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

March 21, 2025

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

Dear Deputy Secretary Meyer:

On February 28, 2025, the Centers for Medicare & Medicaid Services (CMS) received via email your acknowledgement and acceptance of the special terms and conditions (STCs) to amend the state's section 1115 demonstration entitled, "Florida Managed Medical Assistance" (MMA) (Project Numbers 11-W-00206/4 and 21-W-00069/4). This amendment was approved by CMS on January 31, 2025.

CMS is accepting Florida's proposed edit to STC 88 and is issuing a technical correction to implement the edit. A copy of the updated STCs is enclosed.

Your CMS project officer for this demonstration is Ms. Jamie John. She is available to answer any questions concerning your section 1115 demonstration and can be reached at Jamie.John@cms.hhs.gov.

Sincerely,

Lisa A. Marunycz -S9
Digitally signed by Lisa A. Marunycz -S9
Date: 2025.03.21 12:37:56 -04'00'

CAPT Lisa Marunycz
Deputy Director
Division of System Reform Demonstrations

Enclosure

cc: Kia Carter-Anderson, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00206/4 and 21-W-00069/4

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 (STCs). 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 approval through June 30, 2030, 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 (PSNs), 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 at the end of the state's authorized postpartum coverage 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 state authorized postpartum coverage period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00206/4 and 21-W-00069/4

TITLE: Florida Managed Medical Assistance

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 or section 2107(e)(2)(A)) of the Act, shall, for the period of this demonstration from the date of the extension approval through June 30, 2030, be regarded as expenditures under Florida's title XIX and title XXI state plan, unless otherwise specified.

TITLE XIX EXPENDITURE AUTHORITY:

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. Such funds may be used by providers to offset the uncompensated costs of treating the uninsured, but this expenditure authority does not make uninsured patients eligible for any benefits under the demonstration.

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 17, effective January 1, 2018.

5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 18 effective January 1, 2018.

6. Expenditures for behavioral health and supportive housing assistance services to individuals in MMA, as described in STC 54 effective as of the approval date of the amendment (March 26, 2019) through June 30, 2025. The state will implement this pilot less than statewide and institute annual enrollment limits of 50,000 member months each demonstration year.

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 requirements are 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 STC 54.

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.

7. **Expenditures for Benefits for Postpartum Women.** Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, as described in STC 61.
   a) For Medicaid "lawfully residing" pregnant and postpartum women covered by the state under sections 1903(v)(4)(A)(i) of the Act, this expenditure authority starts from the effective date of Florida Senate Bill 2526 through the effective end date of the American Rescue Plan (ARP) statutory period.
   b) This expenditure authority will terminate at any time the state fails to offer postpartum coverage to pregnant individuals in both Medicaid and CHIP, exactly as prescribed in statute, while the legal provisions of the ARP are in effect.

8. **Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12 Month Postpartum Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 61.
   a) For Medicaid "lawfully residing" pregnant and postpartum women covered by the state under section 1903(v)(4)(A)(i) of the Act, this expenditure authority starts from the effective date of Florida Senate Bill 2526 through the effective end date of the ARP statutory period.
   b) This expenditure authority will terminate at any time the state fails to offer postpartum coverage to pregnant individuals in both Medicaid and CHIP, exactly as prescribed in

statute, while the legal provisions of the ARP are in effect.

TITLE XXI EXPENDITURE AUTHORITY:

1. **Expenditures for Benefits for Postpartum Individuals.** Expenditures for CHIP state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, as described in STC 61.
   a) For CHIP "lawfully residing" pregnant and postpartum individuals covered by the state under sections 2107(e)(1)(O) of the Act, this expenditure authority starts from the effective date of Senate Bill SB 2526 through the effective end date of the ARP statuary period.
   b) This expenditure authority will terminate at any time the state fails to offer postpartum coverage to pregnant individuals in both Medicaid and CHIP, exactly as prescribed in statute, while the legal provisions of the ARP are in effect.

2. **Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12 Month Postpartum Period.** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 61.
   a) For CHIP "lawfully residing" pregnant and postpartum individuals covered by the state under sections 2107(e)(1)(O) of the Act, this expenditure authority starts from the effective date of Florida Senate Bill 2526 through the effective end date of the ARP statutory period.
   b) This expenditure authority will terminate at any time the state fails to offer postpartum coverage to pregnant individuals in both Medicaid and CHIP, exactly as prescribed in statute, while the legal provisions of the ARP are in effect.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00206/4 and 21-W-00069/4**

TITLE: **Florida Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) 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 or section 2107(e)(2)(A)) 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 extension is no earlier than the date of the extension approval through June 30, 2030.

These STCs have been arranged into the following subject areas:

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 uninsured 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, at that time, provided CMS and the public with the information necessary to effectively monitor and evaluate the MMA

[1] 1 For the "Comprehensive Program Description and Objectives," see Attachment B.

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 individuals, individuals within the state-authorized postpartum coverage period, 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 February 18, 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 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.

On January 15, 2021 the demonstration was extended through June 30, 2030 with the following changes:

- Clarified budget neutrality rebasing will occur in demonstration year DY17 and DY 22;
- Modified the LIP by requiring essential providers to make a good faith effort to contract with each managed care plan in the state, resizing the pool amount, aligning the date of LIP reconciliation, and requiring more frequent periodic monitoring calls with CMS;
- Added needs-based criteria for populations for which services under the behavioral health and supportive housing assistance pilot may be appropriate;
- Extended the behavioral health and supportive housing assistance pilot through June 30,
- 2025; and
- Updated evaluation requirements for the waiver of retroactive eligibility, including a revised Evaluation Design and a Monitoring Protocol, which describes the metrics the state will report quarterly and annually throughout the demonstration extension period.

In accordance with the passage of Florida Senate Bills (SB) 2500 and SB 2518, on September 20, 2021, Florida submitted an amendment to extend postpartum coverage to 12 months following the last day of pregnancy, to allow certain non-profit licensed behavioral health providers to be eligible to receive LIP, and to remove the administrative requirement for Florida to submit a letter to CMS each year following the legislative session reauthorizing the waiver of

retroactive eligibility as well as the essential provider contracting requirement. On March 14, 2022, in response to discussions with CMS, the state received additional legislative authority, under Senate Bill 2526, to also extend the 12 months of postpartum coverage to pregnant individuals enrolled in the Children's Health Insurance Program (CHIP), to align with the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2).

On May 25, 2022, an amendment was approved to the demonstration to permit Florida to extend state plan coverage to 12 months for postpartum individuals in both Medicaid and CHIP in accordance with sections 9812 and 9822 of the ARP. For Medicaid, the extended postpartum coverage is provided to postpartum individuals who have household income up to 191 percent of the federal poverty level (FPL). For CHIP, the extended postpartum coverage is provided to postpartum individuals with family income from 134 up to and including 210 percent of the FPL. Section 9812 and 9822 of the ARP requires states who elect to extend 12 months of postpartum coverage to extend such coverage in both Medicaid and CHIP. The state also provides continuous eligibility for these individuals during the entire postpartum period in accordance with the ARP, ensuring continuity of coverage. The approval also allows for certain non-profit licensed behavioral health providers to be eligible to receive funding from the uncompensated care pool, known in Florida as the Low-Income Pool.

On January 17, 2025, an amendment was approved to the demonstration to make various modifications to coverage and program operations. These changes include expanding the Behavioral Health and Supportive Housing Assistance Pilot to two additional regions; providing voluntary populations who enroll into MMA or the dental managed care program a choice of MMA managed care plans and dental managed care plans and auto-assignment if no choice is made; providing coverage of behavior analysis services through managed care instead of the fee-for-service (FFS) delivery system; providing coverage of non-emergency dental services provided in an ambulatory surgical center (ASC) or hospital through dental managed care plans instead of MMA plans; and incorporating specialty products into comprehensive managed care plans.

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, FQHCs and 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.
- 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 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of Medicaid **and CHIP** 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 and CHIP 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 **or CHIP** programs 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.**

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

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 agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar 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 these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and 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. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received

and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
c. 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;
d. An up-to-date CHIP allotment worksheet, if necessary;
e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and monitoring 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;

   a. 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 a notification letter and a draft transition and phase-out plan to CMS no less than six 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 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and 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, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will

undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to determining the individual ineligible as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 457.350. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/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 and title XXI, as applicable. 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's 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state will 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.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 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, or as 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.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

16. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR Part 438, except as explicitly provided to the contrary in this STC 16. 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 FFS Provider Service Networks (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 85 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 85 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 3 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.

17. **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

18. **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

19. 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 individuals (including during the state's authorized postpartum coverage 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 state authorized postpartum coverage 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 17 and the AIDS CNOM Eligibility Group defined in STC 18.

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.

20. 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 19.

21. 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 Assistance	Children for whom IV-E foster care maintenance payments are made or an adoption assistance agreement is in effect – no Medicaid income limit.	Title XIX	TANF & Related Grp
Pregnant women	Income no more than 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) Payment Standard in effect as of 7/16/1996 (Families whose income is no more than about 31% of the FPL).	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 Adoption Assistance under age 18	Who have an adoption assistance agreement not under title IV-E.	Title XIX	TANF & Related Grp
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit.	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 21(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 21(c).	Title XIX	Aged/Disabled
Demonstration Only Groups			
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) • **Medicare** Eligible receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Individuals diagnosed with AIDS	• 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

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 24.

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 due to 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).

22. 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 55, 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.

23. New Enrollees. 42 CFR 438.71 requires choice counseling for all beneficiaries 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 or who are voluntary for enrollment in an MMA or dental plan must receive information, as specified in 42 CFR 438.54(d)(3) and (c)(3). 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, both mandated and voluntary enrollees, will be enrolled in an 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 an 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. After the 120-day change/disenrollment period, individuals who are voluntary enrollees may still disenroll at any time. 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.

24. 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.

