medicare Advantage Organizations (MAO) to serve Medicare-Medicaid enrollees as a dual eligible special needs plan (D-SNP) under 42 CFR 422.107.

In addition to meeting the solvency (42 CFR 438.116) and network adequacy and sufficiency (42 CFR 438.68, 438.206 and 438.207) requirements, specialty plans must also

meet enhanced standards developed by the state that may include but are not limited to:

- a. Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should include an integrated network of PCPs and specialists appropriate for the target population (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
- b. In recognition that many individuals will have multiple diagnoses, plans should have sufficient capacity of additional specialists to manage the co-occurring diagnoses that may occur within the target population.
- c. Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).
- d. Availability of specialty pharmacies, where appropriate.
- e. Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
- f. Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.
- g. Use of evidence-based clinical guidelines in the management of the disorder.
- h. Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.
- i. Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

40. Requirements for Special Populations.

- a. HIV Specialty Plans
 - i. The state will auto-enroll Medicaid beneficiaries identified with a diagnosis of HIV or AIDS to a specialty plan, where available, if the beneficiary does not select an MMA plan. These beneficiaries may be identified with a combination of diagnosis codes on claims; HIV or AIDS prescription medications; and laboratory tests and results.
 - ii. The state will notify beneficiaries identified with a diagnosis of HIV or AIDS in

writing that the beneficiary must select an MMA plan or the beneficiary will be auto- assigned to a specialty plan, if available, in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty plan. The enrollee will have 120-day period following enrollment to change plans or disenroll without cause.

- iii. When making assignments to an HIV/AIDS specialty plan, the state will consider the beneficiary's PCP and/or current prescriber of HIV or AIDS medications.
- iv. When making assignments to HIV/AIDS specialty plans and the beneficiary's PCP or current prescriber of HIV or AIDS medications is not known or is not an enrolled provider with a specialty plan, the state will assign the beneficiary to a specialty plan available on a rotating basis.
- v. When making assignments to HIV/AIDS specialty plans of beneficiaries who are determined to have co-morbid conditions, the state may assign the beneficiary to the most appropriate specialty plan available in the beneficiary's region.

b. Children's Specialty Plans

- i. The state may elect to contract with Children's Specialty Plans to serve Foster Care Children. These plans will have special requirements for immediate assessment, care coordination, and treatment of Foster Care Children. The Children's Specialty Plans are required to furnish EPSDT for Foster Care Children and follow the state's medication formulary.
- ii. The Foster Care child's legal guardian may enroll the child in an MMA plan, or any specialty plan for which the child is eligible, that are available in the child's region.
- iii. Should a Foster Care child's legal guardian fail to make an affirmative selection of an MMA plan, the state may enroll the foster care child into a Children's Specialty Plan available in the region.

41. Compliance with Medicaid and CHIP Managed Care Regulations. The state must comply with all Medicaid and CHIP managed care requirements set forth in 42 CFR Parts 431, 433, 438, 440, 457 and 495, including the Indian specific provisions at 42 CFR §438.14 unless waived or identified as not applicable in the waiver and expenditure authority documents, of which these STCs are a part. This includes:

- a. **Definitions of Indians and Indian Health Care Provider (IHCP).** Indians and IHCPs are defined in 42 CFR §438.14(a).
- b. **Access to IHCP.** Indians will be able to access covered benefits through the IHCP of their choice, regardless of whether the IHCP is a participating or non-participating provider.

- c. **Referrals and Prior Authorization.** Managed care entities must permit nonparticipating IHCP to refer an Indian to a network provider without having to obtain an additional referral or a prior authorization from a participating provider.
- d. **Access to Out of State IHCPs.** A managed care entity must allow Indian enrollees to access out-of-state IHCPs where timely access to covered services cannot be ensured because there are few or no IHCPs in the state.
- e. **Disenrollment from Managed Care Entity.** Lack of access to in-network IHCP constitutes good cause for disenrollment from the managed care entity.
- f. **Prompt Payment.** A managed care entity must make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 438.14, 447.45 and 447.46.
- g. **Payment Rates and Supplemental Payment.**
 - i. **Non-FQHC.** An IHCP not enrolled in Medicaid as an FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.
 - ii. **FQHC.** An IHCP that is enrolled in Medicaid as an FQHC, but that is not a participating provider of the MCO, PIHP, PAHP or PCCM entity, must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay an FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.
 - iii. **Supplemental Payment.** The state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

X. CONSUMER PROTECTIONS

- 42. **Outreach and Education.** The state must provide outreach and education regarding potential Medicaid eligibility and the application/enrollment process, to mitigate the potentially harmful effects of the waiver of retroactive eligibility.
- 43. **Medical Care Advisory Committee.** In accordance with 42 CFR §431.12, the state must maintain its Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services. The state must ensure that the MCAC is comprised of the representatives set forth in 42 CFR §431.12(d). The state must ensure

that the MCAC includes representation of at least four beneficiaries at all times, and report to CMS any vacant beneficiary slots that are not filled within 90 days of becoming vacant. Beneficiary representation may include former Florida Medicaid recipients, current Florida Medicaid recipients or family members of former or current Florida Medicaid recipients who had direct experience with helping beneficiaries access Florida Medicaid eligibility, benefits, or services. The state may submit justification to CMS for an unfilled beneficiary slot after 90 days and CMS may grant an exception to this requirement at CMS' discretion.

- a. **Subpopulation Advisory Committees.** In addition to the MCAC and 42 CFR 438.110, the state must convene smaller advisory committees that meet on a regular basis (at least quarterly) to focus on subpopulations, including, but not limited to: beneficiaries receiving managed LTSS; beneficiaries with HIV/AIDS; children, including safeguards and performance measures related to foster children and the provision of dental care to all children; and beneficiaries receiving behavioral health/substance use disorder (SUD) services.

Each advisory committee must include representation from relevant advocacy organizations, as well as beneficiaries.

44. Appointment Assistance. The state must provide, or ensure the provision of, necessary assistance with transportation and with scheduling appointments for medical, dental, vision, hearing, and mental health services.

45. Attempts To Gain an Accurate Beneficiary Address. The state shall implement the CMS- approved process for return mail tracking. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address.

46. Verification of Beneficiary's Health Plan Enrollment. The state shall utilize and publicize for health plan network and non-network providers the following eligibility verification processes for beneficiaries' eligibility to be verified so that beneficiaries will not be turned away for services if the beneficiary does not have a card or presents the incorrect card. Providers with a valid Medicaid provider number may use any of the following options to determine enrollee eligibility:

- a. Utilize the Medicaid Eligibility Verification System (MEVS): eligibility transactions may be submitted using computer software supplied by the vendor, via a point of sale device similar to those used for credit card transactions, over the telephone using a voice response system, or other possibilities depending on what the MEVS vendor offers;
- b. Perform single transactions (individual verifications) or batch transactions via a secure area on the Medicaid fiscal agent's web portal;

- c. Utilize the Automated Voice Response System (AVRS): providers enter information via a touchtone telephone and it generates a report with all of the eligibility information for a particular recipient, which can be faxed to the provider's fax machine;
- d. Submit eligibility transactions via the Electronic Data Interchange (EDI);

47. Operated Call Center Operations. The state must operate a call center(s) independent of the managed care plans for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. Call center operations should be able to help enrollees in making independent decisions about plan choice, and enable enrollees to voice complaints about each of the health plans independent of the health plans.

48. State Review of Beneficiary Complaints, Grievances and Appeals. The state must review complaint, grievance, and appeal logs for each health plan and data from the state or health plan operated incident management system, to understand what issues beneficiaries and providers are having with each of the health plans. The state will use this information to implement any immediate corrective actions necessary. The state will continue to monitor these statistics throughout the demonstration period and report on them in the annual reports as specified in STC 76. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. CHOICE COUNSELING

The state must comply with 42 CFR 438.71(b) to provide choice counseling as an additional benefit to beneficiaries. This is additional instruction about how the state must comply with this regulation.

49. Choice Counseling Defined. The state shall contract for choice counselor services in the MMA program regions to provide full and complete information about managed care plans choices. The state will ensure a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

50. Choice Counseling Materials. Through the choice counselor the state offers an extensive enrollee education and plan rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan using the plan report card, and information about the plan report card will be provided to the recipients.

51. Choice Counseling Information. The state or the state's administrator provides information on selecting a managed care plan. The state or the state's designated choice counselor provides information about each plan's coverage in accordance with federal requirements. Information includes, but is not limited to, 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. In addition, the state may supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data. To ensure the information is as helpful as possible, the state may synthesize information into a coherent rating system.

52. Delivery of Choice Counseling Materials. Choice counseling materials will be provided in a variety of ways including the internet, print, telephone, and face-to-face. All enrollee communications, including written materials, spoken scripts and websites shall be at the fourth (4th)-grade comprehension level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, without charge to the enrollee.

53. Contacting the Choice Counselor. Individuals contact the state or the state's designated choice counselor to obtain additional information. Choice counseling and enrollment information is available at the AHCA's website or by phone. The state or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The state must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

XII. HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM

54. Healthy Behaviors Programs. The state must require the MMA plans operating in the MMA program to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan must coordinate their Healthy Behaviors programs with the Medicare Advantage plan. Dental plans may opt to provide Agency-approved healthy behavior programs related to dental services.

- a. The state must monitor to ensure that each MMA plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and an alcohol or substance abuse treatment program that meet all state requirements.
- b. Programs administered by plans (including MMA plans and dental plans) must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). Plans are encouraged to seek an advisory opinion from OIG once the specifics of their Healthy Behaviors programs are determined.

XIII. ADDITIONAL PROGRAMS

55. Behavioral Health and Supportive Housing Assistance Pilot. The state will operate a voluntary pilot program for Medicaid recipients for whom these pilot services are appropriate through this section 1115 demonstration, in order to provide additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD), or SMI with co-occurring SUD, and who are homeless or at risk of homelessness due to their disability. The pilot program will provide enrollees with additional tools necessary to improve health outcomes and achieve stable tenancy, and should have the effect of reducing state costs related to unnecessary beneficiary service utilization. The demonstration provides 1115(a)(2) expenditure authority for the state to implement the pilot in specific geographic areas of the state, less than statewide, and to institute annual enrollment limits. The state will evaluate the extent to which provision of these services results in improved integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

- a. The Behavioral Health and Supportive Housing Assistance Pilot will be available in MMA regions 5 and 7 only. The state may institute annual enrollment limits as specified in the table below:

Demonstration Year (DY)	Enrollment Member Months Limit
DY 13 (SFY 2018; July 1, 2018 through June 30, 2019)	N/A
DY 14 (SFY 2019; July 1, 2019 through June 30, 2020)	50,000
DY 15 (SFY 2020; July 1, 2020 through June 30, 2021)	50,000
DY 16 (SFY 2021; July 1, 2021 through June 30, 2022)	50,000

- b. Participating MMA Plans in the pilot program must either be a plan that provides MMA services or a specialty plan that provides MMA services, serving individuals diagnosed with an SMI, SUD or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability, who meet enrollment requirements as stated in STC 22, and who meet all of the following requirements:
 - i. Provide services under the MMA program in regions five and/or seven,
 - ii. Include providers furnishing services in accordance with Chapters 394 and 397 of Florida Statutes Substance Abuse Services in its provider network,
 - iii. Have the capability to provide supportive housing assistance services specified in STC 55(c) below through agreements with housing providers specified in STC 55 (c)(iii) and (iv), and have relationships with local housing coalitions. Plans must have agreements with local housing community partners, including local housing authorities, community action organizations, and local housing providers, in order to enhance coordination at the local level and prevent duplication of services. The state is working with the Florida Housing Finance

Corporation and the Florida Supportive Housing Coalition to identify all available stable housing options for the target population, and will communicate with the participating managed care plans about these housing options to assist the plans in identifying local housing community partners. Participating managed care plans must have relationships with the local housing entities (housing authorities, community action organizations, local housing providers, etc.), to ensure the overall needs of the population are addressed and met and to ensure that Medicaid is not paying for services that are otherwise available.

c. Services provided:

- i. Transitional housing services: Services that support a recipient in the preparation for, and transition into, housing. This is an intensive service that includes activities such as conducting a tenant screening and housing assessment, developing an individualized housing support plan, assisting with the search for housing and the application process, identifying resources to pay for on-going housing expenses such as rent, and ensuring that the living environment is safe and ready for move-in.
- ii. Tenancy sustaining services: Services that support a recipient in being a successful tenant. Tenancy support services include activities such as early identification and intervention for behaviors that may jeopardize housing such as late rental payment or other lease violations; education and training on the roles, rights and responsibilities of the tenant and landlord; coaching on developing and maintaining key relationships with landlord/property managers; assistance (that may not include legal or financial assistance) in resolving disputes with landlords and/or neighbors to reduce risk of eviction; advocacy and linkage with community resources to prevent eviction, assistance; with the housing assistance eligibility recertification process; and coordinating with the enrollee to review, update, and modify their housing support and crisis plans.
- iii. Mobile crisis management: The delivery of immediate de-escalation services for acute maladaptive symptoms and/or behaviors (such as altered mental status, psychosis, irritability, inability to make decisions, actual or threatened harm to self or others, and behavior that creates an inappropriate risk of harm) at the Florida location in which the crisis occurs, even if the location is outside the region in which the plan is operating. Mobile crisis management is provided to enrollees participating in the pilot who are experiencing a behavioral health crisis. This service is provided by a team of behavioral health professional who are available at all times for (1) the purpose of preventing the need for emergency inpatient psychiatric services, when possible, or (2) the loss of a housing arrangement, when possible. Services will be available for eligible enrollees regardless of residence. Recipients residing in an IMD or who are inmates in a correctional institution are not eligible to participate. The agency is not seeking, and CMS has not approved, a waiver of IMD exclusion or the prohibition against the provision of FFP for services provided to inmates in a correctional institution. If needed, these individuals may receive housing assistance services once they are no longer

residents in an IMD or once released into the community.

- iv. Self-help/peer support: Person centered service promoting skills for coping with and managing symptoms while utilizing natural supports (such as family and friends) and the preservation and enhancement of community living skills with the assistance of state certified peer support specialist. These are (1) mental health substance abuse recovery peer specialists and (2) recovery support specialists that are certified by the state. The peer specialists are required to complete a 40-hour curriculum that covers four content learning areas identified by the state: mentoring, advocacy, recovery support, and professional responsibility.

- d. Enrollee Appropriateness Criteria. This pilot program is designed to provide necessary services for Florida Medicaid recipients age 21 year and older with an SMI, SUD or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The state will use the Department of Housing and Urban Development definition listed in 24 CFR 576.2 to determine risk of homelessness.

- e. HCBS Assurances.
 - i. As a part of its approved Quality Improvement Strategy, the state must develop performance measures within 90 days following approval of the 1115 waiver amendment to address the following requirements of the transitional housing services, tenancy sustaining services, mobile crisis management, and self-help/peer support:
 - A. Service plans that:
 - I. address assessed needs of participants;
 - II. are updated annually; and
 - III. document choice of services and providers.
 - B. Appropriateness Evaluation Requirements: The state will ensure that:
 - I. an evaluation for transitional housing services and tenancy services eligibility is provided to all applicants for whom there is reasonable indication that transitional housing services and tenancy services may be needed in the future;
 - II. the processes and instruments described in the approved program for determining transitional housing services and tenancy support services needs are applied appropriately; and
 - III. appropriateness of services for enrolled individuals is reevaluated at least annually (end of DY) or more frequently, as

specified in the approved program.

- C. Providers meet required qualifications. See STC 55(c)(iii) and (iv).
 - D. Settings meet the home and community-based setting requirements as specified in STC 55 and in accordance with 42 CFR 441.710(a)(1) and (2).
 - E. The SMA retains authority and responsibility for program operations and oversight by MCOs as required in the MCO contract.
 - F. The SMA maintains financial accountability through payment of claims by MCOs for services that are authorized and furnished to participants by qualified providers
 - G. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.
- ii. The state must report annually the actual number of unduplicated individuals served and the estimated number of individuals for the following year. Submission due at the end of the DY.
 - iii. To the extent housing support services are available and accessible for a beneficiary under other programs, those services that might otherwise be available through this demonstration will not be authorized for that particular beneficiary. The transitional housing-services and tenancy support services authorized under this demonstration, however, could cover connecting the beneficiary to such program and helping them secure supportive housing through that program.
- f. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Regional Office no later than 21 months prior to the end of the approved demonstration period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the Regional Office will issue a Draft report to the state and the state will have 90 days to respond. The Regional Office will issue a Final report to the state 60 days following receipt of the state's response to the Draft report.
 - g. The CMS Regional Office will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 12 months prior to the expiration of the demonstration period.
 - h. During the demonstration period, the state must conduct an evaluation to accomplish the following: assess if the pilot program can be transitioned to 1915(c) and 1915(i) authorities and how such transitions are consistent with the state's program goals

including consideration for the impact to services, members, waiver allocation process and budget implications; and, consistent with the assessment, develop a transition plan of the pilot program to 1915(c) or 1915(i) authority. By July 1, 2021, the state must submit a plan to CMS for transition of the pilot program to 1915(c) or 1915(i) authority.

- i. Pilot Evaluation. The state must develop an evaluation design for the pilot program and will submit to CMS for review and approval within 120 days of approval of this demonstration amendment.

56. The Prepaid Dental Health Program (PDHP). PDHP is a statewide Prepaid Ambulatory Health Program (PAHP) as defined under 42 CFR 438.2. The PDHP will provide Florida State Plan Medicaid dental services to all Florida Medicaid recipients and the MEDS AD and AIDS CNOM Eligibility Groups as described above, except the following populations which are excluded because they are either not eligible to receive State Plan dental services, or they receive dental services through the institution in which they reside or the program in which they are enrolled:

- i. Individuals eligible for emergency services only due to immigration status;
- ii. Family Planning Waiver recipients;
- iii. Presumptively eligible pregnant women;
- iv. Individuals residing in one of the following institutional settings:
 - a. State mental health hospital if under the age of 65 years,
 - b. Psychiatric Residential Treatment Facility (PRTF);
- v. Program of All-Inclusive Care for the Elderly enrollees; and
- vi. Partial dual eligibles.
 - a. The state will implement the PDHP in three phases by region, beginning December 1, 2018, with completion by March 1, 2019. In order to provide services to recipients, each dental plan operating under the PDHP must meet readiness and network requirements specified at 42 CFR 438.66(d)(1).
 - b. Dental plans are required to continue previously authorized services at the authorized levels, and through the existing provider, for at least the first sixty days of enrollment. For orthodontia services, dental plans are required to continue previously authorized services at the authorized levels, and through the existing provider, until the care is completed.
 - c. During transition to the PDHP, the state will auto-assign individuals into their existing dental plan that was subcontracted as a dental benefits manager for their current MMA plan. If an individual's existing plan is not a participating dental plan under the PDHP or if the recipient does not have an existing plan, the Agency will auto-assign based on the criteria specified in STC 25. Individuals may choose a different dental plan prior to enrollment and during the 120-day change/disenrollment-period without cause post-enrollment.

57. MEDS AD Program. The MEDS AD program provides coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (FPL). Individuals enrolled in the program receive all services offered through the State Plan as well as the community-based services provided in the programs identified below which are

operated by the state under the authority of 1915(c) of the Act.

- a. Availability of the community-based services is subject to any numeric limitations on enrollment in such programs and the requirements that the individual meets the eligibility and level of care criteria for the services in these programs:
 - i. Program of All-inclusive Care for the Elderly (PACE)
 - ii. Developmental Disabilities Individual Budget Home and Community Based Waiver
 - iii. Model Waiver
 - iv. Long-term Care Waiver.

58. AIDS Program. Recipients enrolled in the AIDS program will receive all services offered through the Florida Medicaid state Plan. For beneficiaries transitioning from the 1915(c) PAC Waiver (0194.R05.00), there will be no loss of services.³ In addition:

- a. Recipients ages 21 years and older will continue to access all State Plan services that are currently covered for adults and will be eligible to receive case management services through their health plan, medically necessary restorative massage, enteral formulas, and incontinence supplies not otherwise available to adult recipients. These incontinence supplies will be in addition to what is offered under the Medicaid State Plan according to the parameters at 42 CFR 440.70—this includes a process whereby individuals can request items that are not on the state’s pre-approved list but are coverable under the benefit.
- b. Recipients under the age of 21 years will continue to have access to all State Plan services and EPSDT benefits that are currently covered for children.

59. Healthy Start Program. The Healthy Start program is available statewide for eligible Medicaid recipients. The Healthy Start program is comprised of the following two components:

- a. **MomCare:** includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is a mandatory benefit for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning

³ The majority of recipients that were enrolled in the 1915(c) PAC waiver received their medical, dental, behavioral health, and prescribed drug services from an MMA plan; therefore, there will be no change in how these individuals receive MMA services, unless they choose to change plans. There will be no change for recipients who are not enrolled in an MMA plan, and instead receive the aforementioned services through a Medicare Advantage Fully Liable D-SNP. This change will not affect how D-SNP enrollees receive their Medicare or Medicaid benefits

services, and Medicaid coverage for the infant and the need to select a primary care physician for the infant.

- b. **Healthy Start Coordinated System of Care:** includes outreach and case management services for eligible pregnant women and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to the age of 3 who are identified to be at risk for a poor birth outcome, poor health and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling. The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

60. Program for All Inclusive Care for Children (Children’s Medical Services Network).

Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP).

- a. Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.
- b. Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.
- c. Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.
- d. Hospice Nursing Services – Assessment, pain and symptom management, and in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.
- e. Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.
- f. Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.
- g. Bereavement and volunteer services are provided but are not reimbursable services.

61. Comprehensive Hemophilia Disease Management Program. The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized

service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the FFS system or a MMA plan are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the up to three contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs from the therapeutic MOF Factor IX, and MOE- Antihemophilic Factors, Corifact (MOC therapeutic class), Stimite (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand. Medicaid-Medicare eligible individuals may voluntarily enroll in the program.

XIV. LOW INCOME POOL

62. Low Income Pool Definition. The LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. The resulting total computable (TC) dollar limit is enumerated in STC 63(a).

63. Availability of Low Income Pool Funds. The following STC presents the TC dollar limit for LIP spending for the current approval period, DY 12 through 16, subject to the assurances that follow.

a. **Total LIP Amount.** The TC dollar limit for LIP expenditures in each DY will be \$1,508,385,773.

b. **Assurance.** As reflected in the LIP participation requirements in STC 71, the state and providers that are participating in LIP will provide assurance that LIP claims include only costs associated with UC that is furnished through a charity care program and that adheres to the principles of the HFMA operated by the provider.

64. Capped Annual Allotments. All annual LIP funds must be expended by September 30 following each authorized DY. Any amount not expended cannot be rolled over to the next DY. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding UC cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable.

65. LIP Reimbursement and Funding Methodology. The Reimbursement and Funding

Methodology Document (RFMD) is prepared by the state for approval by CMS and documents LIP permissible expenditures, including the non-federal share and TC expenditures. The RFMD provides that TC LIP payments to providers for UC costs must be supported by UC costs incurred and reported by providers as charity care on the provider's financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for UC as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the DY. The state must submit and receive approval of a revised RFMD to add the Regional Perinatal Intensive Care Centers and Community Behavioral Health Providers to be eligible for LIP funding.

- a. Prior to August 31, 2017, the state was required to submit a draft of the DY 12 RFMD to CMS for approval—and CMS approved the RFMD on March 15, 2018. The state could not claim FFP for LIP payments in DY 12 until after the RFMD was approved by CMS.
 - i. Beginning in DY 13, in the event the RFMD methodology remains unaltered from the previous DY, the state will submit an attestation attached to the previous DY's RFMD stating that "the methodology contained herein remains in effect for the current DY XX," where XX represents the relevant DY.
 - ii. Beginning in DY 13, in the event the RFMD's methodology is altered from the previous DY, in part or in whole, the state will follow the initial RFMD submission process outlined for DY 12 RFMDs and/or attestations will be due for each DY to CMS on July 31 and, like all deliverables, should be submitted through the PMDA Portal.⁴
 - iii. Beginning in DY 15, prior to August 31 of each DY, the state must submit a draft of the RFMD for that DY to CMS for approval. The state may not claim FFP for LIP payments in that DY until after the RFMD for that DY has been approved by CMS.
 - iv. Continuing in DY 16, prior to August 31 of each DY, the state must submit a draft of the RFMD for that DY to CMS for approval. The state may not claim FFP for LIP payments in that DY until after the RFMD for that DY has been approved by CMS.
 - i.
- b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed UC costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within three years after the end of each DY showing cost reconciliation results by provider. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to exceed allowed UC costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (on Form CMS-64, Line 10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue

⁴ Available at <https://portal.cms.gov/wps/portal/unauthportal/home/>.

a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for the DY for which the LIP Cost Reconciliation Report is overdue.

- c. A provider, may at any time during a DY, disclose to the state that LIP payments to that provider exceeded allowed UC costs. If a provider refunds an overpayment to the state, the state must report that refund by including a decreasing expenditure adjustment on Line 10B of the CMS-64 for the quarter that it was received. If the provider reports an overpayment and does not refund that overpayment, the state has one year from the date of discovery, to have the provider refund the overpayment on the CMS-64. If the provider does not refund that overpayment within one year from the date of discovery, the state must refund the overpayment on the CMS-64. Any overpayments that have not been refunded to CMS may be subject to interest as defined under 42 CFR 433.320(a)(4).
- d. A provider is not eligible for an LIP payment or continued LIP payments if (i) the provider is identified in a disallowance notice from CMS to the State as having received an LIP overpayment in a specified amount in a prior year; and (ii) the provider has not entered into a repayment agreement satisfactory to the State within 30 days after the date by which the State must credit CMS with the federal share of the specified overpayment, or (iii) the provider is in breach of a repayment agreement.
- e. A provider that is ineligible for LIP payments on the basis of the above may re-establish eligibility by making repayment arrangements satisfactory to the state. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific disproportionate share hospital (DSH) limits defined in section 1923(g) of the Act.
- f. For the purposes of this STC, allowed UC cost follows the definitions described in STC 66 below.