25. **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 42 CFR 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 42 CFR 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 24.

    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 24 above.

b. If an applicable specialty plan or product is available, as described in STC 37, the recipient should be assigned to the specialty plan or opt-in to the specialty product.

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 product; 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.

26. 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

27. 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 28 through 31, in accordance with section 409.973 Florida Statutes (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 Early and Periodic Screening, Diagnostic, and Treatment (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.

28. **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.

29. **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 30. 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.

30. **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.

31. **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

32. **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.

33. **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

34. **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 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 PSNs, 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 Part 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 Part 438.

c. Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP)- Entities that meet the definition or PIHP or PAHP as described in 42 CFR 438.2 and which must conform to all requirements in 42 CFR Part 438 that apply to PIHPs and PAHPs.

35. **Eligible Plan Selection.** The state will procure a specified number of MMA plans per region in accordance with section 409.974, F.S.. 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.

    The state will procure at least two statewide dental plans for the PDHP in accordance with section 409.973(5), F.S. 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.

36. **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.

37. Specialty Products. A specialty product is defined as a part of an MMA plan that enrolls special needs individuals and that has been approved by the state to offer a specialty product to provide medical services. Specialty products are designed for a target population, for example, children with chronic conditions, or recipients who have been diagnosed with HIV/AIDS. Participation of specialty products will be subject to competitive procurement with the exception of the Children's Medical Services Plan, which will remain a standalone specialty plan operated by the Florida Department of Health which is not subject to competitive procurement. With the exception of MMA plans with a child welfare specialty product and the Children's Medical Services Plan, enrollment for specialty products will not be automatic and will require enrollees to opt in to the services. Enrollees eligible for specialty products will receive written communication informing them that they must contact choice counseling in order to accept the enrollment. 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. Voluntary specialty products will meet 42 CFR §438.3(e) and 42 CFR §438.16 requirements.

38. The state may approve specialty products 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 product's provider network. The state may not approve products 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 products 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.

39. Requirements for Special Populations.

a. HIV Specialty Products

i. The state will notify beneficiaries identified with a diagnosis of HIV or AIDS in writing of their option to enroll in a specialty product, if available, in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty product. The enrollee will have 120-day period following enrollment to change plans or disenroll without cause. These beneficiaries may be identified with a combination of diagnosis codes on claims; HIV or AIDS prescription medications; and laboratory tests and results.

ii. When making assignments to an HIV/AIDS specialty products, the state will consider the beneficiary's PCP and/or current prescriber of HIV or AIDS medications.

iii. When making assignments to HIV/AIDS specialty products 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 product, the state will assign the beneficiary to a specialty product available on a rotating basis.

iv. When making assignments to HIV/AIDS specialty product of beneficiaries who are determined to have co-morbid conditions, the state may assign the beneficiary to the most appropriate specialty product available in the beneficiary's region.

b. MMA Plans with Children's Specialty Products

i. The state may elect to contract with MMA Plans with Children's Specialty Products to serve Foster Care Children. These products will have special requirements for immediate assessment, care coordination, and treatment of Foster Care Children. The MMA Plans with Children's Specialty Products 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 any MMA 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 an MMA Plan with Children's Specialty Products available in the region.

40. 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

41. 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.

42. 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.

43. **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.

44. **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.

45. **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);

46. **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.

47. **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 monitoring 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 all beneficiaries. This is additional instruction about how the state must comply with this regulation.

48. **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.

49. **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.

50. **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.

51. **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.

52. **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

53. **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

54. **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 through June 30, 2025, 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. BH Supportive Housing Pilot Eligibility is available to individuals who meet one of the following target groups and meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Targeting Criteria:

1. **Serious Mental Illness** - General descriptor for one, or a combination of the following diagnostic categories: psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder. Members must be identified using the Agency's SMI algorithm and be flagged as such on the plan's 834 enrollment file.
2. **Substance Use Disorder** - General descriptor for the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. (Substance Abuse and Mental Health Services Administration). *Members must have a diagnosis code in the range of F10-F16 and F18-F19.*
3. **Co-occurring Disorders** – The coexistence of both a serious mental illness and a substance use disorder.

b. Needs-Based Criteria:

The individual is assessed to have a behavioral or substance use health need, which is defined as a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness and/or substance use disorder; and the individual meets at least one of the following risk factors:

1. Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3.

OR

2. At risk of homelessness as defined in 24 CFR 578.3 due to their disability.

c. The Behavioral Health and Supportive Housing Assistance Pilot will be available in MMA regions A, B, C and E 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
DY 17 (SFY 2022; July 1, 2022, through June 30, 2023)	50,000
DY 18 (SFY 2023; July 1, 2023, through June 30, 2024)	50,000
DY 19 (SFY 2024; July 1, 2024, through June 30, 2025)	50,000

d. Participating MMA Plans in the pilot program must either be a plan that provides MMA services or MMA services and a specialty product 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 21, and who meet all of the following requirements:

i. Provide services under the MMA program in regions A, B, C, and E,

ii. Include providers furnishing services in accordance with Chapters 394 and 397 of Florida Statues Substance Abuse Services in its provider network,

iii. Have the capability to provide supportive housing assistance services specified in STC 54(c) below through agreements with housing providers specified in STC 54 (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.

e. 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.

f. Enrollee Appropriateness Criteria. This pilot program is designed to provide necessary services for Florida Medicaid recipients aged 21 years 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.

g. HCBS Assurances.

1. As a part of its approved Quality Improvement Strategy, the state must develop performance measures for services that could have been authorized to individuals under a 1915(i) HCBS State plan 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 54(c)(iii) and (iv).

D. Settings meet the home and community-based setting requirements as specified in STC 54 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.

H. 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.

I. 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.

J. The state will submit a report to CMS 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 Measures and Reporting in 1915(c) Home and Community-Based Waivers. NOTE: This information will be captured in the 1115 Annual Monitoring Reports detailed in STC 76.

K. CMS will evaluate each evidentiary report to determine whether the assurances have been met.

L. During the demonstration period, the state must conduct an evaluation to accomplish the following: assess if the pilot program can be

transitioned to a 1915(i) HCBS State plan benefit and how such transition is 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 a 1915(i) authority. By July 1, 2024, the state must submit a plan to CMS for transition of the pilot program to a 1915(i) HCBS State plan benefit.

2. Pilot Evaluation. The state must develop an Evaluation Design for the pilot program in collaboration with CMS. The draft Evaluation Design should be submitted to CMS for review and approval within 180 calendar days of approval of this demonstration.

i. The State will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

ii. HCBS Beneficiary Protections:

(1) Person-centered planning: The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.725 and the written person-centered service plan meets federal requirements at 42 CFR 441.725(b). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
(2) Conflict of Interest: The state agrees to ensure that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees to ensure that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
(3) The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

55. 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 24. Individuals may choose a different dental plan prior to enrollment and during the 120-day change/disenrollment-period without cause post-enrollment.

56. 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.

57. 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.

58. 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 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 up to the age of 3 identified as 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:

i. Information;
ii. Education and Referral on Identified Risks;
iii. Assessment;
iv. Case Coordination;

[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

v. Childbirth Education;
vi. Parenting Education;
vii. Tobacco Cessation;
viii. Breastfeeding Education;
ix. Nutritional Counseling; and
x. Psychosocial Counseling.

The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

59. 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.

60. 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), Stimate (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.

61. **Postpartum Extension.** The state will extend postpartum coverage for individuals from the end of the state plan 60-day postpartum period to the end of the 12th month following the end of the pregnancy.

To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any CHIP or Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum coverage will remain enrolled continuously regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.

The state will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916 and 42 CFR 457.343. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916(f)(1) prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 C.F.R. 435.917 and 42 C.F.R. Part 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f)(2). Separate CHIP enrollees determined to be no longer eligible for CHIP must be screened for eligibility in other insurance affordability programs in accordance with 42 CFR 457.350(b), and receive timely written notice of termination in accordance with 42 CFR 457.340(e).

a. **Postpartum Coverage Monitoring and Evaluation**. Monitoring reporting and

evaluation for the postpartum extension component of the demonstration will be subject to the requirements that are also applicable for the overall demonstration monitoring and evaluation, as described in Section XVI on General Reporting Requirements and Section XX on Evaluation of the Demonstration of the STCs. The state will be required to amend its Evaluation Design to account for policy changes outlined in this amendment, including but not limited to evaluating the impact of extending the postpartum period from 60 days to 12 months.

b. **Implementation.** The statutory language of sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP), requires states who elect to extend 12 months of postpartum coverage to extend such coverage in both Medicaid and CHIP. The state's proposal to extend Medicaid coverage up to 12 months for postpartum individuals may not be implemented until the effective date of Florida Senate Bill (SB) 2526, which provides title XXI funded individuals coverage for the duration of pregnancy and the postpartum period consisting of the 12-month period beginning on the last day of a pregnancy, as required in the ARP (Pub. L. 117-2). To ensure federal drawdown of allowable claims in accordance with statute, the state is required to submit a letter notifying CMS when Florida SB 2526 has become effective, at which time the postpartum extension for both Medicaid and CHIP individuals may be implemented.

   While the legal provision of the ARP is in effect, the state is required to extend 12 months of postpartum coverage to pregnant individuals in both Medicaid and CHIP. If at any time, while the ARP is in effect, postpartum benefits are not extended to postpartum individuals in either CHIP or Medicaid, exactly as prescribed in statute, the postpartum expenditure authority authorized through these STCs will automatically terminate.

c. Enrollment upon the Effective Date of the Postpartum Extension Period: Upon the effective date of this approval, individuals who are within 12 months postpartum, but whom are outside of the state plan 60-day postpartum coverage period, may be enrolled or reenrolled in Medicaid or CHIP for the purpose of receiving extended postpartum coverage for the period of time that equates to the end of the 12th month following the end of the pregnancy. These individuals enrolled in the extended postpartum coverage period, not immediately following pregnancy but at a later point in time within the 12-month coverage period, are only eligible for the period of time that remains prior to the end of the 12th month following the end of the pregnancy. For example, an eligible individual who is enrolled in the fourth month following pregnancy, will only be eligible to receive eight additional months of continuous postpartum coverage.