66. Low Income Pool Permissible Expenditures. Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act.

- a. These health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals who are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the HFMA.
 - i. Providers may be categorized in up to four groups: hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers. Each group may be divided into up to five tiered subgroups, any of which may be based on ownership, UC Ratio, or ownership and UC Ratio, or (for purposes of FQHCs/RHCs only) Section 330 Public Health Service Act grant type, or FQHC Look-Alike status. UC Ratio is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its privately insured patient care costs. UC Ratio for FQHCs/RHCs

is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its total costs. To define subgroups by UC Ratio, providers must be ranked based on their relative UC Ratios, and may be formed into subgroups based on contiguous ranges of UC Ratios. Hospital ownership subgroups may consist of one or more of the following categories: local government, state government, or private and may be grouped by the hospital's publically owned, statutory teaching, freestanding children's, and Regional Perinatal Intensive Care Center hospital status. For each DY, up to \$75,000,000 of the capped annual allotment of the LIP may be apportioned to FQHCs/RHCs. FQHCs/RHCs may be tiered in subgroups by the type of Section 330 Public Health Service Act grant type and FQHC Look-Alike status.

- ii. All providers that must receive some amount of payment (following (i) above) must be paid the same percentage of their charity care cost within each subgroup.
- iii. Within each group and ownership subgroup, providers in tiers with a lower range of UC Ratios cannot be paid a greater share of their charity care cost than providers in tiers with higher UC Ratios.
- iv. Determination of (i) through (iii) may be effectuated using hospital-specific cost data for the DY for which payments are being allocated, or for a prior year not more than three years prior to that DY.

67. Low Income Pool Permissible Hospital Expenditures. Hospital cost expenditures from the LIP will be paid up to cost and are further defined in the RFMD utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs that will be defined in the RFMD. The state shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

68. Low Income Pool Permissible Non-Hospital-Based Expenditures. To ensure services are paid up to or at cost, the RFMD defines the cost reporting strategies required to support non-hospital based LIP expenditures.

69. Permissible Sources of Funding Criteria. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other federal programs (unless expressly authorized by federal statute to be used for matching purposes) shall be impermissible as sources of non-federal funding.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

70. Aggregate LIP Funding. Up to \$1,508,385,773 in LIP funds will be available to the state each DY. That amount will be reduced by any penalties that are assessed by CMS pursuant to STC 64 and/or reconciliation overpayments as discussed in STC 65. Provider Participation requirements, described in STC 71, must be met for the state to draw and

providers to be paid from the annual LIP funds for payment to providers.

71. LIP Provider Participation Requirements. Hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers must meet the participation requirements set forth in this STC to be eligible to receive LIP funds. The state may grant an exemption to a hospital with respect to the requirement in 71(a)(ii) below, upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter from a Specialty Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding. The state may grant an exemption to an FQHC/RHC with respect to the requirement in 71(c)(i) below, upon finding that the FQHC/RHC has demonstrated that it was refused a contract despite a good faith negotiation with a Standard Plan. A letter from a Standard Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding.

a. **Hospitals.**

- i. Must contract with at least fifty percent of the Standard Plan MCOs in their corresponding region.
- ii. Must contract with at least one Specialty Plan for each target population that is served by a specialty plan in their corresponding region.
- iii. Must participate in the Florida Encounter Notification Service⁵ program, except that participation is voluntary for hospitals with 25 or fewer beds.
- iv. The state and participating providers will provide assurance that LIP claims include only costs associated with UC furnished through a charity care program and that adheres to the principles of the HFMA and is operated by the provider.
- v. Participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.
- vi. This LIP category also includes Regional Perinatal Intensive Care Centers as an eligible hospital subgroup, effective December 1, 2018. Regional Perinatal Intensive Care Centers have special perinatal intensive care capabilities as defined in section 383.16, Florida Statutes.

b. **Medical School Physician Practices**

- i. Must participate in the Florida Medical Schools Quality Network.

⁵ Available at <https://www.florida-hie.net/ens/index.html>.

- ii. The state and participating providers will provide assurance that LIP claims include only costs associated with UC through the provider's charity care program and that adheres to the principles of the HFMA
- iii. Participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization. The state will review data submitted by the participating providers to determine the percentage of Medicaid utilization.

c. **Federally Qualified Health Centers and Rural Health Clinics**

- i. Must contract with at least 50 percent of Standard Plan MCOs in their corresponding region.
- ii. Must be enrolled in Medicaid.

d. **Community Behavioral Health Providers**

- i. Community Behavioral Health providers are providers in the substance abuse and mental health safety net system (Central Receiving Systems) administered by the Florida Department of Children and Families. A Central Receiving System consists of a designated central receiving facility and other service providers that serve as a single point or a coordinated system of entry for individuals needing evaluation or stabilization under section 394.463 or section 397.675, Florida Statutes, or crisis services as defined in section 394.67, Florida Statutes.
- ii. Community Behavioral Health providers is a LIP provider category effective as of December 1, 2018.
- iii. Must be enrolled in Medicaid.

72. Deliverable Requirements. By June 1 of each year, the state must submit to CMS a report detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider amount of uncompensated care to be furnished through charity care, and the estimated IGTs associated with each provider. By October 1 of each year, for the demonstration year just ended, the state must submit to CMS the final report of the LIP providers, final uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state's Medicaid website.

XVI. GENERAL REPORTING REQUIREMENTS

73. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

a. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

1. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
2. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and
3. Submit deliverables to the appropriate system as directed by CMS.

74. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 80.

75. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

76. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The compiled Annual Report is due no later than ninety (90) days following the end of the DY. Quarterly reports are limited in scope to the behavioral health and housing services pilot, Statewide Prepaid Dental Health Program, and the retroactive eligibility waiver. The state shall also submit semi-annual report(s) at the request of CMS. If semi-annual reports are requested, the state will have ninety (90) days to submit following the CMS request. In addition, CMS reserves the right to increase the frequency of reporting as deemed necessary by CMS Officials (e.g., to require quarterly reports).

- a. The monitoring reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).

- b. The monitoring reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolved, and be provided in a structured manner that supports federal tracking and analysis.
 - i. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. Performance Metrics –Any required monitoring and performance metrics must be included in writing in the monitoring reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis. The state must also submit performance metrics, to be agreed upon by CMS and the state and which align with CMS guidance, associated with the waiver of retroactive eligibility and the behavior health and supportive housing assistance services pilot.
 - iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated BN workbook with every quarterly and annual report that meets all the reporting requirements for monitoring BN set forth in the General Financial Requirements section of these STCs, including the submission of corrected BN data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.
 - iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

77. Additional Demonstration Annual Operational Report Requirements. Annual Report must, at a minimum, include the requirements outlined below:

- a. Items included must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- c. Total contributions, withdrawals, balances, and credits; and
- d. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the BN agreement.

78. Monitoring Calls. CMS will convene quarterly conference calls, as needed, with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls. Areas to be addressed during the monitoring call may include, but are not limited to:

- a. Transition and implementation activities;
- b. Stakeholder concerns;
- c. Operations and performance;
- d. Enrollment;
- e. Cost sharing;
- f. Quality of care;
- g. Beneficiary access;
- h. Benefit package and wrap around benefits;
- i. Audits;
- j. Lawsuits;
- k. Financial reporting and BN issues;
- l. Progress on evaluation activities and contracts;
- m. Related legislative developments in the state; and
- n. Any demonstration changes or amendments the state is considering.

79. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in its compiled Annual Report.

80. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS will issue deferrals in the amount of \$5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for

late or non-compliant submissions of required deliverables.

- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.
 - ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
- c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
- f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

XVII. GENERAL FINANCIAL REQUIREMENTS

81. Quarterly Expenditure Reports: CMS 64. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to BN. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XVII.

82. Reporting Expenditures Under the Demonstration: CMS-64. All expenditures for health care services for demonstration participants and categories, as described in section (d), are subject to the BN agreement. The following describes the reporting of expenditures subject to the BN agreement:

- a. Tracking Expenditures. In order to track expenditures, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. All

demonstration expenditures subject to the BN expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00206/4) assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were paid. The state will work with CMS to develop a method of reporting spending on dental care through the health plans.

- b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 and 10C, as instructed in the State Medicaid Manual. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.
- c. Pharmacy Rebates. The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as state and Federal revenue consistent with the federal matching rates under which the claim was paid.
- d. Use of Waiver Forms. For each DY, a waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter, reporting expenditures for the demonstration populations by eligibility group. Payments made to provide health care services to the eligibility groups listed below are expenditures subject to the BN limit. The waiver names designate the waiver forms in the MBES/CBES system to report Title XIX expenditures associated with the demonstration.
 1. The CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA mandatory and voluntary populations. The following Medicaid Eligibility Group (MEG) names and definitions will be utilized for CMS-64 reporting purposes:
 - i. MEG 1: Aged and disabled demonstration enrollees. Waiver Name: “Aged/Disabled”
 - ii. MEG 2: TANF demonstration enrollees. Waiver Name: “TANF & Related Group”
 - iii. MEG 3: Low Income Pool expenditures. Waiver Name: “LIP”
 - iv. MEG 4: MEDS AD demonstration enrollees. Waiver Name: “MEDS AD”
 - v. MEG 5: AIDS demonstration enrollees. Waiver Name: “AIDS”

CNOM”

- vi. MEG 6: Healthy Start expenditures. Waiver Name: “Healthy Start CNOM”
 - vii. MEG 7: PACC expenditures. Waiver Name: “PACC CNOM”
 - viii. MEG 8: Behavioral Health and Supportive Housing Assistance Pilot “BH SH Pilot”
2. **Changes to AIDS Expenditure Reporting.** Beginning January 1, 2018, expenditures for the individuals described in STC 58 must be reported under MEG 5 on form CMS-64.9—and excluded from MEGs 1 and 2.
 3. **Changes to Healthy Start & PACC Expenditure Reporting.** Beginning January 1, 2018, expenditures for the Healthy Start and PACC CNOMs must be reported under MEGs 6 and 7, respectively, on CMS-64.9 forms.
 4. **Progress Reports.** The state must submit quarterly progress reports on its progress in developing new programming logic to accommodate the necessary CMS-64 reporting system changes (see STC 101).
- e. Excluded Services. The following services are excluded from the demonstration, in that they are excluded from the list of benefits for which MMA managed care plans will provide coverage. Expenditures for these services are not expenditures subject to the BN limit, so should not be reported on any Forms CMS-64.9 Waiver and/or 64.9P Waiver for this demonstration.
1. Home and Community Based Service Waiver Services (Model Waiver (formerly Katie Beckett Model Waiver Services), Familial Dysautonomia, Development Disabilities Individual Budgeting);
 2. Long Term Care Waiver;
 3. ICF/IID Institutional Services;
 4. School Based Administrative Claiming;
 5. Prescribed pediatric extended care (PPEC) services;
 6. County matching programs (Substance Abuse and Medicaid Certified School Match Services);
 7. State Mental Health Hospital services for recipients age 65 and older;
 8. Certain physician-injectable procedures; and
 9. Vaccines for Children program for MediKids.
- f. Cost-Sharing Adjustments. Applicable cost-sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both TC and federal share) should also be reported separately by DY on

Form CMS-64 Narrative. In the calculation of expenditures subject to the BN expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

- g. Administrative Costs. Administrative costs will not be included in the BN agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver with the waiver name "ADM".
- h. Claiming Period. All claims for expenditures subject to the BN agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining BN.
- i. Sanctions and Liquidated Damages. If the state imposes monetary sanctions or liquidated damages against an MCO, the state must report the monetary amounts on the CMS-64 Summary Line 9D in the quarter in which the plan has exhausted all administrative appeals or the time to seek an administrative appeal has expired.
- j. Expenditures Subject to the Budget Neutrality Limits. The following types of expenditures are subject to the BN limits for this demonstration.
 - 1. All medical assistance expenditures for Medicaid beneficiaries in the categories listed in STC 22(a), (b), or (c) (regardless of their managed care enrollment status), other than expenditures for services listed in STC 82(e),
 - 2. All expenditures made under section 1115(a)(2) expenditure authority, including all payments made under LIP, through June 30, 2022.

83. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

- a. For the purpose of calculating the BN expenditure limit and for other purposes, the state must provide to CMS, as part of the Budget Neutrality Monitoring Tool required under STC 102, the actual number of eligible member months for the MEGs described in subparagraph (d) below. The state must submit a statement accompanying the Budget Neutrality Monitoring Tool, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.
- b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible

for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

- c. The state must report separate member month totals for mandatory and voluntary individuals enrolled in MMA that are not already represented in the member month reporting in place prior to that date. The member months must be subtotaled according to the MEGs defined in STC 82 (d)(1) above.
- d. The state must report member months for MEGs 1, 2 and 4.

84. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (TC and federal share) subject to the BN expenditure limit and separately report these expenditures by quarter for each federal fiscal year (FFY) on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

85. Extent of FFP. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the following, subject to the limits described in Section XVIII:

- a. Administrative costs associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration;
- c. Net expenditures and prior period adjustments for MMA Plan premiums paid to managed care entities and fee for service coverage carve-out services and for voluntary MMA populations that choose to stay in FFS;
- d. Net Expenditures associated with the LIP, as described in Section XIV; and,

Pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) pursuant to the payment exclusion in paragraph (A) following section 1905(a)(29) of the Act.

In addition, pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who has not attained 65 year of age and who is a patient in an institution for mental diseases pursuant to the payment exclusion in paragraph (B) following section 1905(a)(29) of the Act, except as provided in section 1905(a)(16) for inpatient psychiatric services for individuals under age 21.

86. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration are state/local monies, and that local funding is derived from state or local tax revenues. The state further certifies that such funds shall not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Title XIX the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. The state shall provide information to CMS regarding all sources of the non-federal share of funding for any amendments that impact the financial status of the program.
- c. The state assures that all health care related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State Plan.

87. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of the demonstration expenditures are met:

- a. Units of government, including governmentally-operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration;
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures;
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments; and,
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the

Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

88. Monitoring the Demonstration. The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

89. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XVIII. MONITORING BUDGET NEUTRALITY

The following describes the method by which BN will be assured under the demonstration. The demonstration will be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the demonstration period. STCs 86-87 specify the two independent financial caps on the amount of federal Title XIX funding that the state may receive on expenditures subject to the BN limit as defined in STC 91. Federal financial payments for the MMA aspects of the demonstration are limited by a Per Member Per Month (PMPM) method cap and the payments for the LIP aspects are limited by an aggregate cap.

90. Budget Neutrality Limit for the LIP. The maximum allowable LIP amount is capped annually at \$1,508,385,773 (TC). LIP funds not distributed in a DY cannot be rolled over to the next. The federal share of the TC LIP amount is the maximum amount of FFP that the state may receive for the LIP permissible expenditures detailed in STC 66. For each DY, the federal share will be calculated using the FMAP rate(s) applicable to that year.

91. Limit on PMPM Title XIX Funding. The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on the Medicaid and demonstration expenditures identified in STC 85 during the approval period of the demonstration. The limit is determined using a PMPM method. The BN targets are set on a yearly basis with a cumulative BN limit for the length of the entire demonstration (see STC 93 (b)). All data supplied by the state to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified BN limit. CMS' assessment of the state's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

92. Risk. The state shall be at risk for the per capita cost of demonstration enrollees under this BN agreement, but not for the number of demonstration enrollees. Providing FFP for all demonstration enrollees ensures that the state will not be put at risk solely due to changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed

the level of expenditures that would have occurred had there been no demonstration.

93. Budget Neutrality Expenditure Limit. The following describes the method for calculating the BN expenditure limit for the demonstration. Demonstration expenditures shall be reported under the Medicaid Eligibility Groups (MEG) listed in STC 82 (d). For the purpose of calculating the overall PMPM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a DY basis. The annual estimates will then be summed to obtain an expenditure estimate for the entire demonstration period. The federal share of this estimate will represent the maximum amount of FFP that the state may receive for the types of Medicaid expenditures described in this section. Budget neutrality calculations for both “With Waiver” (WW) and “Without Waiver” (WOW) expenditures are applied on a statewide basis. The federal share of the BN limit will be the total computable BN limit times Composite Federal Share #1 (described below). For the purpose of monitoring BN, the annual LIP expenditures enumerated in STC 65(a) shall be considered as both WW and WOW expenditures (i.e. pass through costs).

a. Projecting Service Expenditures - Each yearly estimate of MMA service expenditures will be the cost projections for the MEGs in sub-STC (b) below. The annual budget estimate for each MEG will be the product of the projected PMPM cost for the MEG, times the actual number of eligible member months as reported to CMS by the state under the guidelines set forth in STC 83.

Specifically,

1. “Aged/Disabled” MEG PMPM is multiplied by MEG 1 member months
2. “TANF & Rel Grp” MEG PMPM is multiplied by MEG 2 member months

b. Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual BN expenditure limit for this demonstration is specified below in Table 2.

Table 2. PMPM Costs by MEG and Demonstration Year

	Aged/Disabled MEG 1	Trend Rate	TANF & Rel Grp MEG 2	Trend Rate
DY12	\$1,027.49	4.0%	\$267.77	4.6%
DY13	\$1,068.59	4.0%	\$280.09	4.6%
DY14	\$1,111.33	4.0%	\$292.97	4.6%
DY15	\$1,155.78	4.0%	\$306.45	4.6%
DY16	\$1,202.01	4.0%	\$320.55	4.6%

94. How the Limit will be Applied. The limits as defined in STCs 93-95 will apply to the actual expenditures for the demonstration, as reported by the state under Section 95, and specifically, to expenditures reported for the following MEGs: MEG 1, MEG 2, MEG 5, MEG 6, and MEG 7. If at the end of the demonstration period the BN provision has been

exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for recipients and program categories not listed.

95. Hypotheticals & Supplemental Budget Neutrality Test: MEDS-AD. Optional demonstration expenditures that *could have been* covered via the Medicaid State Plan, but instead are provided through section 1115(a) expenditure authority, may be designated as “hypotheticals” for the purposes of BN. In these cases, CMS may allow adjustment(s) to the WOW baseline to hold states harmless for the spending which it could have hypothetically provided through the Medicaid State Plan. Separate WOW limits are provided below for the costs associated with this demonstration’s hypothetical expenditures and, if the limits are exceeded, that excess spending must be “paid for” with overall BN savings.

- a. The MEDS AD MEG listed in Table 3 below is included in the MEDS-AD Supplemental Budget Neutrality Test.

Table 3.1. PMPMs for Supplemental BN Test

	Trend	DY12	DY13	DY14	DY15	DY16
MEDS AD PMPM	0.00%	\$1,004.22	\$1,004.22	\$1,004.22	\$1,004.22	\$1,004.22

- b. The MEDS AD expenditures cap for the supplemental BN test is calculated by multiplying the projected PMPM for the MEDS AD MEG, each DY, by the number of actual eligible MEDS AD member months for the same/corresponding MEG/DY—and summing the products together across all DYs. The federal share of the MEDS AD expenditure cap is obtained by multiplying this cap by the Composite Federal Share #2 described in STC 99 below.
- c. If the actual FFP claimed by the state for the MEDS AD MEG for all DYs is greater than the federal share of the MEDS AD expenditure cap defined in sub-STC (b) above, then that overage will be subtracted from the demonstration’s overall BN variance.

96. Hypotheticals & Supplemental Budget Neutrality Test: Behavioral Health and Supportive Housing Assistance Pilot. Optional demonstration expenditures that could have been covered via the Medicaid State Plan, but instead are provided through section 1115(a) expenditure authority, may be designated as “hypotheticals” for the purposes of BN. In these cases, CMS may allow adjustment(s) to the WOW baseline to hold states harmless for the spending which it could have hypothetically provided through the Medicaid State Plan. Separate WOW limits are provided below for the costs associated with this demonstration’s hypothetical expenditures and, if the limits are exceeded, that excess spending must be “paid for” with overall BN savings.

- a. The BH SH Pilot MEG listed in Table 3.2 below is included in the Behavioral

Health and Supportive Housing Assistance Pilot Supplemental Budget Neutrality Test.

Table 3.2. Total Spending for Supplemental BN Test-BH SH Pilot

	Trend	DY12	DY13	DY14	DY15	DY16
BH SH Pilot	0.00%	N/A	N/A	\$9,714,500	\$9,714,500	\$9,714,500

- b. The projected BH SH Pilot for each DY is the amount shown in Table 3.2. The BH SH Pilot expenditures cap is the sum of the annual DY-specific amounts for all DY. The federal share of the BH SH Pilot expenditure cap is obtained by multiplying this cap by the Composite Federal Share #3 described in STC 99 below.
- c. If the actual FFP claimed by the state for the BH SH Pilot MEG for all DYs is greater than the federal share of the BH SH Pilot expenditure cap defined in sub-STC (b) above, then that overage will be subtracted from the demonstration’s overall BN variance.

97. Savings Phase-Out. Each DY, the net variance between the WOW cost and actual WW cost will be reduced for selected population-based MEGs. The reduced variance, to be calculated as a percentage of the total variance, will supersede the total variance in determining overall BN for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the WOW cost estimate.) The formula for calculating the reduced variance is: reduced variance equals total variance multiplied by the applicable percentage. The applicable percentages for each MEG and DY are determined based upon length of time the associated population has been enrolled in managed care; lower percentages are associated with longer established managed care populations. The MEGs affected by this provision and the applicable percentages are shown in Table 4 below, except that if the total variance for a MEG in a DY is negative, the applicable percentage is 100 percent.

Table 4. Savings Phase-Out Percentages

	DY 12	DY 13	DY 14	DY 15	DY 16
MEG 1 and MEG 2	66%	60%	55%	49%	44%

98. Impermissible DSH, Taxes or Donations. CMS reserves the right to adjust the BN ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through state Medicaid Director Letters, other memoranda or regulations. CMS reserves the right to make adjustments to the BN cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w)

of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

99. Composite Federal Share Ratio. The federal share of the BN expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, with consideration of allowable demonstration offsets such as premium collections, by TC demonstration expenditures for the same period as reported on the same forms. Composite Federal Share #1 is determined by applying the above calculation to expenditures reported under MEG 1 and MEG 2 combined. Composite Federal Share #2 is determined by applying the above calculation to expenditures reported under MEG 4. Composite Federal Share #3 is determined by applying the above calculation to expenditures reported under MEG 8. For the purpose of interim monitoring of BN, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

100. Enforcement of Budget Neutrality. CMS shall enforce BN over the life of the demonstration extension, which will be from August 1, 2017 through June 30, 2022. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration periods comprising DY 7 through 11 (but not from any earlier approval period). However, no later than 6 months after the end of each DY, the state will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in Section XVI. This amount will be compared with the actual FFP claimed by the state under BN. Using the schedule in Table 5 below as a guide for the PCCM budget limit, if the state exceeds the cumulative BN expenditure limit, they shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

Table 5. Maximum Budget Neutrality Caps

Demonstration Year	Cumulative Target Definition	Percentage
DY12	Cumulative BN Limit Plus:	2.0 percent
DY12 through DY13	Cumulative BN Limit Plus:	1.5 percent
DY13 through DY14	Cumulative BN Limit Plus:	1.0 percent
DY14 through DY15	Cumulative BN Limit Plus:	0.5 percent
DY15 through DY16	Cumulative BN Limit Plus:	0.0 percent

101. Annual Budget Neutrality Report. On or before June 30, 2018, and on or before June 30 of each year thereafter, the state shall submit to CMS an Annual BN Monitoring Report, which will include an assessment of the demonstration’s BN status based on actual expenditures to-date (including complete or nearly complete actual expenditures for the immediately preceding DY), the cumulative BN limit to-date, and updated projections for both the BN limit and WW expenditures through the end of the current approval period. If the state’s actual expenditures are found to have exceeded the cumulative BN limit by more than the percentages described in Table 5 above, or if the state’s projections indicate that that actual cumulative spending are likely to exceed the

BN limit for the approval period, the state must include corrective actions to ensure BN for the demonstration

102. Budget Neutrality Monitoring Tool. The state will provide CMS with quarterly BN status updates via the reporting of demonstration expenditures in the BN Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool will be jointly developed with the state and incorporate the “Schedule C Report” for comparing demonstration’s actual expenditures to the caps which are subject to BN expenditure limits described in STC 93-95. CMS will provide technical assistance, upon request.

103. Exceeding Budget Neutrality. If the BN expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the BN agreement, the BN test shall be based on the time elapsed through the termination date.

XIX. EVALUATION OF THE DEMONSTRATION

104. Independent Evaluator. At the beginning of the demonstration period, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft Evaluation Design. For scientific integrity, every effort should be made to follow the approved methodology. State evaluations must follow the approved methodology, however, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

105. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

106. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment B of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of the amendment approval. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design. CMS requires states waiving retroactive eligibility to evaluate the impact of the waiver. The state will collaborate with CMS to identify hypotheses and research questions tailored to the state’s provisions, which align with CMS’ guidance on evaluating retroactive eligibility. Possible areas of focus for hypotheses include the effect of the waiver on 1) enrollment and enrollment continuity

(including for different types of enrollees such as applicants and existing beneficiaries, and for individuals who are healthy and those with complex medical needs); 2) health outcomes, including but not limited to, increased transitions of individuals from nursing facilities to home and community-based settings as a result of nursing facilities submitting Medicaid applications more timely and reduced rates of potentially preventable hospital events as a result of hospitals submitting Medicaid applications more timely, and 3) the financial impact on beneficiaries and providers.

107. Evaluation Design Approval and Updates. The state’s draft Evaluation Design may be subject to multiple revisions until a format and the content is agreed upon by CMS. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS’ comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.

108. Evaluation Questions and Hypotheses. Consistent with Attachments B & C of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each waiver and expenditure authority should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

109. State Must Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

- a. At a minimum, the draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (b). The draft design will discuss:
 - i. The outcome measures to be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
 - ii. The data sources and sampling methodology for assessing these outcomes; and
 - iii. A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.
- b. The evaluation must outline and address evaluation questions for all of the

following components:

- i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
- ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
- iii. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
- iv. The impact of LIP funding on hospital charity care programs;
- v. 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;
- vi. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals;
- vii. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner;
- viii. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services;
- ix. The impact of the waiver of retroactive eligibility on beneficiaries and providers.
- x. The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.

110. Interim Evaluation Report. Following approval from CMS on the Evaluation Design, the state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is

submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

- d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment C of these STCs.

111. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment C of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period by December 31, 2023 (i.e., within 18 months of the end of the approval period represented by these STCs). The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

112. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, post approval, in conjunction with these STCs. The state shall present on its interim and summative evaluation in conjunction with these STCs. Presentation may be conducted remotely.

113. Public Access. The State must post all final reports submitted to CMS for approval on the state's Medicaid website within 30 days of approval by CMS.

114. Additional Publications and Presentations. For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XX. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

115. External Quality Review (EQR). The state is required to meet all requirements for external quality review (EQR) found in 42 CFR Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent annual validation of encounter data for all MCOs and PIHPs.

116. Consumer Health Plan Report Cards. On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each managed care plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating plan. The report cards must also address the performance of subcontracted dental plans.

117. Performance Improvement Projects (PIP). In accordance with 42 CFR §438.330, the state must require each managed care plan, including each dental plan, to commit to improving care. In lieu of Performance Improvement Projects (PIPs) identified by CMS as described in § 438.330(a)(2), the state must require each managed care plan, including each dental plan to complete PIPs in the following focus areas, which have the significant potential for achieving the demonstration's goals of improving patient care, population health, and reducing per capita Medicaid expenditure. Specialty plans that do not have sufficient numbers of eligible recipients for the PIP topics identified in 126(a) or 126(b) may conduct alternative PIPs on topics more relevant to their enrolled population in place of the required focus areas, subject to approval by the state.

- a. A PIP combining a focus on improving primary C-section rates, pre-term delivery rates, and neonatal abstinence syndrome rates;
- b. A PIP focused on reducing potentially preventable events, including hospital admissions, readmissions, and emergency department visits;
- c. An administrative PIP focusing on the administration of the transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving to their scheduled appointment on time; and
- d. A choice of PIP in one of two topic areas: behavioral health or integrating primary care and behavioral health.
- e. Dental plans shall perform three PIPs as follows:
 - i. A PIP focused on increasing the rate of enrollees accessing preventive dental services;
 - ii. A PIP focused on reducing potentially preventable dental-related emergency department visits in collaboration with the Statewide Medicaid Managed Care (SMMC) plans.
 - iii. An administrative PIP focused on coordination of transportation services with the SMMC plans.

- f. The state must conduct each PIP in accordance with 42 CFR §438.330 and 438.340. The state will meet its obligations under the regulations.

118. Measurement Activities. The state must ensure that each participating managed care plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level. In addition to requirements set forth at 42 CFR § 438.330 through 438.334, the state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

XXI. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Report	Section XVI, STC 76
90 days following the end of the DY	Annual Report	Section XVI, STC 76
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 81
July 31, Annually	LIP Draft RFMD and/or Attestation	Section XIV, STC 65
Within 3 years of the end of each DY	LIP Cost Reconciliation Report	Section XIV, STC 65b
June 1, Annually	LIP Provider UC and IGT estimate report	Section XV, STC 72
October 1, Annually	LIP Provider, UC and IGT final report	Section XV, STC 72
Within 120 Days of the effective date of STCs	Draft Evaluation Design	Section XIX, STC 107

ATTACHMENT A

COMPREHENSIVE PROGRAM DESCRIPTION AND OBJECTIVES

The Florida Medicaid Reform demonstration was approved October 19, 2005. The state implemented the demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007. On December 15, 2011, CMS agreed to extend the demonstration through June 30, 2014.

The December 2011 renewal included several important improvements to the demonstration, such as; enhanced managed care requirements to ensure increased stability among managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans and to ensure adequate choice of providers. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations. Finally, the renewal included the continuation of the Low Income Pool (LIP) of \$1 billion (TC) annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations.

On June 14, 2013, CMS approved an amendment to the demonstration, which retains all of the improvements noted above, but allowed the state to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. CMS authorized implementation to begin no earlier than January 1, 2014, with the Medicaid Reform demonstration continuing to operate in the five Medicaid Reform counties until the MMA program was implemented there.

Under the June 2013 amended demonstration, most Medicaid eligibles were required to enroll in a managed care plan (either a capitated managed care plan or a FFS Provider Service Network (PSN)) as a condition for receiving Medicaid. Enrollment was mandatory for Temporary Assistance for Needy Families (TANF)-related populations and the aged and disabled, with some exceptions. The demonstration continued to allow plans to offer customized benefit packages and reduced cost sharing, although each plan must cover all mandatory services, and all State Plan services for children and pregnant women (including Early and Periodic Screening, Diagnostic and Treatment (EPSDT)). The demonstration provided incentives for healthy behaviors by offering Enhanced Benefits Accounts that were replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in STC 54. Beneficiaries in counties transitioning from Medicaid Reform to MMA continued to have access to their accrued credits under Enhanced Benefit Account Program (EBAP) for one year.

The June 2013 amended terms and conditions included improvements such as:

- A phased implementation to ensure readiness including a readiness assessment for each region and a requirement for CMS approval of the state's implementation plan which will include identified risks, mitigation strategies, fail safes, stakeholder engagement and rapid cycle improvement strategies;

- Strengthened auto-enrollment criteria to ensure consideration of network capacity, access, continuity of care, and preservation of existing patient-provider relationships when enrolling all beneficiaries into the MMA program, including special populations;
- STCs tailored to special populations, should the state choose to include specialty plans in the final selection of managed care entities and PSNs;
- Strong consumer protections to ensure beneficiary assistance and continuity of care through the MMA transition. Additional STCs to ensure beneficiary choice, including a comprehensive outreach plan to educate and communicate with beneficiaries, providers, and stakeholders and annual Health Plan Report Cards for consumers, which will allow beneficiaries to be more informed on health plan performance and assist beneficiaries in making informed decisions related to plan selection;
- Enhanced Medical Care Advisory Committee (MCAC) requirements to ensure beneficiary and advocate group participation as well as inclusion of sub-population advisory committees;
- Performance Improvement Projects (PIP) to be performed by all health plans;
- Clarification and enhancements of the monitoring and evaluation of plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and,
- A Comprehensive Quality Strategy (CQS) that will span the entire Florida Medicaid program.

The approved 2014 extension of the demonstration continued the improvements authorized in the June 2013 amendment and extended all portions of this demonstration for three years, except for the Low Income Pool (LIP). CMS authorized extension of the Low Income Pool for one year, from July 1, 2014 through June 30, 2015.

- During the one-year extension for the LIP, expenditures were authorized to provide stability for providers for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. Funding sources were limited only to existing state and local funding arrangements. The total amount of LIP funding could not exceed \$2,167,718,341 (TC).
- Florida was required to analyze and develop a plan to reform Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding. Expenditures authorized under the LIP were limited to UC costs of providers, the independent report discussed below, and other categories of expenditure as specified in the STCs.
- UC costs were required to be verified through provider cost reports. CMS indicated that it would disallow unallowable payments to providers in prior DYs as identified on provider cost reports.
- During the one-year LIP extension, the state was required to use a portion of the LIP funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments.

The report was required to recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year (SFY) 2015-2016, to move toward Medicaid FFS and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. The final report was due no later than March 1, 2015.

On June 30, 2015, pursuant to a letter to the state, CMS granted 60 days of interim expenditure authority under section 1115(a)(2) of the Social Security Act, to make federal funding available to Florida for interim LIP payments to providers from July 1, 2015 through August 31, 2015 of DY (DY) 10, subject to a total spending limit of \$166.66 million for the combined federal and state shares of expenditures (with such amount being counted in determining the amount of any further extension of the Low Income Pool).

On October 15, 2015, CMS approved three amendments to the demonstration.

- The first amendment added two populations as voluntary enrollees in managed care: Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services, and recipients residing in group home facilities licensed under section(s) 393.067 Florida Statutes (FS).
- The second amendment authorized changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination. The amendment also changes the auto-assignment criteria. Individuals will receive both their managed care plan assignment and information about choice of plans in their area. Individuals may actively select a plan during a 120-day change/disenrollment period post-enrollment.
- The third amendment authorized expenditures under the LIP through June 30, 2017. The total amount of LIP funding in DY 10 (July 1, 2015 – June 30, 2016) will not exceed \$1 billion (TC). The total amount of LIP funding in DY 11 (July 1, 2016 – June 30, 2017) will not exceed \$607,825,452 million (TC). The changes represent a transition to a LIP that reflects the cost to providers of UC for uninsured individuals in the state, and that no longer pays for care that may be or has been provided through available coverage options. The changes set Florida on a path to administering a LIP in 2016-2017 (DY 11) that distributes funds based on the burden placed on providers by services for low- income, uninsured individuals for whom no other coverage options are, or could be, made available.

On October 12, 2016, CMS approved three amendments, which modified the demonstration to:

- (a) allow Florida flexibility to contract with one to three vendors under the hemophilia program;
- (b) include payments for nursing facility (NF) services in MMA capitation rates for recipients under the age of 18 years; and
- (c) allow flexibility for specialty plans to conduct Performance Improvement Projects (PIP) on topics that have more specific impacts to their enrollees, with Florida approval.⁶

⁶ For the “Comprehensive Program Description and Objectives,” see Attachment B.

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

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Medicaid enrollees in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the (HFMA) principles.⁷

On August 1, 2017, CMS reauthorized the MMA Medicaid managed care program for the 5-year extension without significant changes to the program. The revised STCs for the extension reflected the state's obligation to follow the Medicaid managed care regulations at 42 CFR 438, and CMS and Florida agreed to several revisions to the STCs that previously governed the state's LIP. The revised LIP calculations reflected in the extension STCs led to a new TC annual LIP limit of \$1.5 billion per DY—which was an annual increase of approximately \$900 million compared to the previous DY's LIP amount.

There were two changes which led to the increased annual LIP limit:

- CMS' analysis of more recent Florida hospital cost report data led to an increase of \$450 million in annual LIP; and
- CMS did not apply the previous LIP reduction for Medicaid expansion which led to an additional increase of \$450 million annually—this was the only significant change to CMS' previous methodology for determining UC amounts.

Consistent with CMS' goal of lessening or removing unduly burdensome and/or duplicative state reporting requirements, where appropriate, the extension STCs also omitted the requirement for quarterly reporting on all MMA demonstration activities (although expenditures continue to be reported quarterly, and annual reporting is required, consistent with the statutory requirement of periodic state reports). In addition, the requirement for the state to submit the LIP Reimbursement and Funding Methodology (RFMD) document for

⁷ <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589>

the first extension DY—with subsequent annual attestations that the methodology remains in effect. CMS also eliminated the requirement for a Comprehensive Quality Strategy in the extension; however, the state still is required to develop and maintain a managed care quality strategy as required under 42 CFR §438.340.

Historical PMPMs and Trend Rates

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate
DY 1 (SFY 2006/7)	\$948.79	8.0%	\$199.48	8.0%
DY 2 (SFY 2007/8)	\$1,024.69	8.0%	\$215.44	8.0%
DY 3 (SFY 2008/9)	\$1,106.67	8.0%	\$232.68	8.0%
DY 4 (SFY 2009/10)	\$1,195.20	8.0%	\$251.29	8.0%
DY 5 (SFY 2010/11)	\$1,290.82	8.0%	\$271.39	8.0%
DY 6 (SFY 2011/12)	\$1,356.65	5.1%	\$285.77	5.3%
DY 7 (SFY 2012/13)	\$1,425.84	5.1%	\$300.92	5.3%
DY 8 (SFY 2013/14)	\$1,498.56	5.1%	\$316.87	5.3%
DY 9 (SFY 2014/15)	\$786.70	4.1%	\$324.13	4.6%
DY 10 (SFY 2015/16)	\$830.22	4.1%	\$339.04	4.6%
DY 11 (SFY 2016/17)	\$876.81	4.1%	\$354.64	4.6%

ATTACHMENT B DEVELOPING THE EVALUATION DESIGN

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

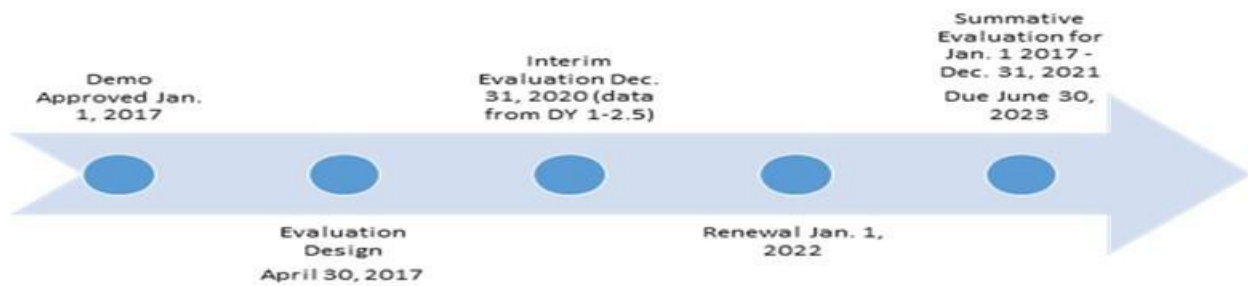
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the State’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state’s hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.
- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (If the state proposes to do a survey as part of the evaluation, CMS will have 45 days from the date of submission to review the survey instrument for approval.

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid FFS and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS 64 reporting or BN; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

- 1) **Independent Evaluator.** The process the state will use for obtaining an independent entity to conduct the analysis and write the Evaluation Report, including a description of the qualifications the entity must possess. As soon as known, this section should be updated to include:
 - a. Information about the organization conducting the evaluation;
 - b. Contact information for the organization, including how to obtain a copy of the evaluation;
 - c. The name and contact information of the Principal Investigator; and
 - d. Curriculum Vitae of the Principal Investigator.

- 2) **No Conflict of Interest.** Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes “No Conflict of Interest” signed conformation statements.

- 3) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to, the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

- 4) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT C PREPARING THE EVALUATION REPORT

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act ("the Act") requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

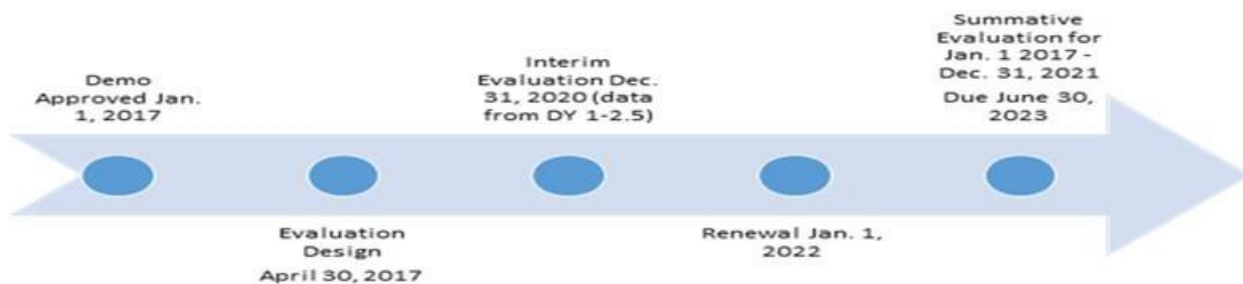
The format for the Interim and Summative Evaluation reports are as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;

- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state’s website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the State’s Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

- 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state’s hypotheses about the outcomes of the demonstration:
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both

quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
- 2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
- 3) *Evaluation Period*—Describe the time periods for which data will be collected
- 4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
- 5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
- 6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

- a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

- 1) What lessons were learned as a result of the demonstration?
- 2) What would you recommend to other states, which may be interested in implementing a similar approach?

J. Attachment

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT D: Evaluation Design

Florida's Managed Medical Assistance (MMA) Program Demonstration Waiver Evaluation: Design Update 2017-2022

Presented to:

Centers for Medicare and Medicaid Services

Prepared by:

Florida Agency for Health Care Administration

and

Department of Health Outcomes & Biomedical Informatics
College of Medicine
University of Florida

and

Department of Behavioral Sciences and Social Medicine
College of Medicine
Florida State University

March 2, 2020

Table of Contents

- A. General Background Information* 1
- B. Evaluation Questions and Hypotheses* 8
- C. Methodology* 21
 - 1. Evaluation Design 22
 - 2. Target and Comparison Populations 22
 - 3. Evaluation Period 22
 - 4. Evaluation Measures 23
 - 5. Data Sources 35
 - 6. Analytic Methods 41
- D. Methodological Limitations* 69
- E. Attachments* 71

List of Tables

Table 1. Mandatory and Optional State Plan Eligibility Group	4
Table 2. CAHPS Measures Used in the Evaluation	23
Table 3. HEDIS and Other Performance Measures Used in the Evaluation	25
Table 4. Additional Measures used in the Evaluation	30
Table 5. Quantitative and Qualitative Data Sources for Florida MMA Evaluation	36
Table 6. Design Table for the Evaluation of the Demonstration.....	48
Table 7. MMA Evaluation Activities, December 31, 2017-December 31, 2023	72

List of Figures

Figure 1. Florida Managed Medical Assistance Program Goals: Driver Diagram	19
Figure 2. Logic Model for Change in Florida's Medicaid Retroactive Enrollment	20
Figure 3. Logic Model for Housing Assistance Pilot Program.....	21

A. General Background Information

1. Issues Addressed by This Demonstration

Under the MMA demonstration, Florida seeks to continue building upon the following objectives that have been fundamental to Florida's Medicaid improvement efforts over the past 15 years:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top-quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner, except those specifically exempted. 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 and federally qualified health care centers (FQHC) and rural health clinics (RHC) that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.¹ Improving continuity of coverage and care and encouraging uptake of preventive services, or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable, as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.
- Improving integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

Florida's motivation for improving its Medicaid program stems from two factors: (1) the nationwide concerns about ensuring continued access to high quality care for its Medicaid enrollees while (2) simultaneously addressing the rapid increases in Medicaid costs that have propelled the Medicaid program to the very top of states' budget priorities nationwide.

2. Name of the Demonstration, Approval Date, and Time Period

Managed Medical Assistance 1115 Waiver Demonstration Extension, Project No. 11-W-00206/4, August 3, 2017 through June 30, 2022.

¹ Healthcare Financial Management Association, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers," Principles and Practices Board Statement 15, December 2012. <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589>, accessed on 11/27/17

3. Description of the Demonstration and History of the Implementation

The Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Research and Demonstration Waiver, "Medicaid Reform", on October 19, 2005. 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 three-year waiver extension request to maintain and continue operations of the Medicaid Reform program. Federal CMS approved the three-year waiver extension request on December 15, 2011 for the period December 16, 2011 through July 31, 2014.

On August 1, 2011, Florida submitted an amendment request to Federal CMS to change the name of the demonstration and implement the Managed Medical Assistance (MMA) program as specified in Part IV of Chapter 409, Florida Statutes (F.S.). The amendment allowed the state to implement a new statewide managed care delivery system without increasing costs and to continue the Low-Income Pool (LIP) program. On June 14, 2013, Federal CMS approved the amendment, along with amended Special Terms and Conditions (STCs), waiver and expenditure authorities. MMA program implementation began May 1, 2014 and was fully implemented in all regions by August 2014. On July 31, 2014, CMS approved the State's request for a three-year extension to the MMA 1115 waiver demonstration, along with newly amended STCs and waiver and expenditure authorities, through June 30, 2017.

The Agency contracted with the University of Florida (UF) to conduct an independent evaluation of the MMA program. UF subcontracted with two other universities to conduct some components of the evaluation (Florida State University and University of Alabama at Birmingham). The Agency provided the evaluators with a description of the objectives of the MMA program and the approved evaluation design.

UF submitted a Final Comprehensive Evaluation Report for DY9 (SFY 2014-15) to the Agency in September 2017. Targeted evaluation questions about the MMA program covered 18 unique domains of focus and were organized into the following five projects:

1. The effect of customized benefit plans and having separate plans for LTC and acute care services on beneficiaries' choice of plans, access to care, quality of care, and cost of care;
2. Healthy Behaviors Programs offered by the MMA plans;
3. MMA program's ability to deter fraud and abuse;
4. The effect of LIP on uncompensated care provided through hospital charity care programs; effect on access, quality and timeliness of care and emergency department usage for the uninsured; and, impact on costs for treating uninsured patients; and,
5. Outcomes for dual-eligible individuals enrolled in a Medicare Advantage Plan and a MMA plan.

The evaluation of the MMA program for DY9 (SFY 2014-15) yielded the following high-level findings:

- In the MMA period, there were sizable declines in service utilization compared to the pre-MMA period for the following:
 - Inpatient stays
 - Outpatient visits
 - Emergency Department visits
 - Professional (physician) visits
- Out of a subset of 26 HEDIS measures, approximately 65 percent (17 measures) of the statewide weighted means improved and 27 percent (7 measures) stayed the same after implementation of MMA. Only 8% (2 measures) declined after implementation.
- Per member per month (PMPM) costs adjusted for age, race, gender, and Chronic Illness and Disability Payment System (CDPS) scores (case-mix) for MMA services are 32.9 percent lower for comprehensive plans (serving both LTC and MMA enrollees) compared to PMPM costs for enrollees who are in separate LTC and MMA plans (\$206 PMPM comprehensive vs. \$306 PMPM separate).
- While the Florida transition to statewide managed care in 2014 was not without challenges, the overall success in implementing such a broad transformation in the span of a few short months, while reducing per member per month (PMPM) costs and maintaining or improving quality measures, stands as a considerable accomplishment.

More details about DY9 findings, as well as for additional demonstration years, will be included in the Interim Draft Evaluation Report (available January 2022).

4. MMA Program Description and Objectives

Federal CMS approved a second extension of the MMA 1115 waiver demonstration (Project No. 11-W-00206/4) for a period of five years beginning August 3, 2017 through June 30, 2022. For the extension, CMS funded the LIP at approximately \$1.5 billion annually based on the most recent available data on hospitals' charity care costs to ensure continuing support for safety-net providers that furnish uncompensated care to the Medicaid, uninsured, and underinsured populations. The STCs for the demonstration were modified to simplify and streamline reporting requirements and to remove requirements that are no longer applicable. All future references to the STCs in this document relate to the March 26, 2019 amended STCs unless otherwise indicated. Florida's 1115 demonstration allows the state to operate a capitated Medicaid managed care program. Under the demonstration, most Medicaid eligibles are required to enroll in one of the managed care plans contracted with the State. Several populations may also voluntarily enroll in managed care through the MMA program. The managed care plans in the MMA program are divided into "standard" and "specialty" plans. Specialty plans serve populations with distinct characteristics, diagnoses or chronic conditions. These plans are tailored to meet the specific needs of the specialty population.

Applicants for Medicaid are given the opportunity to select a managed care plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are auto-assigned into a managed care plan upon an affirmative eligibility determination and subsequently provided with information about their choice of plans. Once an enrollee has selected or been assigned an MMA plan, the enrollee shall be enrolled for a total of 12 months,

until the next open enrollment period. The 12-month period includes a 120-day period to change or voluntarily disenroll from a plan without cause and select another plan.

Managed care plans may provide customized benefits to their members that differ from, but cannot be more restrictive than, the state plan benefits. Participating Medicaid eligibles also have access to Healthy Behaviors programs that provide incentives for adopting healthy behaviors.

4.1 Populations Covered in the MMA Program

MMA program enrollees include individuals eligible under the approved state plan or as a demonstration-only group, and who are described below as “mandatory enrollees” or as “voluntary enrollees.” Mandatory enrollees are required to enroll in a MMA plan as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have the option to enroll in a demonstration MMA plan to receive Medicaid benefits.

1. **Mandatory Managed Care Enrollees** – Individuals who belong to the categories of Medicaid eligibles listed in Table 1 (and who are not listed as excluded from mandatory participation) are required to be MMA program enrollees.

Table 1. Mandatory and Optional State Plan Eligibility Group

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Infants under age 1	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & Related Group
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & Related Group
Children 6-18	No more than 133% of the FPL.	Title XIX	TANF & Related Group
Blind/Disabled Children	Children eligible under Supplemental Security Income (SSI), or deemed to be receiving SSI.	Title XIX	Aged/Disabled

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
IV-E Foster Care and Adoption Subsidy	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & Related Group
Pregnant women	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Group
Section 1931 parents or other caretaker relatives	No more than Aid to Families with Dependent Children (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 Group
Aged/Disabled Adults	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
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 Group

Optional State Plan Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
State-funded Foster Care or Adoption assistance under age 18	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & Related Group

Optional State Plan Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Individuals eligible under a hospice-related eligibility group	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	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 STC 20(c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217	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 STC 20(c).	Title XIX	Aged/Disabled

Demonstration Only Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) *Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) *Medicaid-only eligibles receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed \$5,000 (individual) or \$6,000 (couple)	Title XIX	MEDS AD

Demonstration Only Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
	*Medicare eligible receiving hospice, HCBS, or institutional care services		
Individuals diagnosed with AIDS	*Have an income at or below 222% of the federal poverty level (or 300% of the benefit rate) *Have assets that do not exceed \$2,000 (individual) or \$3,000 (couple) and *Meet hospital level of care, as determined by the State of Florida	Title XIX	AIDS CNOM

Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan 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 beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 25.

2. Voluntary Enrollees – The following individuals are excluded from mandatory enrollment into the MMA program under subparagraph (a) but may choose to voluntarily enroll under the demonstration, in which case the individual would be a voluntary participant in an MMA plan and would receive its benefits:

- a) Individuals who have other creditable health care coverage, excluding Medicare;
- b) Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;
- c) Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
- d) Individuals with developmental disabilities enrolled in the home and community- based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;
- e) Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility; and
- f) Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

3. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from enrollment in managed care plans:

- a) Individuals eligible for emergency services only due to immigration status;
- b) Family planning waiver eligible;
- c) Individuals eligible as women with breast or cervical cancer; and,
- d) Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan, except as inpatients in a medical institution).

B. Evaluation Questions and Hypotheses

This section presents each evaluation component and its associated research questions. Note that for research questions focusing on cost and utilization, the pre-MMA period will include recipients enrolled in fee-for-service (FFS) Medicaid in addition to recipients enrolled in Reform and 1915b waiver plans. A driver diagram based on the components and their research questions is included at the end of this section (Figure 1) along with a logic model (Figure 2) for Component 9 that depicts hypothesized causes/effects associated with the changes in Florida's retroactive enrollment policy and a logic model for Component 10 (Figure 3) that depicts hypothesized causes/effects associated with the implementation of a Housing Assistance Pilot for enrollees with serious mental illness and/or substance abuse who are homeless or at risk of homelessness.

The state of Florida established the MMA program with the goal to improve the quality, access, and costs of care for Florida's Medicaid enrollees. The Agency's specific goal for the managed care plans has been for the plans to reach the National Medicaid 75th percentile on HEDIS measures. The managed care plans' HEDIS rates each year are compared to the previous year National Medicaid percentiles to measure the plans' (and MMA program's) progress toward reaching the 75th percentile. The state's overall goal to improve the quality, access, and costs of care dictates that examining the changes in quality, access, and costs are key to gauging the success of the MMA program. The state therefore seeks a combination of (1) statistically significant beneficial changes in key measures (e.g., cost reductions, access improvements, quality increases) while (2) maintaining performance in those areas where statistically significant beneficial changes are not detected (i.e., not incurring statistically significant cost increases, access reductions, and quality decreases). Given the multitude of measures of cost, access, and quality and the varied populations served by Medicaid, it would be unrealistic to expect across-the-board improvements in every measure of performance for every population.