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. LIP payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals. The resulting total

computable (TC) dollar limit is enumerated in STC 63(a).

63. Availability of Low Income Pool (LIP) Funds. The following STC presents the TC dollar limit for LIP spending, subject to the assurances that follow.

a. **Total LIP Amount.**

LIP Approval Periods	TC Dollar Limit for LIP Expenditures in Each DY
DY 12 – DY 16	**$1,508,385,773**
DY 17 – DY 21	**$2,167,718,341**
DY 22 – DY 24	**TBD**

b. **Assurance.** As reflected in the LIP participation requirements in STC 70, 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.

c. **Reassessment of Hospitals' Uncompensated Charity Care in DY17.** Low Income Pool limits for DY 17-21 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2022. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for federal fiscal year 2019 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 17-21.

i. If the reassessment discussed in in this STC is not completed to produce an updated LIP limit by July 1, 2022, all payments from the LIP will be unavailable until the reassessment is complete.

ii. When the 2019 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 17-21 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 17-21.

iii. The revised Total LIP Amount may not exceed $2,167,718,341 per DY, for the period covered by DY 17-21.[4]

d. **Reassessment of Hospitals' Uncompensated Charity Care in DY22.** Low Income Pool limits for DY 22 – DY 24 will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2027. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for periods beginning in federal fiscal year 2025 on schedule S-10 of the CMS 2552-10

[4] See Comprehensive Program Description and Objectives listed below in attachment A

hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 22 -DY 24.

i. If the reassessment discussed in this STC is not completed to produce an updated LIP limit by July 1, 2027, all payments from the LIP will be unavailable until the reassessment is complete.

ii. When 2025 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 22 - DY 24 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 22 - DY24.

iii. The revised Total LIP Amount may not exceed $2,167,718,341 per DY for the period covered by DY 22-24.[5]

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.

a. 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.

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 that has been examined and attested by an independent accountancy firm to CMS within four years after the end of each DY showing cost reconciliation results by provider as required under 42 CFR. 455.304. 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

[5] See Comprehensive Program Description and Objectives listed below in attachment A

10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue 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 to defray the actual uncompensated cost of furnishing medical services described in section 1905(a)(1) et seq. of the Act to uninsured individuals incurred by qualifying providers.

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 publicly 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 (1) 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 (1) through (3) 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. LIP Provider Participation Requirements. In addition to any other applicable requirements, to be eligible for LIP funding, essential providers must offer to contract with each managed care plan in the state and must make a good faith effort to enter into a network contract with each statewide Medicaid managed care (SMMC) plan. "Essential providers" are defined as faculty plans of Florida medical schools and hospitals licensed as specialty children's hospitals.[6] If the state determines that an essential provider has not offered and negotiated in good faith to enter into a network contract with each managed care plan, then the state will notify the essential provider at least 90 days in advance of the start of the third quarter of the state fiscal year that LIP payments will not be made to the essential provider beginning with the third quarter of the state fiscal year and informing the essential provider how it may avail itself of hearing rights.

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 70(a)(ii) below, upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Product. A letter from a Specialty Product 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 70(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. <u>Hospitals.</u>

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 Product for each target population that is served by a Specialty Product in their corresponding region.

[6] As detailed on AHCA's website, "Statewide essential providers include: (1) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine, Florida State University College of Medicine, and Florida International University College of Medicine." Available at https://ahca.myflorida.com/ITNR/REGION%2002/MAGELLAN/Exhibit%20A-4-b,%20MMA%20Submission%20Requirements/Attachments/MMA%20SRC%2009-Attachment%202_Network%20Adequacy%20Standards%20Policy.pdf.

iii. Must participate in the Florida Encounter Notification Service[7] 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.

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

[7] Available at https://www.florida-hie.net/ens/index.html.

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. Non-profit licensed behavioral health providers who provide behavior health services that have both non-profit status and are licensed that participate in the coordinated system of care in counties that have implemented indigent care programs.

iii. Community Behavioral Health providers is a LIP provider category effective as of December 1, 2018.

iv. Must be enrolled in Medicaid.

71. 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 Medicaid website.

XVI. GENERAL REPORTING REQUIREMENTS

72. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (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 are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The follow process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the

state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required monitoring reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

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

74. 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.

75. Monitoring Protocol. The state must submit to CMS a draft Monitoring Protocol no later than one hundred and fifty (150) calendar days after the start date of the demonstration approval period. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated into the STCs as Attachment D.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct

quarterly and annual monitoring in accordance with CMS's templates. Any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics, CMS will provide the state with a set of required metrics and technical specifications for data collection and analysis covering reporting topics such as enrollment, access to care, quality of care and health outcomes. In addition, CMS will provide the state with metrics related to the key policies being tested under this demonstration, including but not limited to, incentives for healthy behaviors (e.g., utilization of programs outlined in STC 53 and 53a) and the waiver of retroactive eligibility. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

76. Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate monitoring report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The monitoring reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the monitoring report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. 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.

a. Operational Updates – The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The Monitoring 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 issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's annual goals and overall targets, where applicable. As will be identified in the approved Monitoring Protocol, Monitoring Reports will cover key policies under this demonstration, including but not limited to incentives for healthy behaviors (e.g., utilization of programs outlined in STC 53 and 53a) and waivers of retroactive eligibility. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, completion of incentivized healthy behaviors and rewards granted, unpaid medical bills at application (if available), access to care, and quality of care and health outcomes. The state will also be required to report certain metrics related to postpartum coverage. Performance metrics will also include enrollment and utilization information for specialty products to support monitoring the implementation and transition from specialty plans into MMA plans as a specialty product, as well as the expanded Behavioral Health and Supportive Housing Assistance Pilot.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings – Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. 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.

77. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the

right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring indicates indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 9. CMS will withdraw an authority, as described in STC 9, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

78. Close out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS's comments for incorporation into the final Close Out Report.
d. A revised Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.
e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 72.

79. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

80. 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 Monitoring 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 in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

XVII. GENERAL FINANCIAL REQUIREMENTS

81. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

82. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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.

83. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share

sources for any amendments that CMS determines may financially impact the demonstration.

84. Pending Litigation. To the extent any of these Special Terms and Conditions ("STCs") relate to obligations that CMS interprets to be required under section 1903(w) of the Social Security Act (the "Act") and are the subject of pending litigation between the State of Florida and CMS regarding CMS's interpretation of section 1903(w), as stated in CMS's information bulletin dated February 17, 2023 and entitled "Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments" (the "Bulletin"), *See Fla., et al. v. Brooks-LaSure, et al.*, No. 23-CV-61595-WPD, 2024 WL 962433 (S.D. Fla. Mar. 6, 2024), *appeal pending*, No. 24-10875 (11th Cir.) (the "Litigation"), Florida is under no obligation to comply with such STCs if CMS policy is set aside or stayed by any court of competent jurisdiction. Furthermore, until January 1, 2028, CMS will not enforce sections 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act and 42 CFR § 433.68(b)(3) and (f) with respect to health care-related tax programs with hold harmless arrangements involving provider payment redistributions that existed as of April 22, 2024. *See* "Exercise of Enforcement Discretion until Calendar Year 2028 for Existing Health Care-Related Tax Programs with Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments," CMS Informational Bulletin (April 22, 2024).

85. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made

in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. 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, 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.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

86. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

87. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

88. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than January 31, 2026. This deliverable is subject to the deferral as described in STC 72. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

89. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section XVIII:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability;

90. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

91. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEGs) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table (Table 2) provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Aged/ Disabled	Main test	X		X	Medical assistance expenditures for Aged and disabled demonstration enrollees.
TANF & related grp	Main test	X		X	Medical assistance expenditures for TANF demonstration enrollees.
AIDS CNOM	Main test			X	Medical assistance expenditures for AIDS demonstration enrollees
Healthy Start CNOM	Main test			X	Healthy Start expenditures.
PACC CNOM	Main test			X	PACC expenditures
LIP	Hypo 1		X	X	Low Income Pool expenditures
MEDS AD	Hypo 2	X		X	Medical assistance expenditures for MEDS AD demonstration enrollees

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
BH SH Pilot	Hypo 3		X	X	Behavioral Health and Supportive Housing Assistance Pilot expenditures
Postpartum Extension	Hypo 4	X		X	Postpartum Extension expenditures
ADM	N/A			X	Additional administrative costs that are directly attributable to the demonstration

92. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS, (11-W-00206/4 and 21-W-00069/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs. The state will work with CMS to develop a method of reporting spending on dental care through the health plans.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have 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 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. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. Administrative Costs. The state will 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. Unless indicated otherwise on the MEG Charts and in the STCs in section XVIII, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section XVI, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Aged/ Disabled	Medicaid assistance expenditures for all participating individuals defined as Aged/Disabled in Table 1	See Excluded Services[8] and Excluded from MMA Program Participation STC 21(d). Exclude AIDS CNOM, Healthy Start CNOM, and PACC CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/06	6/30/30
TANF & related grp	Medicaid assistance expenditures for all participating individuals defined as TANF & related grp in Table 1	AIDS CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/06	6/30/30

[8] Excluded services: Home and Community Based Service Waiver Services (Model Waiver (formerly Katie Beckett Model Waiver Services), Familial Dysautonomia, Development Disabilities Individual Budgeting); Long Term Care Waiver; ICF/IID Institutional Services; School Based Administrative Claiming; Prescribed pediatric extended care (PPEC) services; County matching programs (Substance Abuse and Medicaid Certified School Match Services); State Mental Health Hospital services for recipients aged; Certain physician-injectable procedures; Vaccines for Children program for MediKids.