In keeping with the goals of the MMA demonstration, the State expects the demonstration to have an overall positive impact on Florida's efforts to improve its Medicaid program under a capitated managed care program.

All hypotheses in this report are stated in null form (i.e., hypothesizing no change). Each null hypothesis will be tested against a two-tailed alternative hypothesis (i.e., hypothesizing a non-zero, positive or negative change) using $\alpha \leq 0.05$.

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

Research Questions:

1A. *What barriers do enrollees encounter when accessing primary care and preventive services?*

Question 1A will be answered descriptively using AHCA complaint, grievance, and appeal data and the Client Information & Registration Tracking (CIRTS) database from the MMA period, and to the extent possible, Medicaid Fair Hearing data. Hence, no hypotheses will be tested.

1B. *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 MMA plans?*

Hypothesis 1B. *There will be no changes in the accessibility of services in MMA plans compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).*

1C. *What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans and pre-MMA 1915(b) waiver plans) to utilization of services in post-MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?*

Hypothesis 1C. *1) There will be no change in the use of services for enrollees in the MMA period compared to the pre-MMA period. 2) There will be no difference in use of services by enrollees in specialty MMA plans compared to use of services by enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are in standard MMA plans.*

1D. *What changes in quality of care for enrollees 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 MMA plans in the MMA period; 2) quality of care in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard plans versus enrollees in the specialty plans (to the extent possible)?*

Hypothesis 1D. *(1) There will be no change in the quality of care for enrollees in MMA plans compared to quality of care for enrollees in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); and 2) There will be no difference in the quality of care for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) in standard plans versus enrollees in specialty plans.*

1E. *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?*

This question will be addressed using qualitative methods (no hypothesis).

1F. *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?*

Hypothesis 1F. *There will be no change in the timeliness of services in MMA plans compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).*

1G. *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 in the MMA period (MMA plans as a whole, standard MMA plans and specialty MMA plans)?*

Hypothesis 1G. *There will be no difference in the per-enrollee cost by eligibility group in MMA plans compared to pre-MMA implementation (FFS, Reform, and 1915 (b) waiver plans).*

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

Since the MMA plans do not offer customized benefit plans, the State will evaluate the effect of expanded benefits on enrollees' utilization of services, access to care, and quality of care.

Research Questions:

2A. *What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the types of expanded benefits to particular populations?*

2B. *How many enrollees utilize expanded benefits and which ones are most commonly used?*

Research questions 2A and 2B were included to provide context (description of plans with expanded benefits) for the analyses for this Component. Therefore, there are no hypotheses to test for these research questions.

2C. *How does Emergency Department (ED) and inpatient hospital utilization differ for those enrollees who use expanded benefits (e.g. additional vaccines, physician home visits, extra outpatient services, extra primary care and prenatal/perinatal visits, and over-the-counter drugs/supplies) vs. those enrollees who do not?*

Hypothesis 2C. *There will be no differences in ED and inpatient hospital utilization for users versus non-users of expanded benefits.*

The following question will be addressed beginning with the evaluation of DY14 (SFY 2019-20):

2D. *How do enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?*

This research question will employ qualitative methods (no hypotheses).

Component 3. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status

Research Questions:

Research Questions 3A-3D are included to provide context (description and number of Healthy Behaviors programs provided by plan as well as associated incentives and rewards) to analyses for this Component. Therefore, there are no hypotheses to be tested for these research questions.

3A. *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)?*

3B. *What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs?*

3C. *How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behaviors programs attract higher numbers of participants?*

3D. *How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees (DY13 and beyond)?²*

3E. *What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating (DY13 and beyond)?*

Hypothesis 3Ei. *There will be no difference in utilization of 1) preventive services and 2) outpatient services between enrollees participating in Healthy Behaviors programs and enrollees not participating in Healthy Behaviors programs.*

Hypothesis 3Eii. *There will be no change in the utilization of ER, inpatient and outpatient hospital and physician specialty services for treatment of conditions that these programs are designed to prevent or manage for enrollees after enrolling in the Healthy Behaviors program.*

Component 4. The impact of LIP funding on hospital charity care programs

For DY10, the State will evaluate the impact of LIP funding on access to care for Medicaid uninsured and underinsured recipients. Beginning with DY11, the state will evaluate the impact of LIP funding on access to care for uncompensated charity care recipients.

² Questions 3D and 3E will be answered when individual-level Healthy Behaviors data for DY13 (SFY 2018-19) and subsequent years become available.

Research Questions:

The following questions will be addressed in the evaluation of DY10 (SFY 2015-16):

4A. *What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?*

Hypothesis 4A. *There will be no impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals.*

4B. *What types of services are being provided to Medicaid, uninsured, and underinsured recipients receiving care in LIP funded hospitals?*

This research question is included to provide context (description of types of services being provided through LIP) for this component. Therefore, there is no hypothesis to test for this research question.

The following questions will be addressed beginning with the evaluation of DY11 (SFY 2016-17):

4C. *What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP funding?*

Hypothesis 4C. *There will be no difference in 1) the number of uncompensated charity care patients served or 2) their expenditures based on 1) hospital access to LIP funding and 2) different tiers of LIP funding.*

4D. *What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals?*

This research question is included to provide context (description of types of services being provided through LIP) for this component. Therefore, there is no hypothesis to test for this research question.

4E. *What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?*

Hypothesis 4E. *There will be no change in the types of services or the number of services offered to uncompensated charity care patients in hospitals receiving LIP funding.*

The following question will be addressed beginning with the evaluation of DY12 (SFY 2017-18):

4F. *What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician*

practices?

Hypothesis 4F. LIP funding will have no effect on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices.

Component 5. 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 care³

This component will sunset after the evaluation of DY12 (SFY 2017-18) because there will no longer be separate programs for acute (medical) care and LTC services beginning with the evaluation of DY13 (SFY 2018-19). All LTC enrollees will be in a plan that offers both acute (medical) care and LTC services.

Research Questions:

5A. How many enrollees are enrolled in separate Medicaid managed care programs for acute (medical) care and LTC services?

5B. How many enrollees are enrolled in comprehensive plans for both acute (medical) care and LTC services?

Research Questions 5A and 5B were included to provide context (descriptive information about enrollment of this population across plan types) for this Component. Therefore, there are no hypotheses associated with these research questions.

5C. Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?

Hypothesis 5C. There will be no difference in service utilization or in the appropriateness of service utilization between enrollees in comprehensive plans and enrollees in separate plans.

Component 6. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals

The State has elected to evaluate this component by focusing on the experiences of dual eligibles in receiving behavioral health services and non-emergency transportation services because these services are covered by Medicaid.

Research Questions:

6A. How many MMA enrollees are also Medicare recipients (dual-eligibles) and to what extent do dual-eligible enrollees utilize behavioral health and non-emergency transportation

³ Component 5 will sunset following the evaluation of DY12 (SFY 2017-18).

services?

Research Question 6A is included to provide context (descriptive information) for this Component, so there is no hypothesis to be tested for this question.

6B. *What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-eligible enrollees?*

6C. *How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health and non-emergency transportation services?*

Research Questions 6B and 6C will be answered using qualitative methods; they are exploratory and descriptive in nature so there are no hypotheses to be tested.

Component 7. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner

Research Questions:

These research questions will produce descriptive results comparing the time to service for enrollees (1) in general, (2) under auto-enrollment, and (3) who switch plans within 120 days. There are no hypotheses associated with these questions.

These research questions will produce descriptive results comparing the time to service for

7A. *How quickly do new enrollees access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible and enrolling in a health plan?*

7B. *Among new enrollees, what is the time to access services for enrollees who are enrolled under Express Enrollment compared to enrollees who were enrolled prior to the implementation of Express Enrollment?*

Component 8. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services.

The research questions for this component will be addressed beginning with the evaluation of Demonstration Year 14 (SFY 2019-20).

Research Questions:

8A. *How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area?*

Research Question 8A is included to provide context (descriptive information) for this component, so there is no hypothesis to be tested for this question.

8B. *What changes in dental health service utilization occur with the implementation of the*

Statewide Medicaid Prepaid Dental Health Program?

Hypothesis 8B. *There will be no change in dental health service utilization with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8C. *What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

Hypothesis 8C. *There will be no change in quality of dental health services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8D. *What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

Hypothesis 8D. *There will be no change in accessibility of dental services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8E. *What barriers do enrollees encounter when accessing dental health services?*

8F. *How many enrollees utilize expanded benefits provided by the dental health plans and which ones are most commonly used?*

Research Questions 8E and 8F will be answered descriptively. Hence, no hypotheses will be tested.

8G. *How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)? How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?*

Hypothesis 8G. *There will be no impact on dental-related hospital events (e.g., Emergency Department, Inpatient Hospitalization) resulting from enrollee utilization of dental health services or utilization of expanded benefits offered by dental health plans.*

8H. *What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

Hypothesis 8H. *There will be no change in per-enrollee cost for dental health services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8I. *How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plans?*

8J. *How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?*

Research Questions 8I and 8J will be answered descriptively based on a random telephone survey of Medicaid enrollees who have used the expanded benefits offered by their dental plan. These questions are exploratory and descriptive in nature so there are no hypotheses to be tested.

Component 9. The impact of the waiver of retroactive eligibility on beneficiaries and providers.

The research questions for this component will be addressed beginning in January of 2020 when the initial encounter data reflective of the waiver of retroactive eligibility become available.

Research Questions:

9A. *How will eliminating retroactive eligibility change enrollment continuity?*

Hypothesis 9A. *Eliminating retroactive eligibility will have no effect on enrollment continuity.*

9B. *How will eliminating retroactive eligibility change the enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility?*

Hypothesis 9B. *Eliminating retroactive eligibility will have no effect on the health status of those subject to the new policy compared to those not subject to the new policy.*

9C. *How will eliminating retroactive eligibility affect new enrollee financial burden?*

Hypothesis 9C. *Eliminating retroactive eligibility will have no effect on new enrollee financial burden.*

9D. *How will eliminating retroactive eligibility affect provider uncompensated care amounts?*

Hypothesis 9D. *Eliminating retroactive eligibility will have no effect on provider uncompensated care amounts.*

9E. *How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?*

Hypothesis 9E. *Eliminating retroactive eligibility will have no effect on provider financial performance (income after expenses).*

9F. *How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?*

Hypothesis 9F. *Eliminating retroactive eligibility will have no effect on the net financial impact of uncompensated care (UCC – LIP payments).*

9G. *Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?*

9H. *What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?*

Research Questions 9G and 9H will be answered descriptively based on a random telephone survey of men and non-pregnant women subject to the new retroactive

enrollment policy. These questions are exploratory and descriptive in nature so there are no hypotheses to be tested.

Component 10. The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.

Research Questions:

10A. How many MMA plans participate in the Housing Assistance Pilot program? How many enrollees are participating in the Housing Assistance Pilot, by plan? How does participation in the Housing Assistance Pilot vary by gender, age, race/ethnicity and health status of enrollees? How did MMA plans implement the Pilot programs?

Hypothesis 10A. These questions are included to provide context and descriptive information about how the Pilot is being implemented by the MMA plans; therefore, there is no hypothesis to test.

10B. What is the frequency and duration of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan? What is the proportion of enrollees who are successfully discharged from the Pilot but subsequently become homeless again and resume using services?

Hypothesis 10B. This question is included to provide context and descriptive information about how the Pilot is being implemented by the MMA plans; therefore, there is no hypothesis to test.

10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving housing assistance services?

Hypothesis 10C. There will be no difference in avoidable hospitalizations and emergency department visits among enrollees with SMI who receive supportive housing assistance compared to enrollees who were placed on the waiting list and did not receive supportive housing assistance.

10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program?

Hypothesis 10D. There will be no difference in use of MMA services among enrollees with SMI who receive supportive housing assistance compared to enrollees who were placed on the waiting list and did not receive supportive housing assistance.

10E. Is care coordination more effective for the study population as a result of the Pilot program?

Hypothesis 10E. This research question will first be addressed using qualitative methods; it is exploratory and descriptive in nature so there is no hypothesis to be tested. However, the qualitative interviews will be used to understand how plans measure care coordination, and once these measures are obtained, they will be related to relevant study outcomes using quantitative methods.

10F. What are enrollee experiences with the Pilot program, including whether service needs were met, their experiences with integration of services, involvement in their care, and satisfaction with the services provided?

Hypothesis 10F. This question is included to provide context and descriptive information about enrollee experiences; therefore, there is no hypothesis to test.

10G. What are the costs of the Pilot program, including the costs of services provided to enrollees and the costs to administer the program?

Hypothesis 10G. This question is included to provide context and descriptive information about the cost of the Pilot program, therefore there is no hypothesis to test.

Driver Diagram and Component 9 and Component 10 Logic Models

The Driver Diagram below presents the overarching goal of the demonstration and provides readers with a visual aid for understanding the rationale behind the cause and effect of the variants behind the demonstration's aim to improve health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. As depicted in the diagram, the overall goal is to utilize all financial and stakeholder resources to improve the access and quality of care in a cost effective manner for Florida Medicaid recipients.

Figure 1. Florida Managed Medical Assistance Program Goals: Driver Diagram

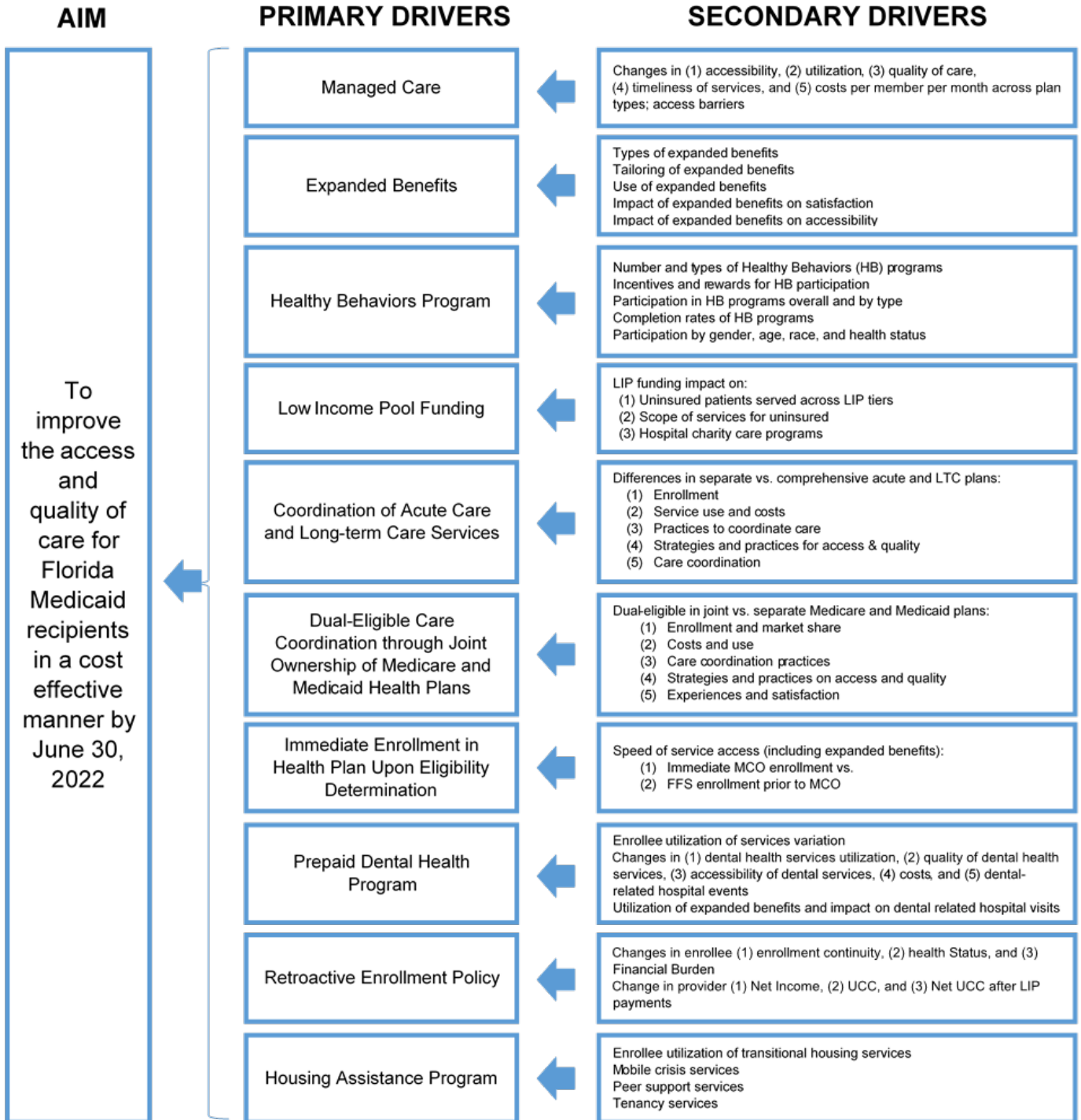
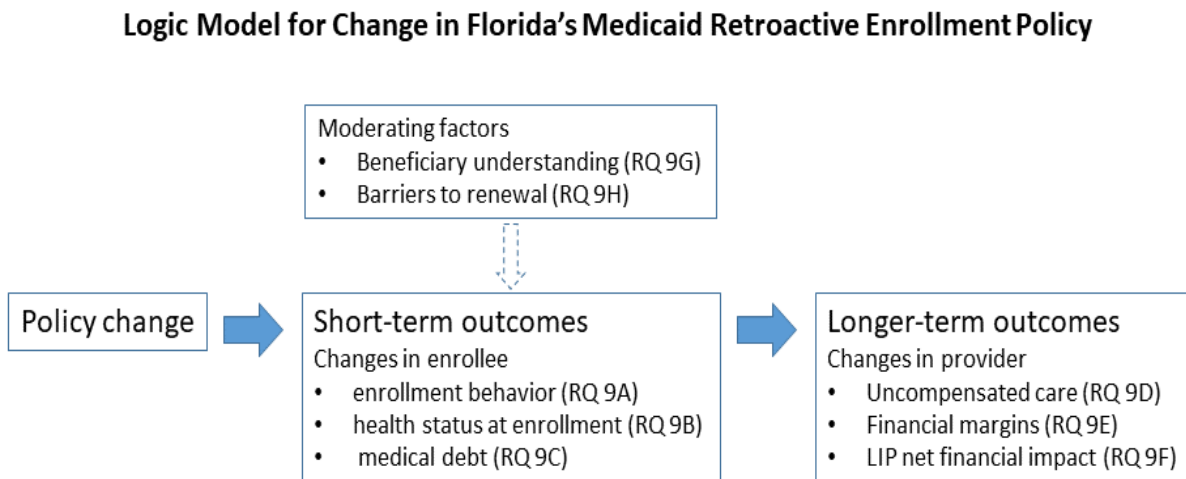


Figure 2 presents the logic model for Component 9 that depicts the hypothesized causes/effects associated with the change in Medicaid retroactive enrollment policy in Florida. The figure starts with the policy change as the intervention that drives the observed changes and lists both short-term outcomes and longer-term outcomes along with moderating factors. Short-term outcomes in Figure 2 include enrollment behavior (RQ 9A), health status at enrollment (RQ 9B), and medical debt (RQ 9C) while longer-term outcomes include uncompensated care (RQ 9D), financial margins (RQ 9E), and LIP net financial impact (RQ 9F). Moderating factors include both beneficiary understanding of the policy change (RQ 9G) and enrollee barriers to timely renewal (RQ 9H).

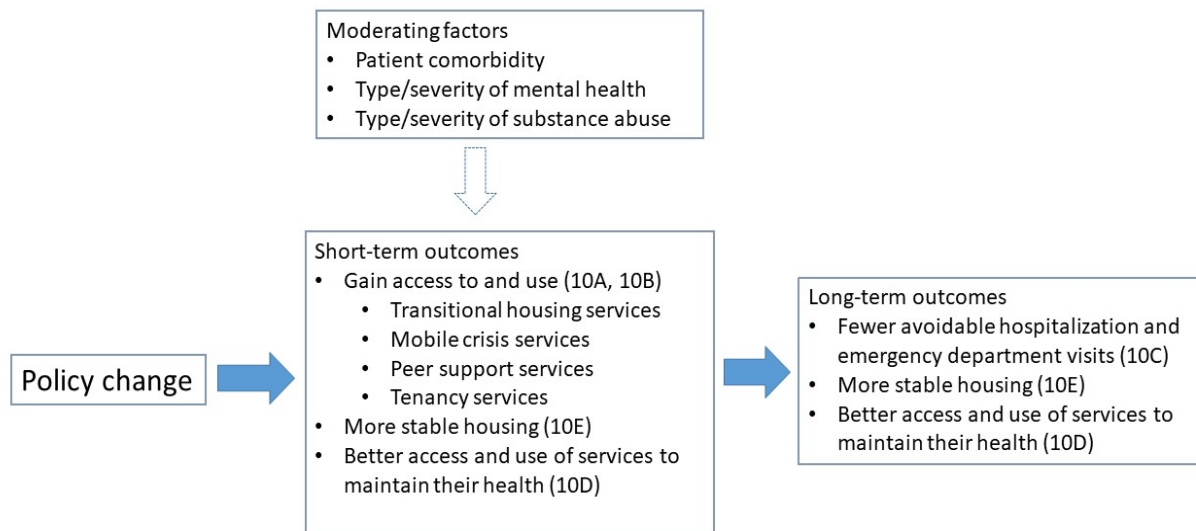
Figure 2. Logic Model for Change in Florida's Medicaid Retroactive Enrollment



Logic Model for Component 10: Housing Assistance Pilot Program

The logic model (Figure 3) for Component 10, which examines the addition of supportive housing services for individuals with mental health or substance abuse conditions who are homeless or at risk of homelessness, assumes that by making these services available in combination with care coordination services (10E), enrollees will gain access to and use transitional housing services, mobile crisis services, peer support services, and tenancy services (10A and 10B). Gaining access and using these services will lead to more stable housing (10E), which in turn will help enrollees better be able to access and use services to maintain their health, such as PCP visits, behavioral health services, and pharmacy services (10D). Use of these services will lead to fewer avoidable hospitalizations and emergency department visits (10C).

Figure 3. Logic Model for Housing Assistance Pilot Program



C. Methodology

This evaluation will employ a variety of quantitative and qualitative methods to answer its research questions and test its hypotheses. Quantitative methods will involve pre-post and post-only comparisons depending on whether the research question is focused on (1) comparing Medicaid performance following MMA implementation to Medicaid performance in the pre-MMA period or (2) the operations of the MMA program following implementation, respectively. Qualitative methods will involve (1) surveys and semi-structured interviews of MMA plan personnel and dual-eligible Medicaid enrollees and (2) content analyses of MMA plan policies and procedures. The remainder of this section provides more detail on the (1) evaluation design, (2) target and comparison populations, (3) evaluation period, (4) evaluation measures, (5) data sources, and (6) analytic methods.

A useful summary of the methodologies employed in this evaluation can be found in Table 6 “Design Table for the Evaluation of the Demonstration,” at the end of this methodology section. Table 6 lists each research question within each component along with the outcome measures, sample or population subgroups to be compared, data sources, and analytic methods used for that research question.

Numerous research questions in this MMA evaluation have associated null statistical hypotheses. Null hypotheses are typically expressed as involving no change in the variable under study, e.g., “There will be no change in costs when moving from FFS to managed care.” Such null hypotheses are tested against either one-tailed or two-tailed alternative hypotheses. One-tailed alternative hypotheses (e.g., “Costs will go up in moving from FFS to

managed care” or “Costs will go down in moving from FFS to managed care”) are appropriate when there is an expected direction of change in the variable under study, such as when quantitative program targets have been established (e.g., “Health care costs will decrease by 5%”). By contrast, two-tailed alternative hypotheses (i.e., “The change in cost in moving from FFS to managed care will not equal zero.”) are appropriate to test for changes that could be either positive or negative.

This evaluation employs two-tailed alternative hypotheses because the direction of change induced by the MMA program is not always clear a priori. Also, evaluation results for DY9 demonstrated that some specific measures (e.g., some categories of costs) may increase while other specific measures may decrease. When changes occur in the opposite direction to what is expected using one-tailed alternative hypotheses, statistical testing can only result in a failure to reject the null hypothesis of zero change. Statistically speaking, this is an inconclusive result. By contrast, two-tailed alternative hypotheses allow rejection of the null hypothesis of zero change in favor of the alternative hypothesis of non-zero change.

1. Evaluation Design

This evaluation employs both pre-post and post-only analyses as appropriate for the research question under examination. For example, for Research Question 1G, “What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (Fee For Service (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)?”, a pre-post perspective is required.

The qualitative design is discussed in the context of specific research questions in “Analytic Methods” below.

2. Target and Comparison Populations

The target and comparison populations vary across the research questions and are driven by (1) the pre-post or post-only focus of the research question, and (2) the specific population focus of the research question, e.g., enrollees in standard MMA plans vs. enrollees in specialty MMA plans. The population foci of individual research questions are listed in [Table 6](#) below.

3. Evaluation Period

The evaluation period began with SFY 2014-15 (Demonstration Year 9 (DY9)) and extends through SFY 2021-22 (DY16). SFY 2011-12 (DY6) and SFY 2012-13 (DY7) comprise the pre-MMA period and are used as a baseline for this evaluation, while SFY 2014-15 (DY9) through SFY 2021-22 (DY16) comprise the MMA period. SFY 2013-14 (DY8) was the implementation year for the MMA program and was excluded from this evaluation in order to avoid any data issues created by the transition from claims reporting to encounter reporting.

As of November 2017, the first MMA evaluation report compared quality, access, and cost measures during the pre-MMA period (SFY 2011-12 and SFY 2012-13) to the first complete year of the MMA period (SFY 2014-15). Subsequent evaluation reports will incorporate additional years from the MMA period as data become available and will focus on the evolution of the MMA program impacts across time.

4. Evaluation Measures

This evaluation uses a wide variety of measures of quality, access, and costs. [Table 2](#) and

[Table 3](#), below, list the CAHPS and HEDIS measures, and [Table 4](#) lists additional measures used in this evaluation.