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
AIDS CNOM	Medicaid assistance expenditures for all participating individuals in AIDS Program	Healthy Start CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30
Healthy Start CNOM	Medicaid assistance expenditures for all participating individuals in Healthy Start Program	PACC CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30
PACC CNOM	Medicaid assistance expenditures for all participating individuals in Program for All Inclusive Care for Children	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
LIP	Medical assistance expenditures for categorically needy individuals without Medicare receiving HCBS services (of the kind listed in Table 5) in the STAR+PLUS service areas, per Expenditure Authority 1	None	Use Line 1C Inpatient Hospital - Sup. Payments or Line 5B Physician & Surgical Services - Sup. Payments	Date of payment	MAP	N	7/1/06	6/30/30
MEDS AD	All expenditures that count against UC Pool limits	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/17	6/30/30
BH SH Pilot	All expenditures for the Behavioral Health and Supportive Housing Assistance Pilot	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/19	6/30/30
Postpartum Extension	All expenditures for the Postpartum Extension	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	Upon the effective date of Florida SB 2526	6/30/30

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
ADM	Additional administrative costs that are directly attributable to the demonstration	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N/A	7/1/06	6/30/30

93. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 4: Demonstration Years

Demonstration Year 15	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 16	July 1, 2021 to June 30, 2022	12 months
Demonstration Year 17	July 1, 2022 to June 30, 2023	12 months
Demonstration Year 18	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 19	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 20	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 21	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 22	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 23	July 1, 2028 to June 30, 2029	12 months
Demonstration Year 24	July 1, 2029 to June 30, 2030	12 months

94. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the

demonstration's actual expenditures to the budget neutrality expenditure limits described in section XVIII. CMS will provide technical assistance, upon request.[9]

95. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will 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 budget neutrality.

96. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit 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 section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded

[9] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

97. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 97(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XVIII. MONITORING BUDGET NEUTRALITY

98. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

99. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 2, Master MEG Chart and Table 3, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

100. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

101. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 5. Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
Aged/Disabled	PC	Both	4.7%	$1,313.67	$1,375.41	$1,440.05	$1,507.73	$1,578.59
TANF & Related Group	PC	Both	5.6%	$286.04	$302.06	$318.98	$336.84	$355.70
AIDS CNOM	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Healthy Start CNOM	Agg	WW only	N/A	The state must have savings to offset these expenditures.				

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
PACC CNOM	Agg	WW only	N/A	The state must have savings to offset these expenditures.				

102. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

103. Hypothetical Budget Neutrality Test 1: LIP. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
LIP	Agg	Both	N/A	$2,167,718,341	$2,167,718,341	$2,167,718,341	$2,167,718,341	$2,167,718,341

104. Hypothetical Budget Neutrality Test 2: MEDS AD. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7. Hypothetical Budget Neutrality Test 2

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
MEDS AD	PC	Both	4.7%	$1,244.87	$1,303.38	$1,364.64	$1,428.78	$1,495.93

105. Hypothetical Budget Neutrality Test 3: BH SH Pilot. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8. Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
BH SH Pilot	Agg	Both	N/A	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500

106. Hypothetical Budget Neutrality Test 4: Postpartum Extension. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9. Hypothetical Budget Neutrality Test 4

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 17	DY 18	DY 19	DY 20	DY 21
Postpartum Extension	PC	Both	4.6%	$370.40	$387.43	$405.25	$423.89	$443.39

107. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining

to each particular test.

108. Rebasing. The budget neutrality limits for this demonstration were rebased consistent with the requirements outlined in State Medicaid Director Letter (SMDL) #18-009 and other CMS guidance. In 2027, this demonstration will need to be rebased again using the new SMDL #24-003. CMS will recalculate the LIP UC limits as part of the rebasing calculation. The new PMPMs and UC from the July 1, 2027, rebase will be effective from DY 22 to DY 24.

109. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 1/15/2021 to 6/30/2030. If at the end of the demonstration approval period, the Main Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

110. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 10. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 17	Cumulative budget neutrality limit plus:	2.0 percent
DY 17 through DY 18	Cumulative budget neutrality limit plus:	1.5 percent
DY 17 through DY 19	Cumulative budget neutrality limit plus:	1.0 percent
DY 17 through DY 20	Cumulative budget neutrality limit plus:	0.5 percent
DY 17 through DY 21	Cumulative budget neutrality limit plus:	0.0 percent

XIX. FINANCIAL AND ALLOTMENT NEUTRALITY MONITORING REQUIREMENTS UNDER TITLE XXI

111. Scope of FFP for Title XXI Demonstration Expenditures. CMS will provide FFP only for the medical assistance services described in STC 61 and associated administrative expenditures. CMS will provide FFP as outlined below, subject to the state's title XXI allotment limit:

a. Administrative costs, including those associated with the administration of the demonstration.
b. Net expenditures and prior period adjustments that are paid in accordance with the approved CHIP state plan.

c. Medical assistance expenditures made under this demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability or CMS payment adjustments.

112. Reporting Expenditures Subject to the Title XXI Allotment. The following describes the reporting of title XXI expenditures authorized under this demonstration, subject to the state's title XXI allotment limit:

a. Tracking Expenditures: In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms: Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate forms CMS-21 Waiver and/or CMS-21P Waiver using the waiver name "Postpartum Extension."

c. Claiming Period: All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

113. Standard CHIP Funding Process. The standard CHIP funding process will continue to be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the CHIP demonstration population. 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-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

114. Title XXI Administrative Costs. Administrative costs will not be included in the allotment neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "CHIP ADM".

115. Limit on Title XXI Funding. The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on current eligible CHIP state plan populations and the demonstration population described in STC 21(d) during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

116. Exhaustion of Title XXI Funds. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI state plan separate child health program population and the demonstration population described in STC 61 with state funds.

XX. EVALUATION OF THE DEMONSTRATION

117. 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 72.

118. Independent Evaluator. Upon approval of the demonstration, the state must begin to 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 state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

119. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design pertinent to this demonstration extension period, no later than one hundred eighty (180) calendar days after the approval of this extension. The draft Evaluation Design must be developed in accordance with Attachment B (Developing the Evaluation Design) of these STCs and must include timeline for key evaluation activities including evaluation deliverables, as outlined in STCs 123 and 124. The state may choose

to use the expertise of the independent party in the development of the draft Evaluation Design.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

(a) Attachment B (Developing the Evaluation Design) of these STCs, and all applicable technical assistance on applying robust evaluation approaches, including how to establish causal inference and comparison groups in developing a strong Evaluation Design.

(b) All applicable Evaluation Design guidance, including guidance about waiver of retroactive eligibility and overall demonstration sustainability.

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 STC 121. 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.

120. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar 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 a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

121. Evaluation Questions and Hypotheses. Consistent with Attachments B and C (Developing the Evaluation Design and Preparing the Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component 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).

The evaluation must outline and address well-crafted hypotheses and research questions for all of the following demonstration components:

a. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
b. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
c. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
d. The impact of LIP funding on hospital charity care programs;
e. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals;
f. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner;
g. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services;
h. The impact of the waiver of retroactive eligibility on beneficiaries and providers. Hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity).
i. 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.
j. The impact of extending postpartum coverage from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy.
k. In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.
l. The impact of voluntary enrollees ability to select an MMA plan and dental plan.
m. The impact of coverage and access to care for specialty services which are being transitioned to specialty products under MMA plans.
n. The impact on coverage and access to care for dental services in alignment with the transition from MMA to dental managed care plans.

The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

122. 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, or if the estimates appear to be excessive.

123. Interim Evaluation Reports. The state must submit three Interim Evaluation Reports for the completed years of the demonstration specified in subparagraph c, 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 Reports will discuss evaluation progress and present findings to date as per the approved Evaluation Design, and address the evaluation questions described in STC 121.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report(s) must include an evaluation of the authority as approved by CMS.

c. The state must provide draft Interim Evaluation Reports for the corresponding years described below. The state must submit a revised Interim Evaluation Report for each Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the corresponding draft report. The final version of each of the Interim Evaluation Reports must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

    i. A Draft Interim Evaluation Report for demonstration years 15-17 (July 1, 2020 – June 30, 2023) will be due no later than December 31, 2024.

    ii. A Draft Interim Evaluation Report for demonstration years 15-19 (July 1, 2020 – June 30, 2025) will be due no later than December 31, 2026.

    iii. A Draft Interim Evaluation Report for demonstration years 15-22 (July 1, 2020 – June 30, 2028) will be due no later than December 31, 2029.

d. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report, representing demonstration years 15-22 (July

1, 2020 – June 30, 2028) is due when the application for renewal is submitted. If the state is not requesting a demonstration extension, the last draft Interim Evaluation Report, as noted in c(iii) above, 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.

e. The Interim Evaluation Reports must comply with Attachment C (Preparing the Evaluation Reports) of these STCs.

124. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment C (Preparing the Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period by December 31, 2031 (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 a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

125. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report(s). A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services, increases in provider uncompensated care costs). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

126. 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, the Interim Evaluation Reports, and/or the Summative Evaluation Report. Presentation may be conducted remotely.

127. Public Access. The State shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Reports, and

Summative Evaluation Report) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

128. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to 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 over which the state has control. 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 ten (10) business 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. This requirement does not apply to the release or presentation of these materials to state or local government officials.

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

129. 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.

130. 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.

131. Performance Improvement Projects (PIP). In accordance with 42 CFR §438.330, the state must require each managed care plan, including each dental plan and the Children's Medical Services 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 and the Children's Medical Services Plan, to complete PIPs in focus areas that have the significant potential for achieving the demonstration's approved goals. Specialty products may conduct PIPs on topics more specific to their enrolled population, subject to approval by the state.

132. 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.