Table 2. CAHPS Measures Used in the Evaluation

Measure	CAHPS Version 5 Adult & Child Questions for MMA Evaluation
Getting Needed Care (Adult and Child)	Percentage of respondents reporting it is usually or always easy to get needed care (vs. sometimes or never)
Getting Care Quickly (Adult and Child)	Percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)
Rate the Number of Doctors (Adult and Child)	Percentage of respondents rating the number of doctors to choose from as excellent or very good (vs. good, fair, or poor)
Health Plan Information and Customer Service (Adult and Child)	Percentage of respondents reporting they usually or always get the help/information needed from their plan's customer service staff (vs. sometimes or never)
Overall Rating of Health Plan (Adult and Child)	Percentage of respondents rating their plan an 8, 9 or 10 on a scale of 0 (worst) – 10 (best)
Overall Rating of Health Care (Adult and Child)	Percentage of respondents rating their health care an 8, 9 or 10 on a scale of 0 (worst)- 10 (best)
Shared Decision-Making (Adult and Child)	Percentage of respondents reporting there is shared decision-making between the provider and respondent (Yes vs. No)
Overall Rating of Personal Doctor (Adult and Child)	Percentage of respondents rating their doctor an 8, 9, or 10 on a scale of 0 (worst)- 10 (best)
Overall Rating of Specialist	Percentage of respondents rating their specialist an 8, 9, or 10 on a scale of 0 (worst)- 10 (best)

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey*
	Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.
Care from Dentists and Staff	<p>Percentage of respondents reporting their regular dentist usually or always explains things in a way that is easy to understand (vs. sometimes or never)</p> <p>Percentage of respondents reporting their regular dentist usually or always listens to them carefully (vs. sometimes or never)</p> <p>Percentage of respondents reporting their regular dentist usually or always treats them with courtesy and respect (vs. sometimes or never)</p> <p>Percentage of respondents reporting their regular dentist usually or always spends enough time with them (vs. sometimes or never)</p> <p>Percentage of respondents reporting dentists or dental staff usually or always do everything they can to help them feel as comfortable as possible during their dental work (vs. sometimes or never)</p> <p>Percentage of respondents reporting that their dentists or dental staff usually or always explain what they are doing while treating them (vs. sometimes or never)</p>

Measure	<p align="center">Patient Experience Measures for the CAHPS Dental Plan Survey*</p> <p align="center">Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.</p>
Access to Dental Care	<p>Percentage of respondents reporting their dental appointments are usually or always as soon as they want (vs. sometimes or never)</p> <p>Percentage of respondents reporting they usually or always get an appointment with their dental specialist as soon as they want (vs. sometimes or never)</p> <p>Percentage of respondents reporting they usually or always spend 15 minutes or less in the waiting room before seeing someone for their appointment (vs. sometimes or never)</p> <p>Percentage of respondents reporting someone usually or always tells them why there is a delay or how long the delay will be if they have to wait more than 15 minutes in the waiting room before being seen for an appointment (vs. sometimes or never)</p> <p>Percentage of respondents answering “somewhat yes” or “definitely yes” when asked whether they get to see a dentist as soon as they want if they have a dental emergency (vs. “somewhat no” or “definitely no”)</p>
Dental Plan Coverage and Services	<p>Percentage of respondents reporting their dental plan usually or always covers all of the services they think are covered (vs. sometimes or never)</p> <p>Percentage of respondents reporting that the 800 number, written materials, or website usually or always provides the information they want (vs. sometimes or never)</p> <p>Percentage of respondents reporting their dental plan’s customer service usually or always gives them the information they want or the help they need (vs. sometimes or never)</p> <p>Percentage of respondents reporting their dental plan’s customer service staff usually or always treats them with courtesy and respect (vs. sometimes or never)</p> <p>Percentage of respondents answering “somewhat yes” or “definitely yes” when asked whether their dental plan covers what they and their family need to get done (vs. “somewhat no” or “definitely no”)</p> <p>Percentage of respondents answering “somewhat yes” or “definitely yes” when asked whether information from their dental plan helps them find a dentist they are happy with (vs. “somewhat no” or “definitely no”)</p>
Patients’ Rating	<p>Percentage of respondents rating their regular dentist an 8, 9, or 10 on a scale of 0 (worst) to 10 (best)</p> <p>Percentage of respondents rating all dental care they personally received in the last 12 months an 8, 9, or 10 on a scale of 0 (worst) to 10 (best)</p> <p>Percentage of respondents rating how easy it was to find a dentist an 8, 9, or 10 on a scale of 0 (extremely difficult) to 10 (extremely easy)</p> <p>Percentage of respondents rating their dental plan an 8, 9, or 10 on a scale of 0 (worst dental plan possible) to 10 (best dental plan possible)</p>

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey* Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.
Dental Plan Expanded Benefits	Percentage of respondents who rated their dental expanded benefits as an 8, 9, or 10 on a scale of 1 to 10 Percentage of respondents who rated their access to dental expanded benefits an 8, 9, or 10 on a scale of 1 to 10

*Many of the dental survey items will be grouped into one overarching composite measure

Table 3. HEDIS and Other Performance Measures Used in the Evaluation

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
Adolescent Well-Care Visits	--	NCQA HEDIS	Child	--
Adults' Access to Preventive/Ambulatory Health Services	20-44 years 45-64 years 65+ years Total	NCQA HEDIS	--	--
Breast Cancer Screening	--	NCQA HEDIS	Adult	2372
Cervical Cancer Screening	--	NCQA HEDIS	Adult	0032
Childhood Immunization Status	Combo 2 Combo 3	NCQA HEDIS	Child	0038
Children and Adolescents' Access to Primary Care Practitioners	12-24 months 25 mos –6 yrs 7-11 years 12-19 years	NCQA HEDIS	Child	--
Chlamydia Screening in Women	16-20 years 21-24 years Total	NCQA HEDIS	Child and Adult	0033
HIV-Related Outpatient Medical Visits	≥ 2 visits (182 days apart)	Agency-defined	--	--

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
(Note – This measure will not be reported after CY 2016 data)				
Immunizations for Adolescents	Combination 1	NCQA HEDIS	Child	1407
Lead Screening in Children	--	NCQA HEDIS	--	--
Prenatal and Postpartum Care	Prenatal Postpartum	NCQA HEDIS	Child (Prenatal) and Adult (Postpartum)	1517
Frequency of Ongoing Prenatal Care/Prenatal Care Frequency	≥ 81% of expected visits	NCQA HEDIS/Agency-defined	Child	1391
Transportation Availability (Note – This measure will not be reported after CY 2016 data)		Agency-defined	--	--
Well-Child Visits in the First 15 Months of Life	0 visits 6+ visits	NCQA HEDIS	Child	1392
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	--	NCQA HEDIS	Child	1516
Adult BMI Assessment		NCQA HEDIS	Adult	--
Antidepressant Medication Management	Acute; Continuation	NCQA HEDIS	Adult	0105
Comprehensive Diabetes Care	HbA1C Testing	NCQA HEDIS	Adult	0057
Comprehensive Diabetes Care	HbA1c Good Control	NCQA HEDIS	--	0575
Comprehensive Diabetes Care	HbA1c Poor Control	NCQA HEDIS	Adult	0059
Comprehensive Diabetes Care	Eye Exam	NCQA HEDIS	--	0055
Comprehensive Diabetes Care	Nephropathy	NCQA HEDIS	--	0062

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
Comprehensive Diabetes Care	LDL-C Screening	NCQA HEDIS	Adult	0063
Comprehensive Diabetes Care	LDL-C Control	NCQA HEDIS	Adult	0064
Controlling High Blood Pressure		NCQA HEDIS	Adult	0018
Follow-up After Hospitalization for Mental Illness	7-day 30-day	NCQA HEDIS	Adult	0576
Follow-up Care for Children Prescribed ADHD Medication	Continuation and Maintenance	NCQA HEDIS	Child	0108
Highly Active Anti-Retroviral Treatment		Agency-defined	--	
Mental Health Readmission Rate		Agency-defined	--	
Medication Management for People with Asthma		NCQA HEDIS	--	1799
Transportation Timeliness		Agency-defined	--	
Dental Performance Measures				
Annual Dental Visit	Total	NCQA HEDIS		1388
Preventive Dental Services		CMS Medicaid & CHIP Child Core Set	Child	—
Dental Treatment Services		Agency- defined/CMS-416 Data	Child	—
Sealants for 6-9 Year-old Children at Elevated Caries Risk		CMS Medicaid & CHIP Child Core Set/Dental Quality Alliance (DQA)	Child	2508
Oral Evaluation		DQA/NQF	Child	2517
Topical Fluoride for Children at Elevated Caries Risk		DQA/NQF	Child	2528

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children		DQA/NQF	Child	2689
Follow-up after Emergency Department Visits for Dental Caries in Children		DQA/NQF	Child	2695

The following provides descriptions and numerators/denominators for the seven Agency-defined measures shown in

Table 3, above:

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.

Denominator: The eligible population.

Numerator: Four separate numerators are calculated:

- a. Enrollees who were seen twice in measurement year, \geq 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.

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.

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.

Transportation Availability (TRA)

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

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

Numerator: The number of transports delivered.

Highly Active Anti-Retroviral Treatment – (HAART)

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

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with ICD-10-CM diagnosis code B20, B97.35, or Z21 during the first six months of the measurement year.

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

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

Mental Health Readmission Rate (RER)

Description: The percentage 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: 6 years and older as of the date of discharge.

Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

Numerator: Discharges that result in a readmission to an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

Transportation Timeliness (TRT)

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

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.

Dental Treatment Services

Description: The percentage of individuals ages 1 to 20 who are enrolled in the plan for at least 90 continuous days, are eligible for EPSDT services, and who received at least one dental treatment service during the reporting period.

Denominator: The total unduplicated number of individuals ages 1-20 that have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services.

Numerator: The unduplicated number of individuals receiving at least one dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000-D9999 (CDT codes D2000-D9999) or equivalent CPT codes, that is, only those CPT codes that involved periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services.

Table 4 lists the additional measures used in this evaluation beyond the HEDIS and CAHPS measures presented in Tables 2 and 3. These additional measures deal with

- Enrollee grievances and complaints,
- Service use,
- PCP appointment wait times,
- Mean costs by type of service,
- Expanded benefit types,
- Common themes from plan interviews,
- Types of Health Behaviors programs and incentives, and
- Enrollee participation and completion rates in Healthy Behaviors programs.

Measures of costs and utilization in Table 4 will vary depending on the research question and the type of care (e.g., inpatient or outpatient) under study. When enrollee encounter cost and utilization data are employed, the units of measurement for utilization will depend upon the definition of utilization reported in the encounter data. While cost data will be measured in dollars, the measurement of costs will differ depending on (1) whether the focus is on overall program efficiency where claim amounts and capitation payments will be used for the pre-MMA and MMA periods, respectively, or (2) the focus in on the cost of individual services where claims amounts and amounts paid by the MCO to the provider will be used for the pre-MMA and MMA periods, respectively.

Table 4. Additional Measures used in the Evaluation

Measure	Description	Research Question(s)
Plan Reported Enrollee Issues/Grievances	Number of grievances and appeals by type	1A

Measure	Description	Research Question(s)
Access to care issues/complaints (by plan type)	Extract from Agency's Client Information & Registration Tracking database. Type of complaint (e.g. access, quality of care)	1A
Service Utilization. Use Claims and encounter data		
Inpatient	Per Member Per Month (PMPM) average number of visits that a Medicaid enrollee had in a month	1C
Outpatient	PMPM average number of visits that a Medicaid enrollee had in a month	1C
ED	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Professional Physician	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Specialist	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Service Use per Enrollee per Year. Service utilization is per actual enrollee year. Statistical analysis of use to rely on binomial regression models of service use by the type of service		
Hospital Inpatient Admissions	Mean Service Use	5C
Hospital Inpatient Days	Mean Service Use	5C
Hospital Outpatient Visits	Mean Service Use	5C, 10D
Physician Primary Care Visits	Mean Service Use	5C, 10D
Physician Specialist Visits	Mean Service Use	5C
Pharmacy Claims	Mean Service Use	5C, 10D
Emergency Dept. Visits	Mean Service Use	5C
LTC Services	Mean Service Use	5C
Assisted Living	Mean Service Use	
HCBS	Mean Service Use	5C
Home Health	Mean Service Use	5C
Hospice	Mean Service Use	5C
Nursing Home	Mean Service Use	5C
Transitional Housing Services	Mean Service Use	10B
Mobile Crisis Services	Mean Service Use	10B
Peer Support Services	Mean Service Use	10B
Tenancy Services	Mean Service Use	10B
Potentially Preventable Hospitalizations	Mean Service Use	10C
Potentially Preventable Emergency Department Visits	Mean Service Use	10C
Behavioral Health Services	Mean Service Use	10D
Average PCP Appointment Wait Times. Average appointment wait times. Data Source: Timely Access PCP Wait Times Report		
Urgent Care	Days	1F
Routine Sick	Days	1F
Wellcare Visit	Days	1F
Mean Costs. Cost of specific MMA services will be obtained from the amount paid by the MMA plan to the provider in the encounter record. For MMA period comparisons to the pre-MMA periods, MMA capitation payments will be used as a measure of the cost to Medicaid under MMA.		

Measure	Description	Research Question(s)
Total MMA and LTC Costs Combined	Per Member Per Month Mean Cost	1G
Total MMA	Per Member Per Month Mean Cost	1G
Hospital Inpatient	Per Member Per Month Mean Cost	1G
Hospital Outpatient	Per Member Per Month Mean Cost	1G
Physician Primary Visit	Per Member Per Month Mean Cost	1G
Physician Specialist Visit	Per Member Per Month Mean Cost	1G
Pharmacy Cost	Per Member Per Month Mean Cost	1G
Emergency Dept. Cost	Per Member Per Month Mean Cost	1G
Total LTC Costs	Per Member Per Month Mean Cost	1G
Assisted Living Costs	Per Member Per Month Mean Cost	1G
HCBS Costs	Per Member Per Month Mean Cost	1G
Home Health Costs	Per Member Per Month Mean Cost	1G
Hospice Costs	Per Member Per Month Mean Cost	1G
Nursing Home Costs	Per Member Per Month Mean Cost	1G
Supportive Housing Service Costs	Per Member Per Month Mean Cost	10G
Expanded Benefits Offered by Plans		
Adult Dental Services	Presence or Absence and Summary Counts	2A
Adult Influenza Vaccine	Presence or Absence and Summary Counts	2A
Adult Pneumonia Vaccine	Presence or Absence and Summary Counts	2A
Adult Shingles Vaccine	Presence or Absence and Summary Counts	2A
Art Therapy	Presence or Absence and Summary Counts	2A
Equine Therapy	Presence or Absence and Summary Counts	2A
Hearing Services	Presence or Absence and Summary Counts	2A
Home Health (non-pregnant adults)	Presence or Absence and Summary Counts	2A
Medically Related Lodging & Food	Presence or Absence and Summary Counts	2A
Newborn Circumcisions	Presence or Absence and Summary Counts	2A
Nutritional Counseling	Presence or Absence and Summary Counts	2A
Extra Outpatient Services	Presence or Absence and Summary Counts	2A
Over-The Counter Drugs/Supplies Aid	Presence or Absence and Summary Counts	2A
Pet Therapy	Presence or Absence and Summary Counts	2A
Physician Home Visits	Presence or Absence and Summary Counts	2A
Post-Discharge Meals	Presence or Absence and Summary Counts	2A
Extra Prenatal/Perinatal Visits	Presence or Absence and Summary Counts	2A
Extra Primary Care Visits	Presence or Absence and Summary Counts	2A
Vision Services	Presence or Absence and Summary Counts	2A
Waived Co-payments	Presence or Absence and Summary Counts	2A
Total Number of Expanded Benefits	Presence or Absence and Summary Counts	2A

Plan Interviews – Most Common Themes

(Subsequent year themes to be determined)

Quality of Care	% of content	1E
Behavioral Health	% of content	6B
Non-emergency Transportation	% of content	6B
Housing Assistance Pilot implementation	% of content	10A
Housing Services Care Coordination	% of content	10E

Types of Healthy Behaviors Programs and Incentives
Data Source: Quarterly Healthy Behaviors Summary Reports

Medically Approved Smoking Cessation Program	#, incentives and value	3A, 3B, 3C
Medically Directed Weight Loss Program	#, incentives and value	3A, 3B, 3C
Medically Approved Alcohol or Substance Abuse Recovery Program	#, incentives and value	3A, 3B, 3C
Preventive Well Child Care	#, incentives and value	3A, 3B, 3C
Prenatal, Maternity, & Postpartum Visits	#, incentives and value	3A, 3B, 3C
Preventive Adult Care (PCP visits)	#, incentives and value	3A, 3B, 3C
Mammograms	#, incentives and value	3A, 3B, 3C
Cervical Cancer Screening	#, incentives and value	3A, 3B, 3C

Enrollee Participation and Completion Rates in Healthy Behaviors Programs (Mandatory and Optional)

Number currently enrolled	#	3C
Enrollees who completed program	#	3C
Plans Offering Program	#	3C
Plan with Most Participants	#	3C
By Gender	# (Male, Female)	3D
By Age Group	# (Age Grp 0-20, 21-40, 41-60, over 60)	3D

5. Data Sources

This evaluation will collect both quantitative and qualitative data from a variety of sources as outlined below in Table 5, “Quantitative and Qualitative Data Sources for Florida MMA Evaluation”. Quantitative data will be collected predominantly from secondary sources (e.g., claims and encounter data, HEDIS performance reports, state MCO performance reports, etc.). The sole exception involving collecting primary quantitative data will involve collecting dual-eligible care coordination experiences via telephone surveys using closed-end questions.

Qualitative data will be collected using both semi-structured interviews and review of policies and procedures documents. Fully coded transcriptions of qualitative interviews will be analyzed through iterations of content analysis and grounded theory to identify salient themes.

The cleaning of Medicaid eligibility, enrollment, encounter, and claims data is done by both the Agency and the evaluation team. The eligibility, enrollment, encounter, and claims data used in his evaluation comes from the Agency’s Special Feed database. These data are more extensively error-checked by the Agency upon receipt to ensure that the data are complete and error-free. The evaluation team conducts additional checks related to data integrity upon receipt of the Special Feed data. “Filler” codes for character variables are checked (e.g., “#####” or “*****”) and detected filler values are set to missing. Range-checking for both numeric and character variables as well as logical consistency checks are made among age, sex, diagnosis and procedure codes. Missingness rates are calculated for each variable in each dataset and compared to missingness rates in previous years of similar data. Voided claims (detail status = V) are removed, as are preliminary records that have been superseded by subsequent revised entries.

These additional checks routinely produce questions from the evaluation team for the Agency data team concerning errors and anomalies. Answers given by the Agency data team are documented for future reference. Questions that cannot be readily answered are resolved by the involvement of additional data personnel and/or the transmittal of corrected data as needed. The HEDIS and CAHPS data used in this evaluation are independently audited prior to being submitted to the Agency. Similarly, Florida hospital discharge, emergency department, and ambulatory surgery center data are cleaned and error-checked by the Florida Health Data Center upon receipt.

Table 5. Quantitative and Qualitative Data Sources for Florida MMA Evaluation

Data Source	Time Period*	Variables
<p>Medicaid claims, eligibility, enrollment and encounter data</p>	<p>Pre-MMA MMA</p>	<p><u>Pre-MMA</u> Inclusion criteria</p> <ul style="list-style-type: none"> ▪ All eligibility categories that are mandated to enroll in a MMA health plan and received services through any delivery system for at least one month during the pre-MMA time period. Note that enrollees gradually transitioned to MMA health plans beginning May 1, 2014, thus some data during the implementation period will be coded as MMA during months where the enrollee was enrolled in a MMA health plan; ▪ All claims and encounter data for drugs and services that are required to be covered by MMA plans; and ▪ All voluntary MMA participants who received services through any delivery system. <p>Exclusion criteria</p> <ul style="list-style-type: none"> ▪ All groups explicitly excluded from MMA program participation. <p>Demographic and health status characteristics</p> <p><u>MMA</u> Inclusion criteria</p> <ul style="list-style-type: none"> ▪ All eligibility categories that are mandated to enroll in a MMA plan and were enrolled in a MMA plan for at least one (1) month during May 1, 2014 – June 30, 2017. ▪ All voluntary MMA participants; and ▪ All claims and encounter data for drugs and services that are required to be covered by MMA plans. <p>Exclusion criteria</p> <ul style="list-style-type: none"> ▪ All groups explicitly excluded from MMA program participation. <p>Demographic and health status characteristics</p>
<p>Consumer Assessment of Health Care Providers and Systems (CAHPS)</p>	<p>Pre-MMA MMA</p>	<p>See Table 2 above for a complete listing of the proposed CAHPS measures for this evaluation.</p>
<p>CAHPS Dental Plan Survey</p>	<p>MMA</p>	<p>See Table 2 above for a complete listing of the proposed dental CAHPS measures for this evaluation. Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.</p>

Data Source	Time Period*	Variables
HEDIS & Agency-defined performance measures, including CMS Child and Adult Core Measures	Pre-MMA (where available): Annual Means CYs 2011-2013 MMA: Annual Means CY 2015 through latest date when complete data is available	See Table 3 above for a complete listing of the proposed HEDIS and Agency-defined performance measures for this evaluation.
Dental Performance Measures	MMA	See Table 3 above for a complete listing of the proposed dental performance measures for this evaluation.
Managed Care Plans' Enrollee Complaint, Grievance, and Appeals Reports	MMA	Number of grievances and appeals by type
Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) Data	Pre-MMA MMA	Enrollee demographic information Type of complaint (e.g., access, quality of care, etc.) Plan enrollment
Medicaid Fair Hearing data	MMA	Date hearing requested Date hearing held Plan Name Service in Question Petitioner's Favor/Respondent's Favor
Managed Care Plans' Performance Improvement Projects (PIPs) and External Quality Review Organization (EQRO) Reports	MMA	Description and overall analyses of plan performance improvement projects (improvement strategies and data analyses) to improve HEDIS/Agency defined measures.
Managed Care Plans' Choice Materials and Managed Care Span	Pre-MMA	Plan benefit data

Data Source	Time Period*	Variables
	MMA	
Agency Quarterly and Annual Reports to CMS	MMA	Review of expanded services
Managed Care Plans' policies and procedures related to care coordination	Pre-MMA MMA	Review of policies and procedures related to care coordination
Timely Access PCP Wait Times Report	MMA	Average appointment wait times
Long-Term Care Case Management and Monitoring Reports	MMA	<p>Case file audit reviews to determine the timeliness of enrollee assessments performed by case managers</p> <p>Reviews of the consistency of enrollee service authorizations performed by case managers</p> <p>Development and implementation of continuous improvement strategies to address identified deficiencies</p>
Medicaid Choice Counseling Data	Pre-MMA MMA	Medicaid choice counseling data will be used to determine auto-enrollment, plan selection, and length of plan enrollment.
Florida Center for Health Information and Transparency Encounter Data	Pre-MMA MMA	All variables available in the inpatient hospital discharge, emergency department, and ambulatory surgery discharge data
MMA Managed Care Plans' reports on Healthy Behaviors programs	MMA	<p>All available data related to each Healthy Behaviors program</p> <p>Caseloads (new and ongoing) for each Healthy Behaviors program at the individual recipient level</p> <p>Amount and type of rewards/incentives provided for each Healthy Behaviors program</p>
Annual Milestone Statistics and Findings Report Data	MMA	<p>LIP Payments by provider (hospital and non-hospital)</p> <p>Number of individuals served (hospital providers) including Medicaid, Uninsured, Total all unduplicated, Inpatient, Outpatient, and Inpatient/ Outpatient combined</p> <p>Average number of individuals served (hospital providers)</p> <p>Growth in the number of individuals served (hospital</p>

Data Source	Time Period*	Variables
		<p>providers)</p> <p>Number of encounters for specific services (hospital providers) including Medicaid, Uninsured/Underinsured, Hospital discharges, Hospital inpatient (days), Emergency care (encounters), ER visits, Hospital outpatient, Affiliated services (encounters), Prescription drugs ` (number of prescriptions filled)</p>
Florida Hospital Uniform Reporting System	DY11-DY16	This report collects financial and utilization statistics each year from Florida Hospitals.
Disproportionate Share Hospital Data	DY11-DY16	This data will be utilized as needed for uninsured and uncompensated care analyses. Note: There is presently a three-year lag in the availability of annual DSH survey data.
Medicare Cost Reports	DY11-DY16	This report includes descriptive, financial, and statistical data on hospitals and may be helpful with identifying facility characteristics, costs and charity care
Information on charity care programs including policies and criteria for all LIP funded hospitals.	DY11-DY16	Descriptive data on hospital charity care programs.
Qualitative data from interviews with health plan care coordination experts	MMA	Themes from qualitative interviews, specifically addressing: (1) care coordination strategies for enrollees needing behavioral health or non-emergency transportation services; (2) the most effective strategies for ensuring access to services; and (3) strategies for coordinating these services specifically for dual-eligible members; (4) strategies that standard MMA and Specialty MMA plans are using to improve quality of care and the strategies that are most effective; and (5) perceived care coordination effectiveness for enrollees who are homeless are at-risk for homeless
Enrollee satisfaction surveys: <ul style="list-style-type: none"> - behavioral health and non-emergency transportation services; - expanded benefits; - dental health services, including expanded dental health benefits. - Housing assistance Services 	MMA	Telephone surveys covering sociodemographic characteristics, health and functional status/needs, and experience and satisfaction with behavioral health services, non-emergency transportation services, expanded benefits, dental health services, expanded dental health service benefits, and supportive housing services.

Enrollee roster reports submitted by MMA plans to identify housing assistance services

MMA

Number of enrollees using transitional housing services, number of enrollees using mobile crisis services, number of enrollees using peer support services, number of enrollees using tenancy services, housing status, Housing Pilot enrollment and disenrollment date,

*Unless otherwise noted, Pre-MMA time period refers to SFYs 2011-12 and 2012-13. MMA time period refers to May 1, 2014 through the latest date when complete data is available.

6. Analytic Methods

This evaluation will employ both quantitative and qualitative methods in answering the research questions outlined above. The quantitative methods will include both simple descriptive methods and multivariable statistical methods while the qualitative methods will include analysis of structured administrative interview data and thematic analyses of semi-structured interview data (using content analyses and grounded theory).

The remainder of this section describes these methods in greater detail. Table 6 following these descriptions lists each research question along with the associated analytic method to be used in answering that question.

Overall Analytic Design Issues

Pre-post comparisons have well-known limitations concerning the influence of intervening factors beyond the intervention under study that can bias the observed treatment effect. Similarly, post-only comparisons face the challenge of unobserved heterogeneity between the treatment and comparison groups that influence both outcomes and selection into the treatment vs. comparison groups.

Unfortunately, evaluation designs such as difference-in-differences and propensity-score matching that address the limitations of pre-post and post-only designs are not ideally suited for evaluating Florida's MMA program, with the exception of selected questions in (1) the Housing Assistance Pilot (Component 10) and (2) the impact of Florida's retroactive enrollment policy change on new enrollee financial burden (Component 9). Florida's statewide transition to the MMA program took place over a three-month period⁴ and included over 90 percent of Florida's Medicaid enrollees. This poses special challenges for employing evaluation designs such as difference-in-differences and propensity-score matching since no suitable comparison groups were available within Florida Medicaid following MMA implementation. Employing comparison groups outside of Florida Medicaid is problematic because such comparison groups will differ in systematic ways from Florida Medicaid enrollees. Such systematic differences will likely generate large pre-period treatment-comparison differences that will likely violate the parallel time trends assumption of difference-in-differences.

However, because there are limits to the number of enrollees who can participate in the Housing Assistance Pilot, individuals who are placed on a waiting list for the program can serve as controls, which will allow for standard and/or modified difference-in-differences analysis of the Housing Assistance Pilot.

Furthermore, evaluating the impact of Florida's retroactive enrollment policy change on new enrollee financial burden poses special challenges to traditional pre-post and post-only research designs. The large number of new Florida Medicaid enrollees each month will likely convey sufficient statistical power to detect even minute differences across groups in financial burden as statistically significant. In addition, because financial burden can change due to a myriad of factors beyond unpaid medical bills (e.g., job loss, unexpected financial losses, and non-health family emergencies), the potential for intervening time factors to create history bias is very high.

For these reasons, we are proposing to use modified difference-in-differences designs to

assess new enrollee financial burden associated with the February 2019 retroactive enrollment policy change. The modified difference-in-differences designs relax the stringent parallel time trends assumption of standard difference-in-differences designs. These designs are discussed in detail in Attachment 6 of this document.

The remainder of the MMA evaluation questions will employ pre-post- and post-only comparisons as dictated by the research question under study. In general, a pre-post perspective will be used when the focus is on the overall impact of the MMA intervention on costs and utilization. A post-only perspective will be used when the research question is focused on some aspect of the MMA program operation, such as separate vs. comprehensive MMA and LTC service organization. Multivariable statistical models will be used whenever feasible to control for other factors that might influence the outcome.

⁴ This three-month period covered virtually the full transition to the MMA program, although one MMA plan (Freedom) began operations in January 2015.

Statistical Testing and Modeling

Basic statistical tests (e.g., t-tests and chi-square tests) will be employed wherever possible to ensure that observed differences are not simply the results of random variation. However, such testing will not always be feasible since distributional measures for the data, standard deviation or variance, and enrollee sample sizes will not always be available from the statewide and plan-level data provided for various years. In such cases, it will not be possible to calculate the standard errors necessary for making statistical inferences, and therefore, the data will be presented as simple descriptive comparisons with brief comments.

Multivariable statistical models will be used when analyzing individual enrollee encounter cost and utilization data to control for factors that influence costs and utilization and isolate the effect of the characteristic under study (e.g., the MMA intervention and separate vs. comprehensive MMA and LTC services). The impact of factor under study (e.g., the MMA program) will be assessed using a two-part mixture model which first assesses the odds of having any expenditure or use using a random effects logit model (Equation 1) that accounts for clustering by month and by individual, and then uses a random effects log-linear generalized least squares regression (Equation 2) that also accounted for clustering by month and by individual. Both models assess the impact of the MMA program by including an indicator for whether or not the observation was from an individual enrolled in an MMA plan during the MMA study period. This shows the shift in the intercept associated with the MMA program (i.e., the average difference in PMPM expenditures or use between the pre-MMA and MMA periods). The two equations estimated used the following specifications:

$$\ln \left(\frac{p(\text{any } \$ = 1)}{p(\text{any } \$ = 0)} \right)_{it} = MMA \cdot \beta_1 + Age \cdot \beta_2 + Gender \cdot \beta_3 + Race \cdot \beta_4 + RiskScore \cdot \beta_5 + \epsilon_{it}$$

$$\ln(PMPM \$)_{it} = MMA \cdot \beta_1 + Age \cdot \beta_2 + Gender \cdot \beta_3 + Race \cdot \beta_4 + RiskScore \cdot \beta_5 + \epsilon_{it}$$

given month, while $\ln(\text{PMPM } \$)$ is the natural log of expenditures by an individual in any given month given that they incurred any expenditures. To obtain an estimate of the likely difference in expenditures due to the MMA program, average PMPM expenditures were predicted assuming all enrollees continued in the pre-MMA program using the multivariate models, and then average PMPM expenditures were calculated again to determine what PMPM expenditures would have been if the trend in expenditures had instead followed the trend observed in the MMA program.

The multivariate model specifications for the comparison of pre-MMA to specialty MMA plans and pre-MMA to standard MMA plans was essentially the same except only observations from specialty MMA plan enrollees were used to assess expenditures during the MMA period for the specialty MMA analysis while only observations from standard MMA plan enrollees during the MMA period were used for the standard MMA plan analysis.

As discussed above, the multivariate model comparing service utilization associated with participation in the Housing Assistance Pilot will use a standard or modified difference-in-difference approach, where changes in utilization from the year prior to implementation of the Pilot to utilization in the year after implementation for participating enrollees will be compared to changes in utilization over the same time period for enrollees who were placed on the waiting list for participation in the Housing Assistance Pilot. A modified difference-in-differences approach will also be employed to study the impact of the retroactive enrollment policy change on new enrollee financial burden (see Research Question 9C).

Qualitative Analyses

Qualitative research questions in this evaluation are found in Components 1, 2, 6, 8, 9, and 10:

- **RQ1E:** *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?*
- **RQ 2D:** *How do enrollees rate their experience and satisfaction with the expanded benefits that are offered by their health plan?*
- **RQ 6B:** *What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-eligible enrollees?*
- **RQ 6C:** *How do dual-eligible enrollees rate their experience and satisfaction with the delivery of care they receive related to behavioral health and non-emergency transportation services?*
- **RQ 8J:** *How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?*
- **RQ 9A:** *How will eliminating retroactive eligibility change enrollment continuity?*
- **RQ 9G:** *Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?*

- **RQ 9H.** *What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?*
- **RQ 10A.** *How did MMA plans implement the Pilot program?*
- **RQ 10E:** *Is care coordination more effective for the study population as a result of the Housing Assistance Pilot Program?*

Methods

Qualitative interviews with MMA plan experts. Experts in quality of care (RQ1E), care coordination (RQ6B, RQ10E), and program implementation (10A) at each of the MMA plans will be identified to participate in in-depth interviews. Each plan's contract manager will assist the investigators in identifying and contacting the appropriate experts. Identified experts will receive an introductory email that includes: the purpose of the study, contact information of qualitative team personnel who can answer questions about the study or the request and assist with any technical issues. In addition, the email will notify experts that we would like to schedule a 30- to 60-minute telephone interview with them. To assist the evaluation team in preparing for the interview, the introductory email will include a form-fillable PDF document with preliminary questions addressing the topics to be covered in the interviews (described below). The MMA plan experts will be asked to prepare written responses to these questions and email the completed PDF form to the study team prior to their scheduled interview.

The research teams will develop qualitative interview guides with a list of questions relevant to Research Questions 1E, 6B, 10A and 10E, respectively, which will be asked of all MMA plans for RQ1E and RQ6B, and for MMA plans participating in the Housing Pilot for RQ10A and RQ10E. All data collection tools will be reviewed by the Agency prior to administration. The interview guides will include questions for plans that also participate in the LTC program to address the role LTC case managers (RQ6B) have in addressing the respective topics. Before each MMA plan's scheduled telephone interview, the research teams will review: (1) the MMA plan's updated Policy and Procedure document(s) provided by the Agency related to quality of care and performance improvement (RQ1E) or coordination of behavioral health services and non-emergency transportation services (RQ6B); and (2) the MMA plan's written responses to the preliminary questions in PDF format. These reviews may generate follow-up questions and points of clarification tailored to each specific health plan, which will be added to the plan's telephone interview guide prior to the plan's scheduled interview. They also will help to streamline the interview process and minimize respondent burden.

Follow-up telephone interviews will be conducted with the same experts who were initially contacted and who provided the written PDF responses, or appropriate delegated individuals who are knowledgeable in the areas of interest. In addition, participants may include other health plan experts in the interviews. Interviews will follow a qualitative, semi-structured format. Interviews will be conducted by trained qualitative interviewers by telephone (lasting 30 to 60 minutes), audio recorded and transcribed for coding and analysis.

The qualitative team that comprises researchers from UF, UAB and FSU will administer the interviews that are specific to their component areas.

Qualitative interview analysis. Qualitative research teams will use Atlas.ti (V8) or Nvivo to analyze interview transcripts produced for research questions RQ1E and RQ6C, following iterations of content analysis and grounded theory. For each research question, an initial

codebook of priori themes will be developed based on the interview guide. Coding of transcripts will be conducted concurrently with data collection and reviewed in team meetings to ensure inter-rater reliability. Following grounded theory methods, reviewers will define codes for new themes that emerge in the analysis; as new codes are produced, the codebook will be updated and previously-coded transcripts will be back-coded to capture the new themes. After all MMA plan interviews have been completed and their transcripts coded, the research teams will conduct a content analysis to determine the most common themes and relevant co-occurrences among the themes. Based on findings of the content analysis, the research teams will conduct targeted queries to identify patterns in responses and exemplary quotes.

Member surveys. The research teams will design structured telephone surveys to be administered to MMA plan members, addressing experiences and satisfaction with expanded health plan benefits (RQ2D), coordination of behavioral health and non-emergency transportation for dual-eligible members (RQ6C), expanded benefits offered by prepaid dental health plans (RQ8J), new enrollee health status (RQ9B), enrollee understanding of retroactive enrollment changes and barriers to enrollment renewal (RQ9G and RQ9H), and enrollee experiences with whether their services needs were met, integration of services, involvement in care, and satisfaction with services provided through the Housing Pilot program (RQ10F). The surveys will be administered to MMA and prepaid dental plan members (RQ2D, RQ8J), dual-eligible MMA plan members (RQ6C) who were enrolled in an MMA standard or MMA specialty plan in the last 12 months, MMA new enrollees (RQ9B), MMA enrollees subject to the new retroactive enrollment policy (RQ9G and RQ9H), and plan members who participated in the Housing Assistance Pilot (RQ10F). Sources of survey questions are specific to the research questions and described in the sections below. Additional questions may be developed by the research teams upon written approval of the Agency.

Telephone surveys will be conducted by trained interviewers by phone. Participants will have the option to complete the surveys in English or Spanish. Telephone survey data will be analyzed by the research teams using SPSS V23, SAS, or Stata.

Qualitative issues and approaches for specific questions.

Research Question 1E

In addition to plan document reviews and interviews with plan experts, this component will review the *2015-2016 Florida Annual Performance Improvement Project Validation Summary Report* produced by the Health Services Advisory Group to identify specific performance improvement projects (PIPs) offered by health plans. During the in-depth interviews, experts will be specifically asked about their own performance improvement projects, including associated indicator rates. In addition, during the in-depth interviews experts will be asked to comment on which projects are most effective at improving quality and why they are effective.

Research Question 2D

A random sample of MMA enrollees who used at least one expanded benefit during the previous 12 months will be included in this study.

Research Question 6B and 10E

Experts in care coordination at the MMA and MMA specialty plans will include individuals at all 11 MMA standard plans and 4 of the MMA specialty plans. Among the MMA standard plans, Amerigroup, Better Health, and Simply are owned by the same parent company (Anthem) and share the same policies and procedures; these three plans will therefore be considered as a single unit for analysis (i.e., only one “Anthem” interview will be conducted, covering Amerigroup, Better Health, and Simply). Among the six MMA specialty plans, two will be excluded because they are specific to children and do not cover the dual-eligible population of interest in this study (Children’s Medical Services and Sunshine Child Welfare). The remaining four MMA specialty plans (Clear Health Alliance, Freedom Health, Magellan Complete Care, and Positive Health) will be included in this study. A total of 13 health plan units will be included in the analysis.

Research Question 6C

A stratified random sample of dual-eligible survey respondents will be selected from the populations of adult dual-eligible enrollees (18+ years) who were continuously enrolled in the same MMA standard plan (Group 1) or MMA specialty plan (Group 2) during the 12 months prior to sampling.

The survey tool to be administered for research question 6C may include: (1) items from the CAHPS Health Plan Survey for Medicaid, Version 4.0 supplemental set addressing health plan transportation, (2) the Experience of Care and Health Outcomes (ECHO) Survey – a validated survey tool from the Agency for Healthcare Research and Quality that assesses experiences with behavioral health care, (3) other questions on non-emergency transportation provided in correspondence with AHCA, and (4) questions from the Medicare Health Beneficiary Survey to collect information on self-reported health and functional status for dual-eligible members.

The survey will have the option to be completed by sampled members or (in cases where the member is physically or mentally unable to participate) by proxy respondents (such as family members) who are familiar with the member’s health and health care.

Research Question 8J

Sampling and other survey methods specific to RQ 8J will likely be similar to those used for RQs 2D and 6C, and will be determined after more information on the operation and utilization rates of the prepaid dental health program becomes available.

Research Question 9A

RQ 9A proposes to survey hospital and nursing facilities to determine their changes in enrollment application procedures following or in anticipation of the change in retroactive enrollment policy. Sampling and other survey methods for RQ 9A will likely be similar to those used for RQ 1E.

Research Question 9B

RQ 9B will survey new MMA enrollees to measure their health status. Note: The lack of new enrollee health status data prior to the change in retroactive enrollment policy may limit the

ability to conduct analyses of these data.

Research Question 9G

RQ 9G examines enrollee understanding of the change in retroactive enrollment policy and the implications of this change for Medicaid coverage during enrollment gaps. The survey sampling frame for RQ 9G will include men and non-pregnant women as the population most likely to be impacted by the policy change. Both new and existing enrollees will be chosen at random for the survey since the retroactive policy change applies to both groups.

Research Question 9H

RQ 9H examines enrollee perceptions of common barriers to timely renewal of Medicaid coverage following the change in retroactive enrollment policy. The survey sampling frame and inclusion criteria for RQ 9H will be the same as for RQ 9G.

Research Question 10A

RQ 10A examines how participating MMA plans implemented the Housing Assistance Pilot. MMA plan staff with knowledge of the Pilot implementation process will be identified and administered qualitative surveys to assess steps used to implement the Pilot.

Research Question 10E

RQ 10E examines whether care coordination is more effective for the study population as a result of the Housing Pilot program. Care coordinators at each participating MMA plan will be selected to participate in qualitative surveys. Questions will address how plans measure care coordination and to identify relevant outcomes being measured by plans. This information will be subsequently used to assess the association of care coordination activities with relevant study outcomes using quantitative methods.

Table 6. Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 1: The effect of managed care on access to care, quality and efficiency of care, and the cost of care				
<p>1A. What barriers do enrollees encounter when accessing primary care and preventive services?</p>	<p>-Frequencies of complaints, grievances, and appeals related to access to care</p>	<p>-MMA enrollees reporting complaints, and issues to (1) the Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) or (2) individual plan reports of complaints, grievances, and appeals</p>	<p>-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data</p> <p>-Plan data on frequencies of complaints, grievances, and appeals related to access to care</p> <p>-Medicaid Fair Hearing data</p>	<p>-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to access to primary care and preventive services</p>
<p>1B. 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 MMA plans?</p>	<p>-Standard measures and composites of the CAHPS survey:</p> <p>-Getting Needed Care -Getting Care Quickly -Rate the Number of Doctors -Health Plan Information and Customer Service</p> <p>- MMA program weighted HEDIS means:</p> <p>-Adolescent Well-Care Visits -Adults' Access to Preventive/Ambulatory Health Services (20-44 years, 45-64 years, 65+ years, Total) -Breast Cancer Screening -Cervical Cancer Screening -Childhood Immunization Status (Combo 2, Combo 3)</p>	<p>-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data</p> <p>-MMA program weighted HEDIS means compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of the MMA program</p>	<p>-CAHPS, HEDIS, encounter data as necessary</p>	<p>-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of services</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	<ul style="list-style-type: none"> -Children and Adolescents' Access to Primary Care Practitioners (12-24 months, 25 mos-6 years, 7-11 years, 12-19 years) -Chlamydia Screening in Women (16-20 years, 21-24 years, Total) -HIV-Related Outpatient Medical Visits (2 visits \geq182 days apart) -Immunizations for Adolescents (Combo 1) -Lead Screening in Children -Prenatal and Postpartum Care (Timeliness of Prenatal Care, Postpartum Care) -Frequency of Ongoing Prenatal Care/Prenatal Care Frequency (\geq 81% of expected visits) -Transportation Availability -Well-Child Visits in the First 15 Months of Life (0 visits, 6+ visits) -Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life 			
<p>1C. What changes in the utilization of services for enrollees are evident post MMA implementation, comparing:</p> <p>1) utilization of services in the pre-MMA period (FFS, Reform plans, and pre-MMA 1915(b) waiver plans) to</p>	<p>Utilization:</p> <ul style="list-style-type: none"> - Inpatient -Outpatient -ED -Professional (Physician, Specialist) 	<ul style="list-style-type: none"> -Pre-MMA vs. MMA periods -Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans 	<ul style="list-style-type: none"> -Medicaid claims, eligibility, enrollment, encounter data 	<ul style="list-style-type: none"> -Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
<p>utilization of services in post MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?</p>				
<p>1D. What changes in quality of care for enrollees 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 MMA plans in the MMA period; and 2) quality of care in specialty MMA plans vs. standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard plans vs. enrollees in specialty plans (to the extent possible)?</p>	<p>-Standard measures and composites of the CAHPS survey:</p> <ul style="list-style-type: none"> -Overall Rating of Health Plan -Overall Rating of Health Care -Shared Decision-Making -Overall Rating of Personal Doctor -Overall Rating of Specialist <p>-MMA program weighted HEDIS means:</p> <ul style="list-style-type: none"> -Adolescent Well-Care Visits -Childhood Immunization Status (Combo 2 , Combo 3) -Children and Adolescents' Access to Primary Care Practitioners (12-24 mos, 25 mos-6 yrs, 7-11 yrs, 12-19 yrs) -Chlamydia Screening 	<p>-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data</p> <p>-Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans</p>	<p>-Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data</p> <p>-HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures</p>	<p>-Descriptive statistics and t-test. Analyze overall ratings variables related to satisfaction with health care, health plan, shared decision-making, personal doctor, and specialists</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	<ul style="list-style-type: none"> in Women (16-20 yrs, 21-24 yrs, Total) -HIV-Related Outpatient Medical Visits (2 visits \geq182 days apart) -Immunizations for Adolescents (Combo 1) -Lead Screening in Children -Well-Child Visits in the First 15 Months of Life (0 visits, 6+ visits) -Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life -Adult BMI Assessment -Antidepressant Medication Management (Acute, Continuation) -Comprehensive Diabetes Care (HbA1c Testing, HbA1c Good Control, HbA1c Poor Control, Eye Exam, Nephropathy, LDL-C Screening, LDL-C Control) -Controlling High Blood Pressure -Follow-up After Hospitalization for a Mental Illness (7 day, 30 day) -Follow-up Care for Children Prescribed ADHD Medication (Continuation, Maintenance) -Highly Active Anti-Retroviral Treatment -Mental Health Readmission Rate -Medication Management for People with Asthma (50% and 75% medication) 			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	compliance)			
1E. 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?	<ul style="list-style-type: none"> -Descriptions of Performance Improvement Projects (PIPs), including their objectives, interventions, and outcomes -Themes from qualitative interviews with plan experts on quality of care 	<ul style="list-style-type: none"> -Standard plan populations -Specialty plan populations -Populations outlined in PIPs - Representatives of MMA and MMA specialty plans 	<ul style="list-style-type: none"> -EQRO reports and plan PIPs as available. -Qualitative Interviews 	<ul style="list-style-type: none"> -Descriptive analyses -Qualitative analyses (interviews with health plan Quality Improvement contacts)
1F. 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?	<ul style="list-style-type: none"> -Standard measures and composites of the CAHPS survey: -Getting Care Quickly -Average PCP appointment wait times for urgent care, routine sick visits, and well care visits -MMA program weighted HEDIS and other performance measure means: -Prenatal and Postpartum care (Prenatal, Postpartum) -Transportation Timeliness 	<ul style="list-style-type: none"> -MMA program as a whole compared to Reform and 1915 (b) waiver plans for CAHPS timeliness of services data -Pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) and post-MMA implementation plans -Comparison of Florida MMA program weighted means to Medicaid National Means and Percentiles for HEDIS measures 	<ul style="list-style-type: none"> -CAHPS (Adult and Child): Getting Care Quickly survey measure -Timely Access PCP Wait Times report -HEDIS measures related to timeliness of services -Agency defined measure related to transportation timeliness 	<ul style="list-style-type: none"> -Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of services (e.g., getting care quickly, timeliness of prenatal care, postpartum care and transportation timeliness)
1G. 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 in the MMA period (MMA plans as a whole, standard	<ul style="list-style-type: none"> -Per-member per-month expenditures as measured by monthly risk-adjusted capitated payment to plans 	<ul style="list-style-type: none"> -Pre-MMA beneficiaries enrolled in FFS, Reform and 1915 (b) waiver plans at any point in time during DY8 -Beneficiaries in MMA plans at any point in time during DY9- DY16 	<ul style="list-style-type: none"> -Medicaid FFS and capitation claims, Medicaid eligibility data 	<ul style="list-style-type: none"> -Univariate analysis -Multivariate regression and interrupted time series analyses (as appropriate) to assess PMPM expenditures before and after implementation of the MMA program as well as across

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
MMA plans and specialty MMA plans)?				standard MMA and specialty MMA plans. Evaluators will examine trends in PMPM expenditures over time. Multivariate controls will include age, gender, risk score, and race/ethnicity
Component 2: The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care				
2A. What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the types of expanded benefits to particular populations?	-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 across plans, for both specialty and standard MMA plans	-Standard and specialty plans that offer expanded benefits	-Health plan choice materials and Agency quarterly and annual reports to Federal CMS; evaluators will use these data sources to identify any expanded/additional services plans cover -Other health plan benefit data as identified	-Descriptive analyses
2B. How many enrollees utilize expanded benefits and which ones are most commonly used?	-Number of enrollees that use expanded benefits. -Expanded benefits that are used most frequently by enrollees.	-Users of expanded benefits	-Encounter data -Data on the types of expanded benefits offered by each plan.	-Descriptive analyses
2C. How does Emergency Department (ED) and inpatient hospitalization differ for those enrollees who use expanded benefits (e.g., additional vaccines,	-ED utilization -Inpatient hospitalizations	-Users of expanded benefits vs non-users of expanded benefits	-Encounter data	-Multivariate analyses, when applicable & to the extent possible

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
physician home visits, extra outpatient services, extra primary care and prenatal/perinatal visits, and over-the-counter drugs/supplies) vs. those enrollees who do not?				
Beginning with the evaluation of DY11 (SFY 2016-17) 2D. How do enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?	-Enrollee satisfaction with expanded benefits	-Health plan enrollees	-Surveys	-Qualitative analyses
Component 3: Participation in the Healthy Behaviors programs and its effect on participant behavior or health status				
3A. 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)?	-Types and number of Healthy Behaviors programs	-MMA standard and specialty plans	-MMA managed care plan reports on healthy behaviors	-Descriptive analyses
3B. What incentives and rewards do MMA plans offer to their enrollees for participating in	-Incentives and rewards offered by the plans to enrollees participating in HB programs.	-MMA standard and specialty plans	-MMA managed care plan reports on healthy behaviors.	-Descriptive analyses

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Healthy Behaviors programs?				
<p>3C. How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behaviors programs attract higher numbers of participants?</p> <p>3D. How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees? (evaluation of DY13 SFY 2018-19 and beyond, upon receipt of individual-level Healthy Behaviors data)</p> <p>3E. What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating? (evaluation of DY13 and beyond, upon receipt of individual-level Healthy Behaviors data)</p>	<p>-Healthy Behaviors enrollees (gender, age)</p> <p>-Healthy Behaviors enrollees (race/ethnicity, health status beginning with the evaluation of DY13 – SFY 2018-19)</p> <p>-Healthy Behaviors program types</p> <p>-Service utilization (evaluation of DY13 and beyond)</p>	<p>-Healthy Behaviors program enrollees</p>	<p>-Healthy Behaviors plan summary reports, quarterly</p> <p>-Individual data, DY13 and beyond</p>	<p>-Descriptive analyses</p> <p>-Multivariate analyses for 3E, DY13 and beyond</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 4 : The impact of LIP funding on hospital charity care programs				
<p>For the evaluation of DY10 (SFY 2015-16) only</p> <p>4A. What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?</p>	<p>-Number of uninsured/underinsured patient served in LIP funded hospitals in DY10</p>	<p>-Hospitals that received LIP funding in DY10</p>	<p>-LIP providers</p> <p>-Payment amounts and type of payments (category) made to each provider.</p> <p>- "Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured</p>	<p>-Descriptive statistics and univariate analyses as applicable and to the extent possible</p>
<p>For the evaluation of DY10 (SFY 2015-16) only</p> <p>4B. What types of services are being provided to Medicaid, uninsured, and underinsured recipients receiving care in LIP funded hospitals?</p>	<p>-Number and types of services provided to uninsured/underinsured patients served in LIP funded hospitals in DY10</p>	<p>-Hospitals that received LIP funding in DY10</p>	<p>- LIP providers</p> <p>- "Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured</p>	<p>-Descriptive statistics and univariate analyses as applicable</p>
<p>Beginning with the evaluation of DY11 (SFY 2016-17)</p> <p>4C. What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many</p>	<p>-Volume of services provided to uninsured patients: adjusted days (total inpatient days adjusted by patient-care revenues for outpatient services)</p> <p>-Dollar amount of charity care provided: gross revenue, net revenue, operating expense</p>	<p>-All organizations receiving LIP funding beginning with the evaluation of DY11</p>	<p>-FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net revenues for uncompensated care patients, and operating expenses)</p> <p>-LIP data: LIP</p>	<p>-Descriptive statistics and univariate analyses as applicable</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
<p>uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP funding?</p> <p>4D. What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals?</p> <p>4E. What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?</p>			<p>providers</p> <p>-Payment amounts and type of payments (category) made to each provider</p> <p>-LIP funding tiers including the specific organizations included in each tier</p> <p>-"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured</p> <p>-Medicare cost reports</p> <p>-DSH reporting data as available</p> <p>-Information on hospital charity care programs (policies, procedures, descriptions etc.)</p>	
<p>Beginning with the evaluation of DY12 (SFY 2017-18)</p> <p>4F. What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical</p>	<p>-Number of uncompensated charity care patients served</p> <p>-Types of services provided for each provider within each provider type category</p>	<p>-LIP funded FQHCs, RHCs, and medical school physician practices</p>	<p>-Number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices</p> <p>-FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net</p>	<p>-Descriptive and univariate analyses, to the extent possible</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
school physician practices?			revenues for uncompensated care patients, and operating expenses) -Payment amounts and type of payments (category) made to each provider -LIP funding tiers including the specific organizations included in each tier -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured -Medicare cost reports -DSH reporting data as available	
Component 5: The effect of having separate managed care plans for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care (This Component will sunset following the evaluation of DY12 – SFY 2017-18)				
5A. How many enrollees are enrolled in separate Medicaid managed care programs for acute (medical) care and LTC services? 5B. How many enrollees are enrolled in comprehensive	-Enrollment numbers -Service utilization and cost per enrollee per year	-Medicaid enrollees in separate acute and LTC plans -Enrollees in comprehensive plans that provide both acute and LTC services	-Enrollment data -FL Hospital Discharge, ambulatory surgery visit and emergency department visits data -Medicaid claims and encounter data	-Descriptive statistics -Multivariate analysis