XXII. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
Within 150 calendar days of the demonstration approval	Monitoring Protocol	Section XVI, STC 75
60 days following the end of the quarter	Quarterly Monitoring Report	Section XVI, STC 76
90 days following the end of the DY	Annual Monitoring Report	Section XVI, STC 76
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 85
Before August 31, Annually	LIP Draft RFMD	Section XIV, STC 65
Within 4 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 71
October 1, Annually	LIP Provider, UC and IGT final report	Section XV, STC 71
Within 180 calendar days of the demonstration approval	Draft Evaluation Design	Section XIX, STC 119
No later than December 31, 2024	Draft Interim Evaluation Report 1 (DY15 – DY17)	Section XIX, STC 123
No later than December 31, 2026	Draft Interim Evaluation Report 2 (DY15 – DY19)	Section XIX, STC 123
No later than December 31, 2029 or with application for renewal	Draft Interim Evaluation Report 3 (DY15 – DY 22)	Section XIX, STC 123
Within 18 months of the end of the approval period	Draft Summative Evaluation Report	Section XIX, STC 124
March 31, 2021	Draft Budget Neutrality with LIP Data Rebasing Workbook	STC 108
March 31, 2027	Draft Budget Neutrality with LIP Data Rebasing Workbook	STC 108

ATTACHMENT A
HISTORICAL 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.[11]

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.[12]

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

[11] For the "Comprehensive Program Description and Objectives," see Attachment B.
[12] http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589

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 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 need rigorous quantitative and qualitative evidence to inform policy decisions.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups, identifying causal inferences, phasing implementation to support evaluation, and designing and administering beneficiary surveys are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115- demo/evaluation-reports/evaluation-designs-and-reports/index.html. If the state needs additional technical assistance using this outline or developing the evaluation design, the state should contact the demonstration team.

Expectations for Evaluation Designs

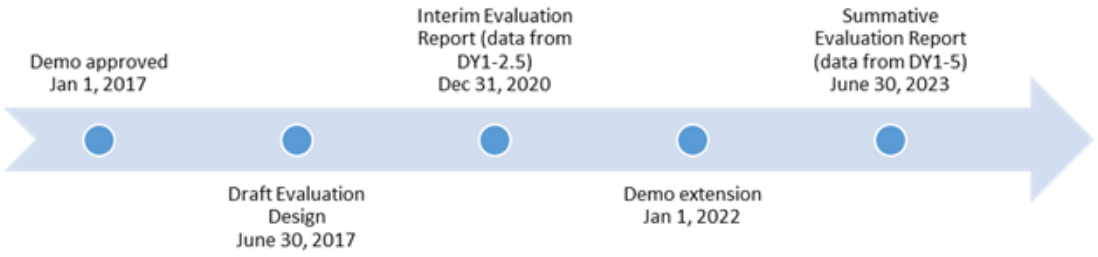
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances

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 a deliverables timeline for a 5-year demonstration). 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 thirty (30) calendar 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. Copies of any proposed surveys must be reviewed with CMS for approval before implementation.

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.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

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.

F. Attachments

1. *Independent Evaluator.* This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure 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. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. *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, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. *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 the Interim Evaluation Reports 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 REPORTS

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 need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct evaluations that are 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. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the final Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Reports must be included in their entirety with the application submitted to CMS.

Intent of this Attachment

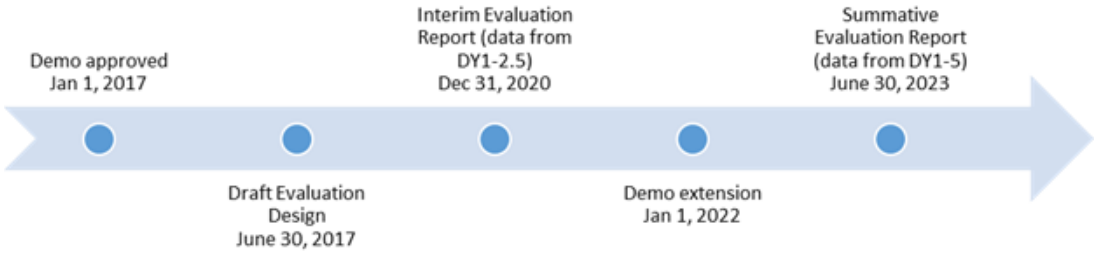
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified 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 a deliverables timeline for a 5-year demonstration). 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 calendar 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 Reports present 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 Reports 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.

The interim reports 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 interim evaluations.

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: APPROVED MONITORING PROTCOL

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Version 2.0)

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Protocol Workbook (Part A) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STCs). This state-specific Part A Workbook reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage demonstration should complete one Monitoring Protocol Template that encompasses every eligibility and coverage policy in its demonstration and the demonstration overall, as outlined in the state's special terms and conditions (STC).[1] CMS will work with the state to ensure there is no duplication in the reporting requirements for different policy components of the demonstration. Each state with an approved eligibility and coverage demonstration should complete one Monitoring Protocol Template (Part B) that applies to each eligibility and coverage policy in its demonstration and the demonstration overall (unlike Part A where every eligibility and coverage policy included in the state's demonstration, as well as the demonstration overall, has a separate section for the state to complete). This state-specific template reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information, the state should contact the section 1115 eligibility and coverage demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov), copying the state's CMS demonstration team on the message.

[1] States should complete Parts A and B for any of the following eligibility and coverage policies included in the demonstration: premiums or account payments, health behavior incentives, community engagement, retroactive eligibility waivers, and non-eligibility periods. There is no standalone Monitoring Protocol Workbook for non-eligibility periods policies. Monitoring metrics that capture non-eligibility periods are captured as part of other standard eligibility and coverage monitoring metrics. For other eligibility and coverage policies that do not have a Monitoring Protocol, such as waiver of non-emergency medical transportation and marketplace-focused premium assistance, states should follow the guidance in the STCs.

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Florida.*
Demonstration name	*Managed Medical Assistance Waiver*
Approval period for section 1115 demonstration	*01/15/2021 – 06/30/2030*
Health behavior incentives	
Health behavior incentives start date[a]	*01/15/2021*
Implementation date, if different from health behavior incentives start date[b]	*N/A*
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	*01/15/2021*
Implementation date, if different from retroactive eligibility waiver start date	*N/A*

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in Sections 3, 4, and 5 of the Monitoring Report Template provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information in quarterly and annual monitoring reports (no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

If a state's monitoring protocol is approved after one or more of its initial quarterly monitoring report submissions, it should report data to CMS retrospectively, for any prior quarters of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. The state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics.

The retrospective report for a state with a first eligibility and coverage demonstration year of less than 12 months, should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the instructions for further guidance determining baseline periods for first eligibility and coverage demonstration years that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Table 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for

instance, the state is not required to describe all metrics changes (+ or -) greater than 2 percent for retrospective reporting periods. Rather, the assessment is an opportunity for the state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not complete renewal and were disenrolled from Medicaid (metric AD_19) over the course of the retrospective reporting period. The state could highlight this change and specify that during this period the state conducted additional outreach to beneficiaries about the renewal process. For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. The state should provide justification for its proposed alternative plan.*

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (AD) (Version 2.0)
State Florida
Demonstration Name Managed Medical Assistance (MMA)

Eligibility and Coverage Demonstration Planned Metrics (AD)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format EandC DY and Q: Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: AD_33 ***(Do not delete or edit this row)***	*EXAMPLE: Preventive care and office visit utilization*	*EXAMPLE: Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period*	*EXAMPLE: 1.1.7 Access to care*	*EXAMPLE: Claims and encounters and other administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE:*	*EXAMPLE: N*	*EXAMPLE: DY1Q4*	*EXAMPLE:*
AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if state has a suspension policy	N				N	The State confirms that it does not have a suspension policy; thus, this metric is not applicable.			
AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if state has a non-eligibility period policy	N				N	The State confirms that it does not have such a policy; thus, this metric is not applicable.			
AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required for states with a defined re-enrollment or re-instatement pathway	N				N	The State confirms that it does not have disenrollment or suspension policies.			
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance)	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	N				N	The State confirms that it does not have a disenrollment policy.			
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Total number of beneficiaries in the demonstration determined ineligible for Medicaid and disenrolled during the measurement period (separate reasons reported in other indicators), other than at renewal	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	N				N	The State confirms that it does not disenroll beneficiaries for failure to provide a change in circumstance.			
AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they are determined ineligible after the state processes a change in circumstance	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	N				N	The State confirms that it does not disenroll beneficiaries after determining that beneficiaries experienced a change in circumstance.			
AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Recommended	N								
AD_12	Enrollment duration, 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	N								
AD_13	Enrollment duration, 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	N								
AD_14	Enrollment duration 7-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 7 or more months (up to 12 months) at the time of disenrollment	1.1.3 Enrollment duration at time of disenrollment	Administrative records	30 days	Month	Quarterly	Recommended	N								
AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y	A request has been sent to the Department of Children and Families to provi	Y	TBD	The Agency is working with the Department of Children and Families to coordinate a phase-in timeline for this metric following the end of the Public Health Emergency.
AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	N				N	The State confirms that it does not have policy that transfers ineligible beneficiaries to CHIP.			
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	N				N	The State confirms that it does not have a policy to keep beneficiaries enrolled for pending or uncompleted renewals.	N		
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Recommended	N				Y				
AD_23	Beneficiaries who reached 5% limit	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month	1.1.5 Cost sharing limit	Administrative records	30 days	Month	Quarterly	Required for states with cost-sharing or premiums	N				N	The State confirms that it does not have a policy for beneficiaries who reach 5% of income limit on cost sharing and premiums during the month.			
AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	N								
AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	1.1.7 Access to care	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly	Required	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	1.1.7 Access to care	Claims and encounters and other administrative records	90 days	Quarter	Quarterly	Recommended	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended. Required for states with copayments for non-emergency use.	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	Y	07/01/2021 - 06/30/2022	Consistent	Consistent	Y		N		
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	1.1.8 Quality of care and health outcomes	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	Y	01/01/2021 - 12/31/2022	Increase	Increase	Y		N		
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N				N				