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
<p>plans that provide both acute (medical) care and LTC services?</p> <p>5C. Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?</p>		<p>-Service utilization and costs</p>	<p>-Capitation payment data</p>	
<p>Component 6: The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals</p>				
<p>6A. How many MMA enrollees are also Medicare recipients (dual-eligibles) and to what extent do dual-eligible enrollees utilize behavioral health and non-emergency transportation services?</p> <p>6B. What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-</p>	<p>-Enrollee counts (6A)</p> <p>-Content analysis results for plans' care coordination practices related to behavioral health and non-emergency transportation services</p> <p>-Qualitative themes from interviews with plan experts on care coordination</p> <p>-CAHPS measures of experience and satisfaction with delivery of non-emergency transportation services; and ECHO measures of experience and satisfaction with</p>	<p>-Representatives of MMA and MMA specialty plans (care coordination experts)</p> <p>-Dual-eligible members in MMA and MMA specialty plans</p>	<p>-Medicaid encounter, eligibility, and enrollment data</p> <p>-Florida Health Data Center hospital and emergency department encounter data for dual-eligibles receiving care under Medicare auspices</p> <p>-MMA and MMA specialty plan P&P documents on coordination of behavioral health and non-emergency transportation services</p>	<p>-Descriptive analysis</p> <p>-Qualitative analysis using Atlas Ti, grounded theory and content analysis for plan care coordination experts</p> <p>-Descriptive analysis of telephone interview data</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
<p>eligible enrollees?</p> <p>6C. How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health and non-emergency transportation services?</p>	<p>behavioral health services</p>		<p>-Follow up Qualitative Interviews</p> <p>-Medicaid eligibility and enrollment data for telephone interview-eligible sample pool of dual-eligibles</p> <p>-Telephone survey results (frequencies for response categories for each question)</p>	
<p>Component 7: The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner</p>				
<p>7A. How quickly do new enrollees access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible and enrolling in a health plan?</p> <p>7B. Among new enrollees, what is the time to access services for enrollees who are enrolled under express enrollment compared to enrollees who were enrolled prior to the implementation of express enrollment?</p>	<p>-Time to access services from enrollment date to date of first service use</p>	<p>New MMA enrollees (7A, 7B)</p> <p>New Medicaid enrollees in pre-MMA HMO and PSN plans in DY7 (7B)</p> <p>-New MMA enrollees who selected their MMA plan (7A)</p> <p>-New MMA enrollees who were auto-enrolled in an MMA plan (7A)</p> <p>-New MMA enrollees who switched plans within 120 days of initial enrollment (7A)</p> <p>-New MMA enrollees who did not switch plans within 120 days of initial enrollment (7A)</p>	<p>-Eligibility and Encounter data</p> <p>-Enrollment data that indicates auto-enrolled vs. enrollee-selected and whether the enrollee switched plans within 120 days</p>	<p>-Descriptive statistics and t-tests as applicable</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 8: The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services				
<p>8A. How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area?</p> <p>8B. What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program (PDHP)?</p>	<p>Dental Utilization:</p> <ul style="list-style-type: none"> - Inpatient -Outpatient -ED -Professional (Physician, Specialist) 	<ul style="list-style-type: none"> -Pre-PDHP period for the two SFYs immediately preceding SMPDHP implementation -PDHP period for SFYs following establishment of prepaid dental program -Enrollees eligible for enrollment in a prepaid dental plan 	<ul style="list-style-type: none"> -Medicaid claims, eligibility, enrollment, encounter data for dental services 	<ul style="list-style-type: none"> -Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.
<p>8C. What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?</p>	<p>-Dental performance measures listed in Table 3:</p> <ul style="list-style-type: none"> -Annual Dental Visit -Dental Treatment Services -Sealants for 6-9 Year-old Children at Elevated Caries Risk - Preventive Dental Services <p>The following four performance measures were not reported by plans prior to PDHP:</p> <ul style="list-style-type: none"> -Oral Evaluation -Topical Fluoride for Children at Elevated Caries Risk -Ambulatory Care Sensitive Emergency Department Visits for 	<ul style="list-style-type: none"> -Pre-PDHP period for the two SFYs immediately preceding PDHP implementation -PDHP period for SFYs following establishment of prepaid dental program -Child enrollees eligible for enrollment in a prepaid dental plan 	<ul style="list-style-type: none"> -PDHP performance measure reports to the Agency 	<ul style="list-style-type: none"> -Univariate analyses of temporal changes in dental quality measures using statistical tests of changes

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	Dental Caries in children -Follow-up after Emergency Department Visits for Dental Caries in Children			
8D. What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	-Measures from CAHPS Dental Survey related to Access to Services (see Table 3): -Percentage of respondents reporting their dental appointments are usually or always as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always get an appointment with their dental specialist as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always spend 15 minutes or less in the waiting room before seeing someone for their appointment (vs. sometimes or never) -Percentage of respondents reporting someone usually or always tells them why there is a delay or how long the delay will be if they have to wait more than 15 minutes in the waiting room before being seen for an	-PDHP program CAHPS access to care results examined over time	-CAHPS data described in Table 3	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of services

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	<p>appointment (vs. sometimes or never)</p> <p>-Percentage of respondents answering "somewhat yes" or "definitely yes" when asked whether they get to see a dentist as soon as they want if they have a dental emergency (vs. "somewhat no" or "definitely no")</p>			
8E. What barriers do enrollees encounter when accessing dental health services?	-Frequencies of complaints, grievances, and appeals related to access to care for dental services	- Statewide Medicaid Prepaid Dental Health Program enrollees reporting complaints, and issues to (1) the Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) or (2) individual plan reports of complaints, grievances, and appeals	-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data -Dental plan data on frequencies of complaints, grievances, and appeals related to access to care -Medicaid Fair Hearing data	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to access to primary care and preventive services
8F. How many enrollees utilize expanded benefits provided by the dental health plans and which ones are most commonly used?	- Number of dental plan enrollees that use expanded dental benefits -Expanded dental benefits that are used most frequently by dental enrollees	-Users of expanded dental benefits	-Dental encounter data -Data on the types of expanded benefits offered by each dental plan.	-Descriptive analyses
8G. How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)?	-Medicaid dental encounter records for dental plan enrollees merged by Medicaid enrollee ID with MMA encounter records for hospital ED and inpatient use -Rates of dental service	-Statewide Medicaid Prepaid Dental Health Program enrollees who also use MMA services	-Medicaid dental and medical encounter data, eligibility, enrollment, encounter data	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?	utilization and associated dental-related hospitalizations			extent possible), and race/ethnicity
8H. What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	-Per-member per-month expenditures as measured by monthly risk-adjusted capitated payment to plans	-Pre-PDHP beneficiaries enrolled in FFS, Reform and 1915 (b) waiver plans at any point in time during pre-PDHP period -PDHP beneficiaries in dental plans following PDHP roll-out	-Medicaid FFS and capitation claims related to dental services -Medicaid and dental eligibility data	-Univariate analysis -Multivariate regression and interrupted time series analyses (as appropriate) to assess PMPM expenditures before and after implementation of the PDHP program. Evaluators will examine trends in PMPM expenditures over time. Multivariate controls will include age, gender, risk score, and race/ethnicity
8I. How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plans?	-CAHPS dental survey measures as listed in this table for Question 8D	-PDHP program child enrollees	-CAHPS Dental Services Survey	-Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of services
8J. How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their	-Enrollee satisfaction with expanded benefits	-PDHP plan Enrollees	-Surveys	-Qualitative analyses

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
dental health plans?				
Component 9: The impact of the waiver of retroactive eligibility on beneficiaries and providers.				
9A. How will eliminating retroactive eligibility change enrollment continuity?	-Pre-post changes in the probability of enrollment renewal for Medicaid cohorts both before and after the policy change -Qualitative information on how hospitals and nursing facilities have changed their enrollment procedures following or in anticipation of the policy change	-Enrollment renewal data for (1) Medicaid enrollee cohorts prior to January 2019 (last month prior to policy change) and (2) Medicaid enrollee cohorts following January 2019 up until the last month available after the policy change	-Primary: Medicaid eligibility and enrollment data -Secondary: Qualitative results of surveys/interviews of hospital and nursing facility administrators for context.	-Pre-post logistic regressions of enrollment renewal controlling for demographics (age and sex), eligibility group, health status (Clinical Risk Group), and retroactive enrollment policy.
9B. How will eliminating retroactive eligibility change the enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility?	-Self-assessed health status based on new enrollee survey or -SF-12 scores (beneficiary survey #1; under development)	-New Medicaid enrollees	-Beneficiary survey #1 (under development) on new enrollees re self-assessed health status and possibly SF-12 health status instrument. NOTE: The evaluation team at present has not located a source for self-assessed health status or SF-12 scores from new Medicaid enrollees prior to the policy change. This may limit our ability to provide analytic results.	-Difference-in-differences testing (if possible) or pre-post statistical models (if possible) of self-assessed health status and/or SF-12 scores -The evaluation team will also explore administering the SF-12 tool
9C. How will eliminating retroactive eligibility affect new enrollee financial burden?	(1) Crediting reporting data concerning individual new enrollee medical debt verified by collection agencies prior to the new enrollee's application date. Note: The evaluation team is currently exploring the availability and cost of purchasing credit reporting data. Should credit reporting data ultimately prove unavailable, RQ 9C will	New Medicaid enrollees	(1) New enrollee credit reporting data should such data be available for these analyses or. Linked (2) statewide Florida Health Information and Transparency (FHIT) Center hospital inpatient, outpatient, ambulatory, and ED utilization data and (3) Medicaid new enrollee encounter	-(1) Modified difference-in-differences models (as explained in Attachment 6) of total and medical debt credit reporting data should such data be available for these analyses, or (2) Pre-post testing of self-pay utilization and charges in the three-months prior to Medicaid application using linked encounter

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	<p>rely on the self-pay charge data prior to enrollment as outlined above.</p> <p>2) Hospital utilization and charges with self-pay payor status from the three-months prior to Medicaid application date both before and after the policy change.</p>		data both before and after the policy change for the three months prior to Medicaid application date.	<p>data both before and after the policy change. In particular, self-pay charges will measure the amount of health care charges previously covered by Medicaid under retroactive eligibility that will now fall to the self-pay patient and/or provider uncompensated care. The evaluation team will also examine any pre-post changes in Medicaid FFS and Medicaid MMA payer classes proportions to determine if any such changes are consistent with earlier enrollment by those no longer eligible for retroactive enrollment.</p>
<p>9D. How will eliminating retroactive eligibility affect provider uncompensated care amounts?</p> <p>9E. How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?</p> <p>9F. How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?</p>	<p>-Hospital and SNF Uncompensated Care Expenditures</p> <p>-Hospital and SNF net income and rates of return</p> <p>-Hospital net change impact of UCC: UCC – LIP payments</p> <p>-Hospital and SNF Uncompensated Care Expenditures</p> <p>-Hospital and SNF net income and rates of return</p> <p>-Hospital net change impact of UCC: UCC – LIP payments</p>	<p>-Florida hospital and SNFs serving Medicaid enrollees</p>	<p>CMS Healthcare Cost Report Information System (HCRIS) Hospital and Skilled Nursing Facility datasets (when available for 2019)</p> <p>-Florida Hospital Uniform Reporting System (FHURS) (if HCRIS data post policy change is unavailable)</p> <p>-Florida Low Income Pool expenditure reports</p> <p>Note: FHURS data is available approximately 180 days (or 6 months) after the fiscal year ends for each hospital.</p>	<p>-Difference-in-Differences models (if possible) or pre-post statistical models examining uncompensated care amounts, net income/rates of return, and uncompensated care net of LIP payments</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
<p>9G. Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?</p> <p>9H. What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?</p>	<p>Beneficiary responses on beneficiary survey #2 to questions pertaining to their (1) understanding of the change in retroactive enrollment policy and its implications for their Medicaid coverage during enrollment gaps and (2) perceptions of common barriers to timely renewal</p>	<p>Random telephone sample of Medicaid enrollees subject to the new retroactive enrollment policy (i.e., male and non-pregnant women)</p>	<p>Beneficiary Survey #2 dealing with understanding of the policy change and common barriers to timely renewal.</p> <p>Beneficiary Survey #2 is under development and will be submitted to CMS for review and approval prior to fielding.</p>	<p>Descriptive tabulations and cross-tabulations of question responses by sex, age group, and enrollment length.</p>
<p>Component 10: The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.</p>				
<p>10A. How many MMA plans participate in the Housing Assistance Services pilot program? How many enrollees are participating in the housing assistance services program, by plan? How does participation in the housing assistance services program vary by gender, age, race/ethnicity and health status of enrollees? How did MMA plans implement the pilot program?</p>	<p>-Total number of participating MMA plans</p> <p>-Total number of enrollees receiving housing assistance services per plan</p> <p>-Total number of enrollees receiving housing assistance services by gender, age, race/ethnicity</p> <p>-Total number and type of services and diagnosis code(s) each enrollee had one year prior to entering the program and while in the program</p> <p>- Implementation processes used by participating MMA plans</p>	<p>-MMA enrollees receiving housing assistance services</p> <p>-MMA program staff involved with the implementation process</p>	<p>-Enrollee Roster Report submitted by MMA plans</p> <p>-Qualitative interview to assess implementation</p>	<p>-Descriptive statistics (means, medians, standard deviations, etc.)</p> <p>-Descriptive tabulations of question responses from qualitative interviews</p>
<p>10B. What is the frequency and duration of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan? What is the proportion of enrollees who are</p>	<p>-Total number of enrollees using transitional housing services</p> <p>-Total number of enrollees using mobile crisis services</p> <p>-Total number of enrollees using peer support</p> <p>-Total number of</p>	<p>-MMA enrollees receiving housing assistance services</p>	<p>-Enrollee Roster Report submitted by MMA plans</p>	<p>-Descriptive statistics (means, medians, standard deviations, etc.)</p>

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
successfully discharged from the pilot but subsequently become homeless again and resume using services?	enrollees using tenancy services			
10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving housing assistance services?	<ul style="list-style-type: none"> -Total number of potentially preventable hospitalizations per enrollee -Total number of potentially preventable emergency department visits per enrollee 	-MMA enrollees with a diagnosis of SMI and homeless or at risk of being homeless	<ul style="list-style-type: none"> -Medicaid claims, eligibility, enrollment and encounter data - Enrollee Roster Report submitted by MMA plans to identify enrollees using housing assistance services 	-Difference-in-difference multivariate analyses comparing changes in utilization rates between the population enrolled in MMA plans to housing assistance services who are participating in the pilot program and enrollees in the same MMA plans who are eligible for the pilot program but are placed on a waiting list and are not yet participating in the pilot program
10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program?	<ul style="list-style-type: none"> -Total number of PCP visits per enrollee -Total number of outpatient visits per enrollee -Total number of pharmacy claims per enrollee -Total number of behavioral health service visits per enrollee 	-MMA enrollees with SMI who are homeless or at risk of being homeless	<ul style="list-style-type: none"> -Medicaid claims and encounter data, specifically looking at utilization of PCP visits, outpatient visits, pharmacy services and behavioral health services - Enrollee Roster Report submitted by MMA plans to identify enrollees using housing assistance services 	-Difference-in-difference multivariate analyses comparing changes in utilization rates between the population enrolled in MMA plans offering housing assistance services who are participating in the pilot program and enrollees in the same MMA plans who are eligible for the pilot program but are placed on a waiting list and are not yet participating in the pilot program
10E. Based on interviews with MMA plan staff, including Care Coordinators, is care coordination more effective for the study population as a result of the Pilot program?	<ul style="list-style-type: none"> -Qualitative assessment of care coordination effectiveness before and after implementation of the Pilot program -Percentage of participants achieving housing permanency -Percentage of participants who days of homelessness were 	<ul style="list-style-type: none"> -MMA plan staff with knowledge of care coordination conducted by the plan -Pilot Participants 	<ul style="list-style-type: none"> -Qualitative data based on survey responses to a Vendor-created survey of MMA staff, including Care Coordinators -Participating MMA plans roster reports 	-Descriptive statistics

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	<p>reduced</p> <p>-Percentage of participants diagnosed with a substance use disorder receiving medication assistance treatment</p> <p>-percentage of participants with serious mental illness who are compliant with medication management requirements</p>			
10F. What are enrollee experiences with the Pilot program, including whether service needs were met, their experiences with integration of services, involvement in their care, and satisfaction with the services provided	-Pilot program participants responses to questions pertaining to service needs, integration of care, involvement in care, and satisfactions with services	-Housing Assistance Pilot program participants	-Responses to Vendor-created survey assessing experiences and satisfaction with services provided through the Pilot program.	-Descriptive Statistics
10G. What are the costs of the Pilot Program, including the costs of services provided to enrollees and the costs to administer the program?	-Per-member-per-month expenditures as measured by paid amounts on encounter data. -Program administrative costs reported by participating MMA plans and AHCA	-Housing Assistance Pilot program participants -Enrollees placed on the waiting list for the Housing Assistance Pilot program	-Medicaid encounter data -Administrative costs reported by participating MMA plans and AHCA	-Univariate analysis -Multivariate regression analysis using a difference-in-difference approach to compare changes in expenditures before and after implementation of the Housing Assistance Pilot.

D. Methodological Limitations

Limitations of the evaluation include the design, the data sources or collection process, analytic methods and the state’s efforts to minimize the limitations. Additionally, this section includes information about features of the demonstration that effectively present methodological constraints the state would like CMS to consider in its review.

- Current and subsequent years will continue to show that the MMA demonstration remains non-complex and mostly unchanged; therefore, evaluation results may be limited in providing additional or divergent findings from prior evaluations. In addition, the MMA program continues to operate smoothly without administration changes, with minimal appeals and grievances, and with no known issues with CMS 64 reporting or budget neutrality. Consequently, the new STCs were modified to simplify and streamline

the state's reporting requirements to CMS, moving from quarterly to annual reporting. In addition, monthly calls with CMS are now on a periodic basis as the need is determined.

- Individual level Healthy Behaviors data will be available beginning with the evaluation of DY13. However, the lack of individual level Healthy Behaviors data for the evaluations of DY10, DY11 and DY12 is a limitation because service utilization patterns will not be known for specific enrollees. For example, it will not be possible to know if participation in the program results in more appropriate use of services if the ability to link to individual enrollment, encounter and claims data is not possible.

Also, responses from dual-eligibles to telephone interviews concerning their assessments of their health care may unavoidably reflect a combination of Medicare and Medicaid experiences for behavioral health services.

Florida implemented the MMA program statewide over a period of three months and enrolled the great majority of Florida Medicaid recipients into MMA at that time. Consequently, there does not exist an appropriate comparison group within Florida Medicaid following the implementation of the MMA program. This poses major issues for conducting either a standard difference-in-differences or propensity score matching analysis. Standard difference-in-differences analysis requires data on both treatment and comparison groups both prior to and subsequent to the implementation of the MMA program. Florida's shift of the vast majority of its Medicaid recipients into the MMA program over a very short period of time precludes identifying a comparison group from within Florida Medicaid post-implementation. While other groups (e.g., the privately insured in Florida or other states' Medicaid enrollees) could furnish a comparison group, such diverse groups are likely to violate the parallel slopes assumption of difference-in-differences since they will be subject to different spatial and temporal trends than MMA enrollees.

Using such heterogeneous groups for propensity score matching to the MMA population poses similar challenges since such groups have intrinsic differences in geographical location and insurance coverage provisions that cannot be controlled through matching.

A major limitation in evaluating retroactive enrollment (Component 9) is the inability to identify enrollees after the policy change who would have been eligible for retroactive enrollment under the rules in effect prior to the policy change. The Agency estimates that only a small percentage of new Medicaid enrollees qualified for retroactive enrollment prior to the policy change. Consequently, any effect of the policy change on current new enrollees who would have qualified for retroactive enrollment under the previous policy will be difficult to capture among the large number of current new enrollees who would have been ineligible for retroactive enrollment under the previous policy.

Another potential challenge for the retroactive enrollment evaluation is the need to merge Medicaid enrollment records with Florida Health Data Center statewide inpatient discharge and ambulatory and ED visit data to capture the utilization of new Medicaid enrollees in the three months prior to Medicaid application. While such a merge should be possible given common identifiers in the datasets, such a merge has not been attempted previously to the best of our knowledge and the match rate is therefore unknown. This will become a material limitation should credit reporting medical and total debt data be unavailable for this evaluation.

E. Attachments

1) Independent Evaluator.

Upon receipt of letters of intent and review of proposals submitted by two universities in 2015, the Agency determined that the University of Florida's (UF) proposals best fit the Agency's needs. Subsequently, in 2016, the Agency contracted with UF, located in Gainesville, FL, to conduct an independent evaluation of the MMA program. UF subcontracts with two other universities to conduct some components of the evaluation (Florida State University and University of Alabama at Birmingham). The Agency provided the evaluators with a description of the objectives of the MMA program and the approved evaluation design.

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See Dr. Vogel's Curriculum Vitae (CV) attached.

2) No Conflict of Interest.

The state has assured that the Independent Evaluator will conduct a fair and impartial evaluation, will prepare an objective Evaluation Report, and that there will be no conflict of interest. "Conflict of Interest" statements have been signed by appropriate Agency staff attesting to the following: No immediate family or business partners have financial interest in the vendor; no immediate family or business partners have a personal relationship with the vendor or their representatives; no gratuities, favors, or anything of monetary value has been offered to or accepted by the vendor or their representatives; no state parties have been employed by the vendor within the past 24 months; no discussions to seek or accept future employment with the vendor or their representatives; and, no other conditions exist which may cause conflict of interest.

3) Evaluation Budget.

The Agency initially contracted with UF for a period of three (3) years (SFY 2016-17 through SFY 2018-19) at a total cost of \$1,290,600.00 (\$430,200 per year). In the first three years, DYs 9, 10, and 11 will be evaluated.

The Agency renewed the contract for a period of three years (SFY 2019-20 through SFY 2021-22) during which time DYs 12, 13, and 14 will be evaluated. The budget for SFY 2019-20 through SFY 2021-22 is \$2,713,542.00. Budgeted amount includes Institution Cost Share.

Components 9 and 10 will be added to the Agency's contract with the university, at which time a revised budget will be requested from the evaluators.

4) Timeline and Major Milestones.

Table 7 outlines the timeline for conducting the evaluation activities, including deliverable submissions and activities related to the renewal and reprocurement of a contractor.

Timelines for Component 9 and 10 will be updated upon CMS approval.

Table 7. MMA Evaluation Activities, December 31, 2017-December 31, 2023

Deliverable / Activity	Due Date
Evaluation Design submitted to CMS*	January 31, 2018
MMA Interim Report - Project 2 DY10: Component 3 (Healthy Behaviors)	April 2, 2018
MMA Interim Report - Project 3 DY10: Component 4 (LIP)	April 2, 2018
MMA Interim Report - Project 1 DY10: Components 1, 2, 5, and 7 (Access, Quality, Cost)	May 1, 2018
Revised Evaluation Design submitted to CMS*	May 7, 2018
MMA Interim Report - Project 4 DY10: Component 6 (Dual-Eligibles)	May 15, 2018
DY11 MMA Program Medicaid Data Request and Verification	Request Due: July 2, 2018 Verification Due: 30 calendar days after data delivery
DY11 Florida Center Data Request and Verification	Request Due: July 2, 2018 Verification Due: 30 calendar days after data delivery
Stakeholder Debriefing Materials	September 4, 2018
Stakeholder Debriefing and Summary	Thirty (30) calendar days after Debriefing completion

Deliverable / Activity	Due Date
Annual Monitoring Report due to CMS*	September 30, 2018
MMA Interim Report-Project 1 DY11-Components 1, 2, 5, and 7 (Access, Quality, Cost)	May 1, 2019
MMA Interim Report-Project 2 DY11-Component 3 (Healthy Behaviors)	April 1, 2019
MMA Interim Report-Project 3 DY11-Component 4 (LIP)	March 1, 2019
MMA Interim Report-Project 4 DY11-Component 6 (Dual-Eligibles)	May 15, 2019
Agency contract with UF is renewed for three (3) years	July 1, 2019
DY12 MMA Program Medicaid Data Request and Verification	Request Due: July 2, 2019 Verification Due: 30 calendar days after data delivery
DY12 Florida Center Data Request and Verification	Request Due: July 2, 2019 Verification Due: 30 calendar days after data delivery
Annual Monitoring Report due to CMS*	September 30, 2019
MMA Interim Report- Project 3 DY12-Component 4 (LIP)	September 3, 2019
MMA Interim Report- Project 2 DY12-Component 3 (Healthy Behaviors)	October 1, 2019
MMA Interim Report-Project 1 DY12-Components 1, 2, 5, and 7 (Access, Quality, Cost)	November 1, 2019

Deliverable / Activity	Due Date
MMA Legislative Report on the Waiver of Medicaid Retroactive Eligibility on Beneficiaries and Providers	November 22, 2019
MMA Interim Report-Project 4 DY12-Component 6 (Dual-Eligibles)	January 15, 2020
DY13 MMA Program Medicaid Data Request and Verification	Request Due: April 30, 2020 Verification Due: 30 calendar days after data delivery
DY13 Florida Center Data Request and Verification	Request Due: April 30, 2020 Verification Due: 30 calendar days after data delivery
Annual Monitoring Report due to CMS*	September 30, 2020
DY14 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2020 Verification Due: 30 calendar days after data delivery
DY14 Florida Center Data Request and Verification	Request Due: October 1, 2020 Verification Due: 30 calendar days after data delivery
DY13 and DY14 Enrollee Satisfaction Survey Materials	December 4, 2020
DY13 and DY14 Health Plan Qualitative Administrative Interview Materials	December 4, 2020
MMA Interim Report- Project 3 DYs 13 and 14-Component 4 (LIP)	February 1, 2021

Deliverable / Activity	Due Date
MMA Interim Report- Project 2 DYs 13 and 14-Component 3 (Healthy Behaviors)	March 1, 2021
MMA Interim Report-Project 1 DYs 13 and 14- Components 1, 2, 5 (DY13 only), and 7 (Access, Quality, Cost)	April 1, 2021
MMA Interim Report-Project 4 DYs 14 and 14-Component 6 (Dual-Eligibles)	April 15, 2021
MMA Interim Report-DY 14- Component 8 (Pre-paid Dental Health Program)	April 30, 2021
Draft Interim Evaluation Report (DYs 9-14) due to Agency	August 16, 2021
Annual Monitoring Report due to CMS*	September 30, 2021
DY15* MMA Program Medicaid Data Request and Verification	October 1, 2021
DY15 Florida Center Data Request and Verification	October 1, 2021
Final Draft Interim Evaluation Report (DYs 9-14) due to Agency	November 1, 2021
DY15 Enrollee Satisfaction Survey Materials	December 3, 2021
DY15 Health Plan Qualitative Administrative Interview Materials	December 3, 2021
MMA Interim Report- Project 3 DY15-Component 4 (LIP)	February 1, 2022
MMA Interim Report- Project 2 DY 15-Component 3 (Health Behaviors)	March 1, 2022
MMA Interim Report- Project 1 DY15-Components 1, 2, 5, and 7 (Access, Quality, Cost)	April 1, 2022
MMA Interim Report- Project 4 DY15-Component 6 (Dual-Eligibles)	April 15, 2022

Deliverable / Activity	Due Date
MMA Interim Report-Project 4 DYs 13 and 14-Component 6 (Dual-Eligibles)	May 15, 2021
Draft of Interim Evaluation Report DY14-Component 8 (Pre-paid Dental Health Program)	June 15, 2021
Draft of Draft Interim Evaluation Report (DYs 9-14) due to Agency	August 15, 2021
Annual Monitoring Report due to CMS*	September 30, 2021
DY15 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2021 Verification Due: 30 calendar days after data delivery
DY15 Florida Center Data Request and Verification	Request Due: October 1, 2021 Verification Due: 30 calendar days after data delivery
Final Draft Interim Evaluation Report (DYs 9-14) due to Agency	November 1, 2021
Draft Interim Evaluation Report (DYs 9-14) due to CMS*	January 1, 2022
MMA Interim Report-Project 1 DY15-Components 1, 2, and 7 (Access, Quality, Cost)	March 1, 2022
MMA Interim Report- Project 2 DY15-Component 3 (Healthy Behaviors)	April 1, 2022
MMA Interim Report- Project 3 DY15-Component 4 (LIP)	May 1, 2022

Deliverable / Activity	Due Date
MMA Interim Report-Project 4 DY15-Component 6 (Dual-Eligibles)	May 15, 2022
Draft of Interim Evaluation Report DY15-Component 8 (Pre-paid Dental Health Program)	June 14, 2022
Anticipated Date of Execution of New Contract with UF	July 1, 2022
Annual Monitoring Report due to CMS*	September 30, 2022
DY16 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2022 Verification Due: 30 calendar days after data delivery
DY16 Florida Center Data Request and Verification	Request Due: October 1, 2022 Verification Due: 30 calendar days after data delivery
MMA Interim Report-Project 1 DY16-Components 1, 2, and 7 (Access, Quality, Cost)	March 1, 2023
MMA Interim Report- Project 2 DY16-Component 3 (Healthy Behaviors)	April 1, 2023
MMA Interim Report- Project 3 DY16-Component 4 (LIP)	May 1, 2023
MMA Interim Report-Project 4 DY16-Component 6 (Dual-Eligibles)	May 15, 2023
Draft of Draft Summative Evaluation Report (DYs 12-16) due to Agency	August 15, 2023

Deliverable / Activity	Due Date
Annual Monitoring Report due to CMS*	September 30, 2023
Final Draft Summative Evaluation Report (DYs 12-16) due to Agency	November 1, 2023
Draft Summative Evaluation Report (DYs 12-16) due to CMS*	December 31, 2023

*Deliverables due to CMS.

5). State Expectations

The following table outlines the State’s expectations for the evaluation’s research questions that have hypotheses associated with them. The evaluators are utilizing two-sided null statistical hypotheses within the evaluation design in order to allow them to objectively test for changes that could be either positive or negative, as well as to eliminate the potential for bias (e.g., confirming their own predictions). However, in keeping with the goals of the MMA demonstration as stated in the design, the State expects the demonstration to have an overall positive impact on Florida’s efforts to improve its Medicaid program under a capitated managed care program.

Research Question*	State Prediction
Component 1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care	
1B. 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 MMA plans?	Accessibility of services will show statistically significant improvement for MMA plans as a whole compared to pre-implementation plans (Reform plans and 1915(b) waiver plans).
1C. What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans and pre-MMA 1915(b) waiver plans) to utilization of services in post-MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?	<ol style="list-style-type: none"> I. Appropriate utilization of services will be statistically significantly greater in MMA plans as a whole than in pre-implementation plans (Reform plans and 1915(b) waiver plans). II. Specialty MMA plans will provide enrollees with improved access to services related to the specialty condition compared to standard MMA plans.
1D. What changes in quality of care for enrollees 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 MMA plans in the MMA period; 2) quality of care in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard plans versus enrollees in the specialty plans (to the extent possible)?	<ol style="list-style-type: none"> I. Quality of care will show statistically significant improvement in MMA plans as a whole compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). II. Quality of care will be statistically significantly higher for enrollees in specialty MMA plans compared to enrollees with the specialty condition (e.g. HIV) in standard MMA plans.
1F. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA	Timeliness of services will show statistically significant improvement in post-MMA implementation plans compared to pre-MMA

implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans?	implementation plans (Reform plans and 1915(b) waiver plans).
1G. 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 in the MMA period (MMA plans as a whole, standard MMA plans and specialty MMA plans)?	Per-enrollee cost by eligibility group will show less month-to-month variability and/or slower rates of increase in the MMA period (MMA plans as a whole, standard MMA plans and specialty MMA plans) compared to pre-MMA implementation (FFS, Reform plans, and pre-MMA 1915(b) waiver plans).
Component 2. The effect of customized benefit plans* on beneficiaries' choice of plans, access to care, or quality of care. * Since MMA plans do not offer customized benefit plans, the State will evaluate the effect of expanded benefits on enrollees' utilization of services, access to care, and quality of care.	
2C. How does Emergency Department (ED) and inpatient hospital utilization differ for those enrollees who use expanded benefits (e.g. additional vaccines, physician home visits, extra outpatient services, extra primary care and prenatal/perinatal visits, and over-the-counter drugs/supplies) vs. those enrollees who do not?	Appropriate utilization of Emergency Department (ED) and inpatient hospitalization services will be statistically significantly greater for enrollees who use expanded benefits versus those who do not.
Component 3. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status	
3E. What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating (DY13 and beyond)?	I. Utilization of preventive services and outpatient services (e.g. Primary Care Physician (PCP) visits and smoking cessation counseling sessions) will be statistically significantly higher for enrollees participating in Healthy Behaviors programs compared to enrollees who are not participating. II. Enrollees who participate in Healthy Behaviors programs will show statistically significant declines in utilization of ED, inpatient and outpatient hospital and services for treatment of conditions that these programs are designed to prevent following their enrollment in the Healthy Behaviors program.

Component 4. The impact of LIP funding on hospital charity care programs	
4A. What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?	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 pre-MMA implementation period.
4C. What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP funding?	There will be a statistically significantly greater number of uninsured patients served and/or a greater amount of expenditures on services by hospitals with higher levels of LIP funding.
4E. What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?	There will be an increase in the type and number of services offered to uncompensated charity care patients in hospitals with higher levels of LIP funding.
4F. What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices?	There will be a statistically significantly greater number of uncompensated charity care patients served and an increase in types and number of services offered to uncompensated charity care patients in FQHCs, RHCs, and medical school physician practices with higher levels of LIP funding.
Component 5*. 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	
*This component will sunset following the evaluation of DY12 (SFY2017-18)	
5C. Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?	Enrollees receiving MMA and LTC services from a single comprehensive plan will show statistically significantly higher service utilization and service appropriateness than enrollees who receive services from separate MMA and LTC plans.
Component 8. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services	
8B. What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Utilization of dental services will show statistically significant increases following the implementation of the Statewide Medicaid Prepaid Dental Health Program.

8C. What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Quality of dental care for enrollees will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program.
8D. What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Accessibility of dental services will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program.
8G. How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)? How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?	<ol style="list-style-type: none"> I. Appropriate use of dental services will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program. II. Appropriate utilization of Emergency Department (ED) and inpatient hospitalization services will show statistically significant improvement for enrollees who use dental expanded benefits compared to those who do not use such benefits.
8H. What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Per-enrollee cost of dental health services will show less month-to-month variability and/or slower rates of increase following implementation of the Statewide Medicaid Prepaid Dental Health Program.
Component 9. The impact of the waiver of retroactive eligibility on beneficiaries and providers.	
9A. How will eliminating retroactive eligibility change enrollment continuity?	Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.
9B. How will eliminating retroactive eligibility change the enrollment of eligible people when they are health relative to those eligible people who have the option of retroactive eligibility?	Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.
9C. How will eliminating retroactive eligibility affect new enrollee financial burden?	Elimination of retroactive coverage eligibility will not have adverse financial impacts on consumers.
9D. How will eliminating retroactive eligibility affect provider uncompensated care amounts?	Elimination of retroactive coverage eligibility will not have adverse financial impacts on provider uncompensated care amounts.

9E. How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?	Elimination of retroactive coverage eligibility will not have adverse financial impacts on provider financial performance.
9F. How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?	Elimination of retroactive coverage eligibility will not have adverse financial impacts on net financial impact of uncompensated care.
Component 10. The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.	
10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving housing assistance services?	There will be fewer avoidable hospitalizations and emergency department visits among enrollees with SMI who receive supportive housing assistance compared to enrollees who did not receive supportive housing assistance.
10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program.	Use of MMA services will be greater among enrollees with SMI who receive supportive housing assistance compared to enrollees who did not receive supportive housing assistance.

*Some RQs within the design were included to provide context, are descriptive in nature, and, thus, have no hypotheses associated with them. Therefore, those RQs do not have an associated State expectation and are not reflected in this table.

6). Modified Difference-in-Differences Approach

This section explains the two modified difference-in-differences methods that the evaluation team will employ in addressing selected questions in (1) the Housing Assistance Pilot (Component 10) and (2) the impact of Florida’s retroactive enrollment policy change (Component 9). To set the stage for these modified approaches, we first present the standard difference-in-differences framework.

Standard Difference in Differences

Evaluations have commonly employed a pre-post design where the treatment group outcome is observed both prior to treatment and subsequent to treatment. The difference in outcomes between the post-treatment period and the pre-treatment period is then an estimate of the treatment effect. The obvious danger in such designs is that intervening time factors (sometimes called historical bias) that coincide with the implementation of treatment may introduce bias into the estimated treatment effect.

Another common approach employs treatment and comparison groups where the comparison group is chosen to resemble the treatment group as closely except that the comparison group only receives usual care. The difference in outcomes between the treatment and comparison groups is then taken as an estimate of the treatment effect. The most common problem here is that treatment and comparison groups may differ from one another in unobserved ways that influence both choice of treatment and outcomes,

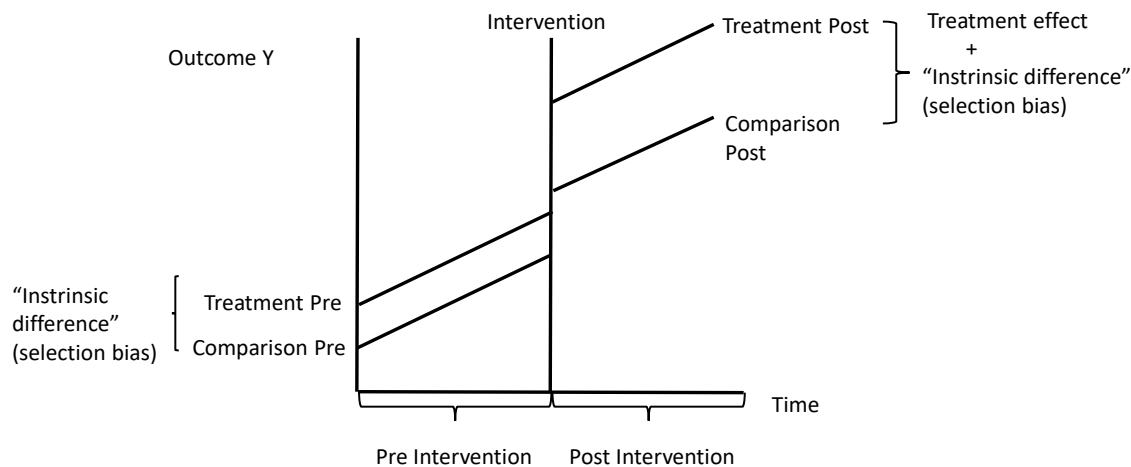
leading to the selection bias described above.

Difference-in-differences (D-i-D) is a research design that attempts to deal with both intervening factors and unobserved selection bias (Imbens & Wooldridge J, 2007). One drawback to D-i-D is that it requires more data than just pre-post observations on a treatment group as in a pre-post design or just a treatment and comparison group observed during the treatment period. D-i-D requires observing both a treatment and comparison group observed both prior to treatment (the pre period) and subsequent to treatment (the post period).

How D-i-D Works

Figure 2⁴ illustrates how difference-in-differences isolates the true treatment effect in the presence of biased selection. We observe both the treatment and comparison group both before and after the intervention is implemented. During the pre-intervention period, both the treatment and comparison groups are observed under usual care. At the intervention point, the comparison group continues to receive usual care while the treatment group transitions to the new intervention. D-i-D isolates the intrinsic difference or selection bias between the treatment and comparison groups by measuring the differences in outcomes in the two groups during the pre-intervention period when both groups are under usual care. To do this, the D-i-D approach assumes that both the treatment and comparison groups' time trends are equal. This is commonly called the "constant slopes" assumption.

Figure 2 - How D-i-D Works



$$\text{Treatment effect} = (\text{Treatment Post} - \text{Comparison Post}) - (\text{Treatment Pre} - \text{Comparison Pre})$$

In the post-intervention period, the true treatment effect is obscured by the presence of the intrinsic difference between the two groups. Taking the difference between the treatment and control groups in the post-intervention period gives the sum of the true treatment effect and the intrinsic difference between the groups (the first difference in difference-in-differences). Then, subtracting from that difference the difference between the treatment and comparison groups in the pre-intervention period (the second difference in

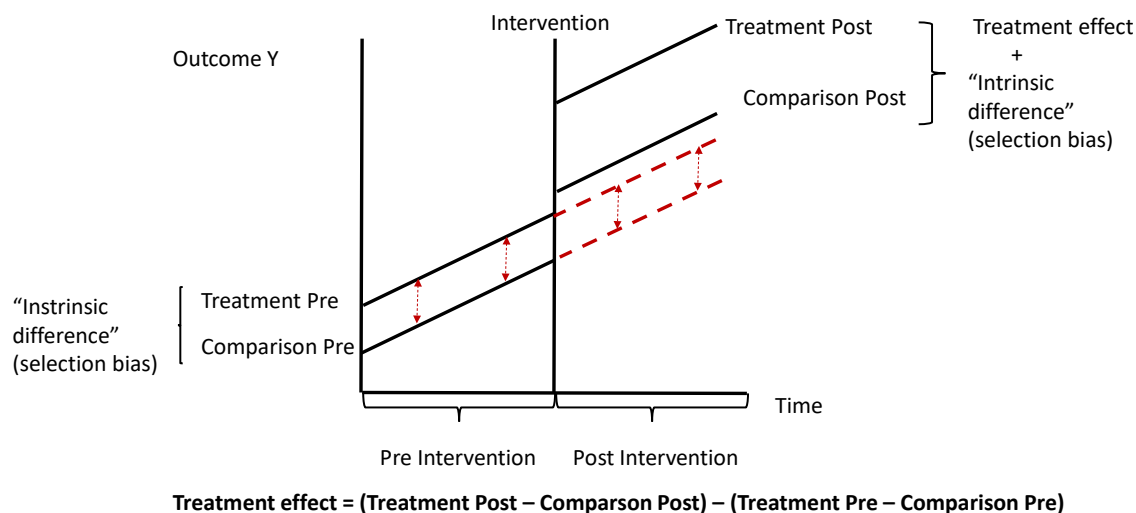
⁴ Figure 1 has been omitted from this attachment for purposes of brevity.

difference-in differences) gives the true treatment effect alone.

Assumes Equal Time Trends

Figure 3 shows why D-i-D must assume time trends for the treatment and comparison groups. Only if the time trends are the same will D-i-D yield a stable estimate of the intrinsic difference between the treatment and comparison groups. This is especially important when you have insufficient data across time to examine the treatment and comparison time trends in your data. When sufficient data are available, you can check this assumption by comparing the trends across time for the treatment and comparison groups.

Figure 3 - D-i-D Assumes Equal Time Trends for Treatment and Comparison Groups



How is D-i-D Implemented?

D-i-D is simple to implement in practice if data for the treatment and comparison groups are available both pre-intervention and post-intervention. The basic D-i-D model incorporates

- 1) a pre/post period dummy variable, POST, where POST=1 during the post-implementation period and POST=0 during the pre-implementation period,
- 2) a treatment/comparison group dummy variable, GROUP, where (GROUP=1 for the treatment group and GROUP=0 for the comparison group),
- 3) the statistical interaction between these two main effects, POST x GROUP, and
- 4) the additional control variables, X, used in outcomes models (e.g., age, sex, and health status).

The D-i-D regression equation is

$$Y = \alpha + \beta_P POST + \beta_G GROUP + \beta_{DiD} POST \times GROUP + \beta_X X + \varepsilon$$

Y is the outcome under study, X represents the control variables, the β 's are the model coefficients, and ε is the disturbance term.

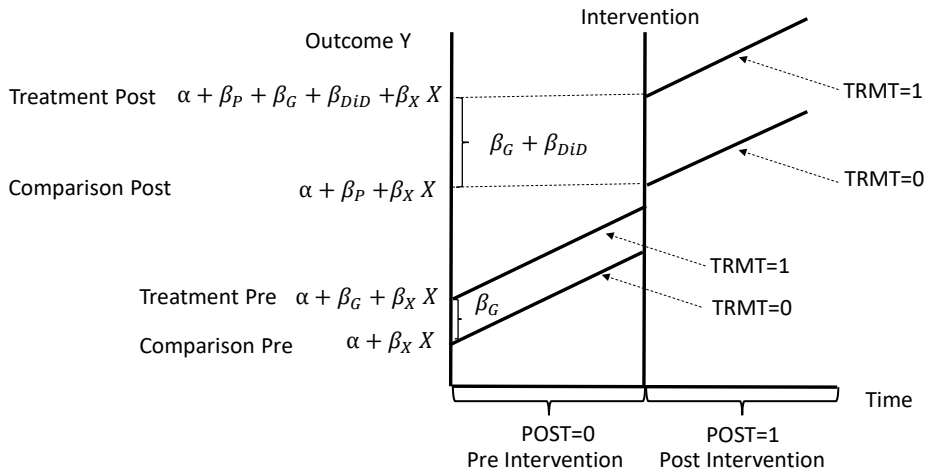
Figure 4 shows graphically the way D-i-D works based on the D-i-D statistical model. In Figure 4, the outcome Y is on the vertical axis and time is on the horizontal axis. The horizontal axis is divided into pre- and post-intervention segments. The four straight lines in Figure 4 correspond to the treatment and comparison groups in the pre and post periods. The four model coefficient sums plotted on the Y axis show the predicted treatment and comparison values for both the pre and post periods. Notice that the difference between the treatment pre and comparison pre values gives β_G , which is a measure of the intrinsic difference between the two groups prior to implementation. The difference between the treatment post and comparison post values gives the sum of the interaction coefficient, β_{DiD} , and the intrinsic difference between the two groups, β_G . The difference-in-differences treatment effect is found by subtracting the treatment-comparison difference in the pre-period from the treatment-comparison difference in the post-period:

$$(\beta_G + \beta_{DiD}) - \beta_G = \beta_{DiD}$$

The coefficient on the interaction term, β_{DiD} , is the estimated treatment effect in a linear D-i-D model.

Figure 4 – How is D-i-D Implemented?

$$\text{Treatment effect} = (\text{Treatment Post} - \text{Comparison Post}) - (\text{Treatment Pre} - \text{Comparison Pre}) = (\beta_G + \beta_{DiD}) - \beta_G = \beta_{DiD}$$



$$\text{Estimate: } Y = \alpha + \beta_P \text{POST} + \beta_G \text{GROUP} + \beta_{DiD} \text{POST} \times \text{GROUP} + \beta_X X + \varepsilon$$

Testing and Relaxing the Strict Assumptions of Difference-in-Differences

Several approaches exist for testing and relaxing the strict assumptions of D-i-D. Florida MMA evaluation principal investigator Jeff Harman and colleagues used the availability of multiple time periods in both the pre and post periods to relax the strict constant slopes assumptions of D-i-D (Harman, Lemak, Al-Amin, Hall, & Duncan, 2011). This was done by introducing into the standard D-i-D model a time trend main effect along with two-way interactions between time and POST and time and GROUP and a three-way interaction between time, POST, and GROUP:

$$Y = \alpha + \beta_t \text{time} + \beta_P \text{POST} + \beta_G \text{GROUP} + \beta_{Pt} \text{POST} \times \text{time} + \beta_{Gt} \text{GROUP} \times \text{time} + \beta_{DiD} \text{POST} \times \text{GROUP} + \beta_{DiDt} \text{POST} \times \text{GROUP} \times \text{time} + \beta_X X + \varepsilon$$

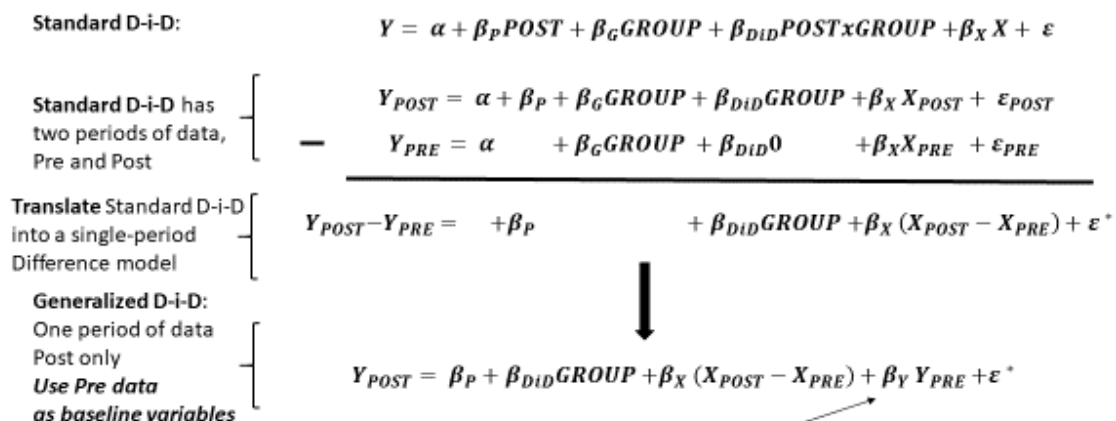
Even when the number of time periods in the pre and/or post periods preclude estimating time trends, the standard D-i-D assumptions can be relaxed. University of Florida faculty member Keith Muller has observed that the standard D-i-D model can be translated from a two period, pre/post model into a single period, post-only model (Wegman et al., 2015). This single period model uses the baseline (pre-period) variables to relax the D-i-D constant slope assumption.

Figure 5 shows how the standard D-i-D model is translated into this more flexible formulation. First, the standard D-i-D model is separated into two parts, one for the post period and one for the pre period. Then, these two equations are differenced to produce a single equation difference model. Lastly, the pre-period outcome, Y_{PRE} , is placed among the regressors with a coefficient, β_Y , to be estimated. When β_Y is treated as a coefficient to be estimated rather than forced to equal one as in standard D-i-D, the constant slope assumption is relaxed.

To be fair, however, this approach to D-i-D is not free of assumptions. The constant slope assumption is replaced with a constant baseline proportionality assumption based on the baseline value of Y . However, it is easy to add an interaction between Y_{PRE} and $GROUP$ so that the constant baseline proportionality assumption can differ between the treatment and comparison groups.

While not perfectly flexible, this modification increases the generality of this D-i-D formulation. Note that this D-i-D formulation subsumes the standard D-i-D formulation as a special case when $\beta_Y=1$. Testing $H_0: \beta_Y=1$ and rejecting $H_0: \beta_Y=1$ in favor of $H_A: \beta_Y \neq 1$ tells you that this new model formulation fits your data better than the standard D-i-D formulation.

Figure 5 – Relaxing the DiD Constant Slopes Assumption



Generalized D-i-D allows $\beta_Y \neq 1$, thereby relaxing the constant slope assumption in standard D-i-D.

Conclusion

We believe that testing for and relaxing the strict assumptions of D-i-D are important for studying the effects of retroactive enrollment policy on new Medicaid enrollee debt in Florida. In particular, we plan to use linked credit reporting data on medical debt for new Medicaid enrollees both prior to and subsequent to the change in retroactive enrollment policy. Consequently, we will have a very large sample size that will likely yield

sufficient statistical power to detect very small changes in medical debt as statistically significant. It is therefore critical to disentangle the effects of retroactive enrollment policy from the other factors than can influence medical indebtedness (enrollee income, employment changes, physical and mental health status, etc.) as discussed in the introduction.

In addition, selecting a control group for D-i-D is difficult since Florida chose to implement the retroactive enrollment policy statewide at a single point in time (February 2019). Consequently, it will likely be necessary to use pregnant women and children as the control group since they remained under the previous retroactive enrollment policy. Unfortunately, the assumption of constant slopes for men and non-pregnant women vs. pregnant women and children is especially tenuous given the obvious differences between these groups. This too argues for exploring techniques for testing and relaxing the constant trends assumptions in standard D-i-D.

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