#	Metric name	Metric description	Reporting topic*	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format ExcelÂ DY and Q, Ex. DY1Q2)	Explanation of any plans to phase in reporting over time
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: 1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2021	Increase	Increase	Y		N		
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2021	Increase	Increase	Y		N		
AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	1.1.8 Quality of care and health outcomes	Claims and encounters or EHR	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2021	Increase	Increase	Y		N		
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2022	Decrease	Decrease	Y		N		
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2022	Decrease	Decrease	Y		N		
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2022	Decrease	Decrease	Y		N		
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	Y	01/01/2021 - 12/31/2022	Decrease	Decrease	Y		N		
AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	1.1.9 Administrative cost	Administrative records	None	Demonstration year	Annually	Recommended	N								
State-specific metrics																	
Add rows for any state-specific metrics																	

* The reporter topics corresponed to the reports for the are demonstration (AD) reporting topic in Section 4 of the monitoring report template.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (HB) (Version 2.0)
State: Florida
Demonstration Name: Managed Medical Assistance (MMA)

Eligibility and Coverage Demonstration Planned Metrics (HB)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic*	Data source	Calculation log	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format: HB DY and Q; Ex. DY1/Q2)	Explanation of any plans to phase in reporting over time
EXAMPLE: HB_7 ***(Do not delete or edit this row)***	*EXAMPLE: Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized health behaviors*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that taken the form of an additional covered benefit or service, by benefit or service type, during the measurement period*	*EXAMPLE: HB.Mod_1: Health behavior incentives*	*EXAMPLE: Administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 10/01/2019 - 01/01/2020*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: Y*	*EXAMPLE*	*EXAMPLE: N*	*EXAMPLE: DY1/Q4*	*EXAMPLE*
HB_1	Total enrollment among beneficiaries subject to health behavior incentives	Number of beneficiaries subject to health behavior incentive policies who were enrolled in the demonstration at any time during the measurement period	HB.Mod_1: Health behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2021 - 12/31/2021	INCREASE	INCREASE	Y		N		
HB_2	Beneficiaries using incentivized services that can be documented through claims, by service	Total number of beneficiaries enrolled in the demonstration at any point during the measurement period who utilized financially incentivized services that can be documented through claims since the beginning of their enrollment spell	HB.Mod_1: Health behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2021 - 12/31/2021	INCREASE	INCREASE	N	1- FL does not have access and cannot provide information for the number of enrollees who have completed an incentivized health behavior only documented through methods other than claims analysis; however, will research the feasibility of obtaining data for completed health incentives not documented through claims analysis and report on the feasibility in a future report to CMS.	Y	DY17Q4	Reporting will be implemented in conjunction with the last quarter of State Fiscal Year 2022-2023.
HB_3	Completion of incentivized health behavior(s) not documented through claims analysis (i.e. health risk assessments), by health behavior	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed each incentivized health behavior not documented through claims analysis (i.e. health risk assessments) since the beginning of their enrollment spell	HB.Mod_1: Health behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	01/01/2021 - 12/31/2021	INCREASE	INCREASE	N	1- FL does not have access and cannot provide information for the number of enrollees who have completed an incentivized health behavior only documented only through claims analysis; however, will research the feasibility of obtaining data for completed health incentives documented through claims analysis and report on the feasibility in a future report to CMS.	Y	DY17Q4	Reporting will be implemented in conjunction with the last quarter of State Fiscal Year 2022-2023.
HB_4	Completion of all incentivized health behaviors (both claims-based and other), if there are multiple	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed all incentivized health behaviors (including incentivized services documented through claims and other health behaviors not documented through claims) since the beginning of their enrollment spell	HB.Mod_1: Health behavior incentives	Administrative records, claims and encounters	90 days	Quarter	Quarterly	Required	Y	01/01/2021 - 12/31/2021	INCREASE	INCREASE	Y		N		
HB_5	Beneficiaries granted a premium reduction for completion of incentivized health behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward related to premium obligations during the measurement period, regardless of whether the premium reduction occurs durinn the measurement period or in the future	HB.Mod_1: Health behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	N				N	1- FL does not provide rewards for health incentives in the form of premium reductions.			
HB_6	Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized health behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward other than a premium reduction during the measurement period, regardless of when the reward is realized	HB.Mod_1: Health behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	Y	07/01/2021-6/30/2022	INCREASE	INCREASE	Y		N		
HB_7	Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized health behaviors	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period	HB.Mod_1: Health behavior incentives	Administrative records	90 days	Quarter	Quarterly	Required	N				N	1- FL does not provide rewards for health incentives in the form of additional covered benefits or services.			
State-specific metrics																	
Add rows for any state-specific metrics																	

#	Metric name	Metric description	Reporting topic[a]

[a] The reporting topic corresponds to the health behavior incentives (HB) reporting topic in Section 3 of the monitoring report template.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (RW) (Version 2.0)
State: Florida
Demonstration Name: Managed Medical Assistance (MMA)

Eligibility and Coverage Demonstration Planned Metrics (RW)

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Reporting topic*	Data source	Calculation for	Measurement period	Reporting frequency	Reporting criteria	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration goal	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, latest resolutions, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format RW DY and Q, Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: RW_1 **(Do not delete or edit this row)**	*EXAMPLE: Beneficiaries who indicated that they had unpaid medical bills at the time of application*	*EXAMPLE: The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question*	*EXAMPLE: RW.Mod_1: Retroactive eligibility and demonstration requirements*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Constant*	*EXAMPLE: Constant*	*EXAMPLE: Y*	*EXAMPLE*	*EXAMPLE: N*	*EXAMPLE: DY1Q4*	*EXAMPLE*
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	30 days	Month	Quarterly	Required	Y				N	The Retroactive Eligibility Report uses credit reporting agency monthly data on new Medicaid enrollee medical and total debt burdens by month of application. These data were obtained under a contract between TransUnion, LLC and the University of Florida about new enrollee financial burdens. The Agency for Health Care Administration does not have access to this data per the contract.The Agency also does not have access to the Medicaid application data, this information is held by the administrative data custodians at the Department of Children and Families.	Y	TBD	The Agency has researched and confirmed that we do not have access to the data that could be used to calculate this metric at this time. We will be reaching out to the Department of Children and Families to explore ways to obtain this data such as adding a question regarding unpaid medical bills to the Florida Medicaid application. We will provide updates on the monthly 1115 Monitoring Calls with CMS on progress towards being able to report this data.
RW_2	Beneficiaries who had a coverage gap at renewal	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal processes on time	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	Y				N	The Retroactive Eligibility Report uses monthly data for the prior year supplied by the Department of Children and Families. This data contains: Basic demographics and eligibility group membership for individual new enrollee applicants by application month both prior to and subsequent to the change in retroactive enrollment policy. The state will research whether there are alternative sources of eligibility and enrollment (RW_2) that could be used to calculate these metrics, or whether the state may be able to phase in this metric for future monitoring reports.	Y	TBD	The Agency has researched and was unable to identify any alternative data source that could be used to calculate this metric at this time. We will be reaching out to the Department of Children and Families to explore ways to phase in this metric for future monitoring reports. We will provide updates on the monthly 1115 Monitoring Calls with CMS on progress towards being able to report this data.
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended, and for whom claims were submitted for services rendered during the period of disenrollment that were denied by the state	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	Y				N	The Retroactive Eligibility Report uses monthly data for the prior year supplied by the Department of Children and Families to assess enrollment renewal status (success, failure, or interrupted) basic demographics, and eligibility group for monthly Medicaid enrollee renewal cohorts by renewal month. The state will research whether there are alternative sources of claims (RW_3) data that could be used to calculate these metrics, or whether the state may be able to phase in this metric for future monitoring reports.	Y	TBD	The Agency has researched and was unable to identify any alternative data source that could be used to calculate this metric at this time. We will be reaching out to the Department of Children and Families to explore ways to phase in this metric for future monitoring reports. We will provide updates on the monthly 1115 Monitoring Calls with CMS on progress towards being able to report this data.
State-specific metrics																	
Add rows for any state-specific metrics																	

* The reporting topic corresponds to the retroactive eligibility waivers (RW) reporting topic in Section 3 of the monitoring report template.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (AD) (Version 2.0)

State	Florida
Demonstration Name	Managed Medical Assistance (MMA)

Eligibility and Coverage Demonstration Planned Subpopulations (AD)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE*	*EXAMPLE:* *Y*	*EXAMPLE*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	AD_1 - AD_23, AD_33 - AD_44	CMS-provided	N				
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	CMS-provided	Y	Y		Y	
Exempt groups	Eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income *EXAMPLE:* *Geographic exemptions, employer sponsored insurance exemptions, exemptions due to medical frailty*	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	N				
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration. *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_44	State-specific	Y		MEG aged & Disabled: Blind/Disabled Children, Aged/Disabled Adults, Individuals eligible under a hospice-related eligibility group, Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236, Institutionalized individuals eligible under the special home and community-based waiver group specified at 42 CFR 435.217. TANF & related grp: Infants under age 1, Children 1-5, Children 6-18, IV-E Foster Care and Adoption Assistance, Pregnant women, Section 1931 parents or other caretaker relatives, Former foster care children up to age 26, and optional State Plan State-funded Adoption 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 not receiving hospice, HCBS, or institutional care services Medicaid-only eligibles receiving hospice, HCBS, or institutional care services Medicare Eligible receiving hospice, HCBS, or institutional care services	Y	

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If applicable. See CMS-provided technical specifications on subpopulation categories.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (HB) (Version 2.0)

State	Florida
Demonstration Name	Managed Medical Assistance (MMA)

Eligibility and Coverage Demonstration Planned Subpopulations (HB)

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Income groups* ***(Do not delete or edit this row)***	*EXAMPLE:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *HB_1 - HB_7*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL	Recommended	HB_1 - HB_7	CMS-provided	Y	Y		N	HB_1
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56-64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	HB_1 - HB_7	CMS-provided	Y	N	Age (0-20, 21-40,41-60, Over 60), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	N	HB_1, HB_2, HB_3, HB_4, HB_6
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration. *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	HB_1 - HB_7	State-specific	Y		1. FL will continue to stratify the HB metric data using the demographic categories the state indicated for Specific demographic groups. To further stratify the HB metric data by eligibility would not be meaningful due to the historically low enrollee participation in the HB programs, i.e., less than 4,000 enrollees reported as participating in the required HB programs for DY14 and DY15. 2. Multiple subpopulations included within the specific eligibility groups are not eligible to participate in the required HB programs (Smoking Cessation, Weight Loss, and Alcohol/Substance Abuse), such as Infants under 1, Children 1-5, and Medicaid-eligible individuals receiving hospice. Therefore, those groups would not be included within the HB data reported by the plans.		
Phase-in cohort[b]	Cohort(s) the state is using to phase in demonstration policies and requirements to manage the gradual implementation of new operational processes or to support evaluation goals. *EXAMPLE:* *Age groups*	Recommended	All metrics if state is phasing in health behavior incentives by cohort	State-specific	N				

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.
[b] If applicable. See CMS-provided technical specifications on subpopulation categories.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule

State: Florida

Demonstration Name: Managed Medical Assistance (MMA)

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the eligibility and coverage demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the eligibility and coverage demonstration reporting schedule table (Table 2). For each of the reporting categories listed in columns E and F, select Y or N in the "Deviation from standard reporting schedule (Y/N)" column to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category, the state should describe these deviations in the "Explanation for deviations" column and use the "Proposed deviations from standard reporting schedule" column to indicate the measurement periods with which it wishes to overwrite the standard schedule. All other columns are locked for editing and should not be altered by the state.

Table 1. Reporting Periods Input Table

	Demonstration reporting periods/dates		
	AD	HB	RW
Dates of first reporting quarter:			
Reporting period (Format DY Q;	DY15Q3	DY15Q3	DY15Q3
Start date	01/01/2021	01/01/2021	01/01/2021
End date	03/31/2021	03/31/2021	03/31/2021
Broader section 1115 demonstration reporting period corresponding with the first E and C reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY Q; Ex. DY1Q3)	DY15Q3	DY15Q3	DY15Q3
First report due date (per STCs) (MM/DD/YYYY)	05/30/2021	05/30/2021	05/30/2021
First report where the state plans to report calendar year (CY) metrics with a 90 day lag			
Reporting period (Format CY; Ex.	CY2021		
associated with report (Format DY Q;	DY17Q1		
Start date	07/01/2022		
End date	09/30/2022		
Dates of last reporting quarter:			
Start date	04/01/2030		
End date	06/30/2030		

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Dates of reporting quarter (MM/DD/YYYY - MM/DD/YYYY)		Report due (per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY Q; Ex. DY1Q3)	Reporting category		For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY Q; Ex. DY1Q3)[8]			Deviation from standard reporting schedule (Y/N)	Explanation for deviations	Proposed deviations from standard reporting schedule (Format DY Q; Ex. DY1Q3)		
Start date	End date			Calculation lag	Measurement period	AD	HB	RW			AD	HB	RW
01/01/2021	03/31/2021	05/30/2021	DY15Q3	None	Narrative information	DY15Q3	DY15Q3	DY15Q3	Y	Due to the public health emergency, Florida has received a reporting extension for DY15.	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)
				30 days	Month	DY15Q3		DY15Q3	Y				
				None	Quarter	DY15Q3			Y				
				90 days	Quarter				Y				
				90 days	Calendar year				Y				
				None	Demonstration year				Y				
04/01/2021	06/30/2021	09/28/2021	DY15Q4	None	Narrative information	DY15Q4	DY15Q4	DY15Q4	Y	Due to the public health emergency, Florida has received a reporting extension for DY15.	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)	Florida will report these metrics in the DY16Q1 report (due October 29, 2021)
				30 days	Month	DY15Q4		DY15Q4	Y				
				None	Quarter	DY15Q4			Y				
				90 days	Quarter	DY15Q3	DY15Q3	DY15Q3	Y				
				90 days	Calendar year				Y				
				None	Demonstration year				Y				
07/01/2021	09/30/2021	11/29/2021	DY16Q1	None	Narrative information	DY16Q1	DY16Q1	DY16Q1	N				
				30 days	Month	DY16Q1		DY16Q1	N				
				None	Quarter	DY16Q1			N				
				90 days	Quarter	DY15Q4	DY15Q4	DY15Q4	N				
				90 days	Calendar year				N				
				None	Demonstration year				N				
10/01/2021	12/31/2021	03/01/2022	DY16Q2	None	Narrative information	DY16Q2	DY16Q2	DY16Q2	N				
				30 days	Month	DY16Q2		DY16Q2	N				
				None	Quarter	DY16Q2			N				
				90 days	Quarter	DY16Q1	DY16Q1	DY16Q1	N				
				90 days	Calendar year				N				
				None	Demonstration year				N				
01/01/2022	03/31/2022	05/30/2022	DY16Q3	None	Narrative information	DY16Q3	DY16Q3	DY16Q3	N				
				30 days	Month	DY16Q3		DY16Q3	N				
				None	Quarter	DY16Q3			N				
				90 days	Quarter	DY16Q2	DY16Q2	DY16Q2	N				
				90 days	Calendar year				N				
				None	Demonstration year				N				
04/01/2022	06/30/2022	09/28/2022	DY16Q4	None	Narrative information	DY16Q4	DY16Q4	DY16Q4	N				
				30 days	Month	DY16Q4		DY16Q4	N				
				None	Quarter	DY16Q4			N				
				90 days	Quarter	DY16Q3	DY16Q3	DY16Q3	N				
				90 days	Calendar year				N				
				None	Demonstration year	DY16			N				
07/01/2022	09/30/2022	11/29/2022	DY17Q1	None	Narrative information	DY17Q1	DY17Q1	DY17Q1	N				
				30 days	Month	DY17Q1		DY17Q1	N				
				None	Quarter	DY17Q1			N				
				90 days	Quarter	DY16Q4	DY16Q4	DY16Q4	N				
				90 days	Calendar year	CY2021			N				
				None	Demonstration year				N				

10/01/2022	12/31/2022	03/01/2023	DY17Q2	None	Narrative information	DY17Q2	DY17Q2	DY17Q2	N					
				30 days	Month	DY17Q2		DY17Q2	N					
				None	Quarter	DY17Q2			N					
				90 days	Quarter	DY17Q1	DY17Q1	DY17Q1	N					

				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2023	03/31/2023	05/30/2023	DY17Q3	None	Narrative information	DY17Q3	DY17Q3	DY17Q3	N					
				30 days	Month	DY17Q3		DY17Q3	N					
				None	Quarter	DY17Q3			N					
				90 days	Quarter	DY17Q2	DY17Q2	DY17Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2023	06/30/2023	09/28/2023	DY17Q4	None	Narrative information	DY17Q4	DY17Q4	DY17Q4	N					
				30 days	Month	DY17Q4		DY17Q4	N					
				None	Quarter	DY17Q4			N					
				90 days	Quarter	DY17Q3	DY17Q3	DY17Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY17			N					
07/01/2023	09/30/2023	11/29/2023	DY18Q1	None	Narrative information	DY18Q1	DY18Q1	DY18Q1	N					
				30 days	Month	DY18Q1		DY18Q1	N					
				None	Quarter	DY18Q1			N					
				90 days	Quarter	DY17Q4	DY17Q4	DY17Q4	N					
				90 days	Calendar year	CY2022			N					
				None	Demonstration year				N					
10/01/2023	12/31/2023	02/29/2024	DY18Q2	None	Narrative information	DY18Q2	DY18Q2	DY18Q2	N					
				30 days	Month	DY18Q2		DY18Q2	N					
				None	Quarter	DY18Q2			N					
				90 days	Quarter	DY18Q1	DY18Q1	DY18Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					

01/01/2024	03/31/2024	05/30/2024	DY18Q3	None	Narrative information	DY18Q3	DY18Q3	DY18Q3	N				
				30 days	Month	DY18Q3		DY18Q3	N				
				None	Quarter	DY18Q3			N				
				90 days	Quarter	DY18Q2	DY18Q2	DY18Q2	N				
				90 days	Calendar year				N				
				None	Demonstration year				N				
04/01/2024	06/30/2024	09/28/2024	DY18Q4	None	Narrative information	DY18Q4	DY18Q4	DY18Q4	N				
				30 days	Month	DY18Q4		DY18Q4	N				
				None	Quarter	DY18Q4			N				
				90 days	Quarter	DY18Q3	DY18Q3	DY18Q3	N				
				90 days	Calendar year				N				
				None	Demonstration year	DY18			N				
07/01/2024	09/30/2024	11/29/2024	DY19Q1	None	Narrative information	DY19Q1	DY19Q1	DY19Q1	N				
				30 days	Month	DY19Q1		DY19Q1	N				
				None	Quarter	DY19Q1			N				
				90 days	Quarter	DY18Q4	DY18Q4	DY18Q4	N				
				90 days	Calendar year	CY2023			N				
				None	Demonstration year				N				
10/01/2024	12/31/2024	03/01/2025	DY19Q2	None	Narrative information	DY19Q2	DY19Q2	DY19Q2	N				
				30 days	Month	DY19Q2		DY19Q2	N				
				None	Quarter	DY19Q2			N				
				90 days	Quarter	DY19Q1	DY19Q1	DY19Q1	N				
				90 days	Calendar year				N				
				None	Demonstration year				N				

01/01/2025	03/31/2025	05/30/2025	DY19Q3	None	Narrative information	DY19Q3	DY19Q3	DY19Q3	N					
				30 days	Month	DY19Q3		DY19Q3	N					
				None	Quarter	DY19Q3			N					
				90 days	Quarter	DY19Q2	DY19Q2	DY19Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2025	06/30/2025	09/28/2025	DY19Q4	None	Narrative information	DY19Q4	DY19Q4	DY19Q4	N					
				30 days	Month	DY19Q4		DY19Q4	N					
				None	Quarter	DY19Q4			N					
				90 days	Quarter	DY19Q3	DY19Q3	DY19Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY19			N					
07/01/2025	09/30/2025	11/29/2025	DY20Q1	None	Narrative information	DY20Q1	DY20Q1	DY20Q1	N					
				30 days	Month	DY20Q1		DY20Q1	N					
				None	Quarter	DY20Q1			N					
				90 days	Quarter	DY19Q4	DY19Q4	DY19Q4	N					
				90 days	Calendar year	CY2024			N					
				None	Demonstration year				N					
10/01/2025	12/31/2025	03/01/2026	DY20Q2	None	Narrative information	DY20Q2	DY20Q2	DY20Q2	N					
				30 days	Month	DY20Q2		DY20Q2	N					
				None	Quarter	DY20Q2			N					
				90 days	Quarter	DY20Q1	DY20Q1	DY20Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2026	03/31/2026	05/30/2026	DY20Q3	None	Narrative information	DY20Q3	DY20Q3	DY20Q3	N					
				30 days	Month	DY20Q3		DY20Q3	N					
				None	Quarter	DY20Q3			N					
				90 days	Quarter	DY20Q2	DY20Q2	DY20Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2026	06/30/2026	09/28/2026	DY20Q4	None	Narrative information	DY20Q4	DY20Q4	DY20Q4	N					
				30 days	Month	DY20Q4		DY20Q4	N					
				None	Quarter	DY20Q4			N					
				90 days	Quarter	DY20Q3	DY20Q3	DY20Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY20			N					
07/01/2026	09/30/2026	11/29/2026	DY21Q1	None	Narrative information	DY21Q1	DY21Q1	DY21Q1	N					
				30 days	Month	DY21Q1		DY21Q1	N					
				None	Quarter	DY21Q1			N					
				90 days	Quarter	DY20Q4	DY20Q4	DY20Q4	N					
				90 days	Calendar year	CY2025			N					
				None	Demonstration year				N					
10/01/2026	12/31/2026	03/01/2027	DY21Q2	None	Narrative information	DY21Q2	DY21Q2	DY21Q2	N					
				30 days	Month	DY21Q2		DY21Q2	N					
				None	Quarter	DY21Q2			N					
				90 days	Quarter	DY21Q1	DY21Q1	DY21Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2027	03/31/2027	05/30/2027	DY21Q3	None	Narrative information	DY21Q3	DY21Q3	DY21Q3	N					
				30 days	Month	DY21Q3		DY21Q3	N					
				None	Quarter	DY21Q3			N					
				90 days	Quarter	DY21Q2	DY21Q2	DY21Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2027	06/30/2027	09/28/2027	DY21Q4	None	Narrative information	DY21Q4	DY21Q4	DY21Q4	N					
				30 days	Month	DY21Q4		DY21Q4	N					
				None	Quarter	DY21Q4			N					
				90 days	Quarter	DY21Q3	DY21Q3	DY21Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY21			N					
07/01/2027	09/30/2027	11/29/2027	DY22Q1	None	Narrative information	DY22Q1	DY22Q1	DY22Q1	N					
				30 days	Month	DY22Q1		DY22Q1	N					
				None	Quarter	DY22Q1			N					
				90 days	Quarter	DY21Q4	DY21Q4	DY21Q4	N					
				90 days	Calendar year	CY2026			N					
				None	Demonstration year				N					
10/01/2027	12/31/2027	02/29/2028	DY22Q2	None	Narrative information	DY22Q2	DY22Q2	DY22Q2	N					
				30 days	Month	DY22Q2		DY22Q2	N					
				None	Quarter	DY22Q2			N					
				90 days	Quarter	DY22Q1	DY22Q1	DY22Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2028	03/31/2028	05/30/2028	DY22Q3	None	Narrative information	DY22Q3	DY22Q3	DY22Q3	N					
				30 days	Month	DY22Q3		DY22Q3	N					
				None	Quarter	DY22Q3			N					
				90 days	Quarter	DY22Q2	DY22Q2	DY22Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2028	06/30/2028	09/28/2028	DY22Q4	None	Narrative information	DY22Q4	DY22Q4	DY22Q4	N					
				30 days	Month	DY22Q4		DY22Q4	N					
				None	Quarter	DY22Q4			N					
				90 days	Quarter	DY22Q3	DY22Q3	DY22Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY22			N					
07/01/2028	09/30/2028	11/29/2028	DY23Q1	None	Narrative information	DY23Q1	DY23Q1	DY23Q1	N					
				30 days	Month	DY23Q1		DY23Q1	N					
				None	Quarter	DY23Q1			N					
				90 days	Quarter	DY22Q4	DY22Q4	DY22Q4	N					
				90 days	Calendar year	CY2027			N					
				None	Demonstration year				N					
10/01/2028	12/31/2028	03/01/2029	DY23Q2	None	Narrative information	DY23Q2	DY23Q2	DY23Q2	N					
				30 days	Month	DY23Q2		DY23Q2	N					
				None	Quarter	DY23Q2			N					
				90 days	Quarter	DY23Q1	DY23Q1	DY23Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2029	03/31/2029	05/30/2029	DY23Q3	None	Narrative information	DY23Q3	DY23Q3	DY23Q3	N					
				30 days	Month	DY23Q3		DY23Q3	N					
				None	Quarter	DY23Q3			N					
				90 days	Quarter	DY23Q2	DY23Q2	DY23Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2029	06/30/2029	09/28/2029	DY23Q4	None	Narrative information	DY23Q4	DY23Q4	DY23Q4	N					
				30 days	Month	DY23Q4		DY23Q4	N					
				None	Quarter	DY23Q4			N					
				90 days	Quarter	DY23Q3	DY23Q3	DY23Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY23			N					
07/01/2029	09/30/2029	11/29/2029	DY24Q1	None	Narrative information	DY24Q1	DY24Q1	DY24Q1	N					
				30 days	Month	DY24Q1		DY24Q1	N					
				None	Quarter	DY24Q1			N					
				90 days	Quarter	DY23Q4	DY23Q4	DY23Q4	N					
				90 days	Calendar year	CY2028			N					
				None	Demonstration year				N					
10/01/2029	12/31/2029	03/01/2030	DY24Q2	None	Narrative information	DY24Q2	DY24Q2	DY24Q2	N					
				30 days	Month	DY24Q2		DY24Q2	N					

				None	Quarter	DY24Q2			N					
				90 days	Quarter	DY24Q1	DY24Q1	DY24Q1	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
01/01/2030	03/31/2030	05/30/2030	DY24Q3	None	Narrative information	DY24Q3	DY24Q3	DY24Q3	N					
				30 days	Month	DY24Q3		DY24Q3	N					
				None	Quarter	DY24Q3			N					
				90 days	Quarter	DY24Q2	DY24Q2	DY24Q2	N					
				90 days	Calendar year				N					
				None	Demonstration year				N					
04/01/2030	06/30/2030	09/28/2030	DY24Q4	None	Narrative information	DY24Q4	DY24Q4	DY24Q4	N					
				30 days	Month	DY24Q4		DY24Q4	N					
				None	Quarter	DY24Q4			N					
				90 days	Quarter	DY24Q3	DY24Q3	DY24Q3	N					
				90 days	Calendar year				N					
				None	Demonstration year	DY24			N					
Add rows for all additional demonstration reporting quarters														

Notes:

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-generated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

ATTACHMENT E: APPROVED EVALUATION DESIGN

Florida's Managed Medical Assistance (MMA) Program Demonstration Waiver Evaluation: Design Update 2021-2030

Presented to:

Centers for Medicare and Medicaid Services

Prepared by:

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Revised by:

Health Services Advisory Group, Inc.

May 25, 2022

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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-

[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

00206/4, January 15, 2021 through June 30, 2030.

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.

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.

On November 30, 2018, CMS approved an amendment to the demonstration that allowed the state to operate a statewide Prepaid Dental Health Program, modified the LIP to add Regional Perinatal Intensive Care Centers as an eligible hospital ownership subgroup and community behavioral health providers as a participating provider group, and waived retroactive eligibility for all beneficiaries under the demonstration, except for 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.

On March 26, 2019, CMS approved an amendment 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 is operated in two regions of the state: Regions 5 (Pasco and Pinellas counties) and Region 7 (Brevard, Orange, Osceola and Seminole counties). On January 15, 2021, CMS approved an extension of the behavioral health and supportive housing assistance pilot through June 30, 2025.

On February 18, 2020, an amendment to the demonstration was approved that enables Florida to increase the behavioral health and supportive housing assistance pilot's annual enrollment limit, modified the LIP's permissible expenditures related to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) and memorialized some budget neutrality-related edits to the behavioral health and supportive housing assistance pilot table in the STCs.

Federal CMS approved a third extension of the MMA 1115 waiver demonstration (Project No. 11-W-00206/4) which was effective beginning January 15, 2021 and will be effective through June 30, 2030.

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

2. 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 Adoption Assistance under age 18	Who have an adoption assistance agreement, not under title IV-E.	Title XIX	TANF & Related Group
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit.	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); and, • 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; and, • 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	• 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.

3. **<u>Voluntary Enrollees</u> –** 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.

4. 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 9) 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 10) 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

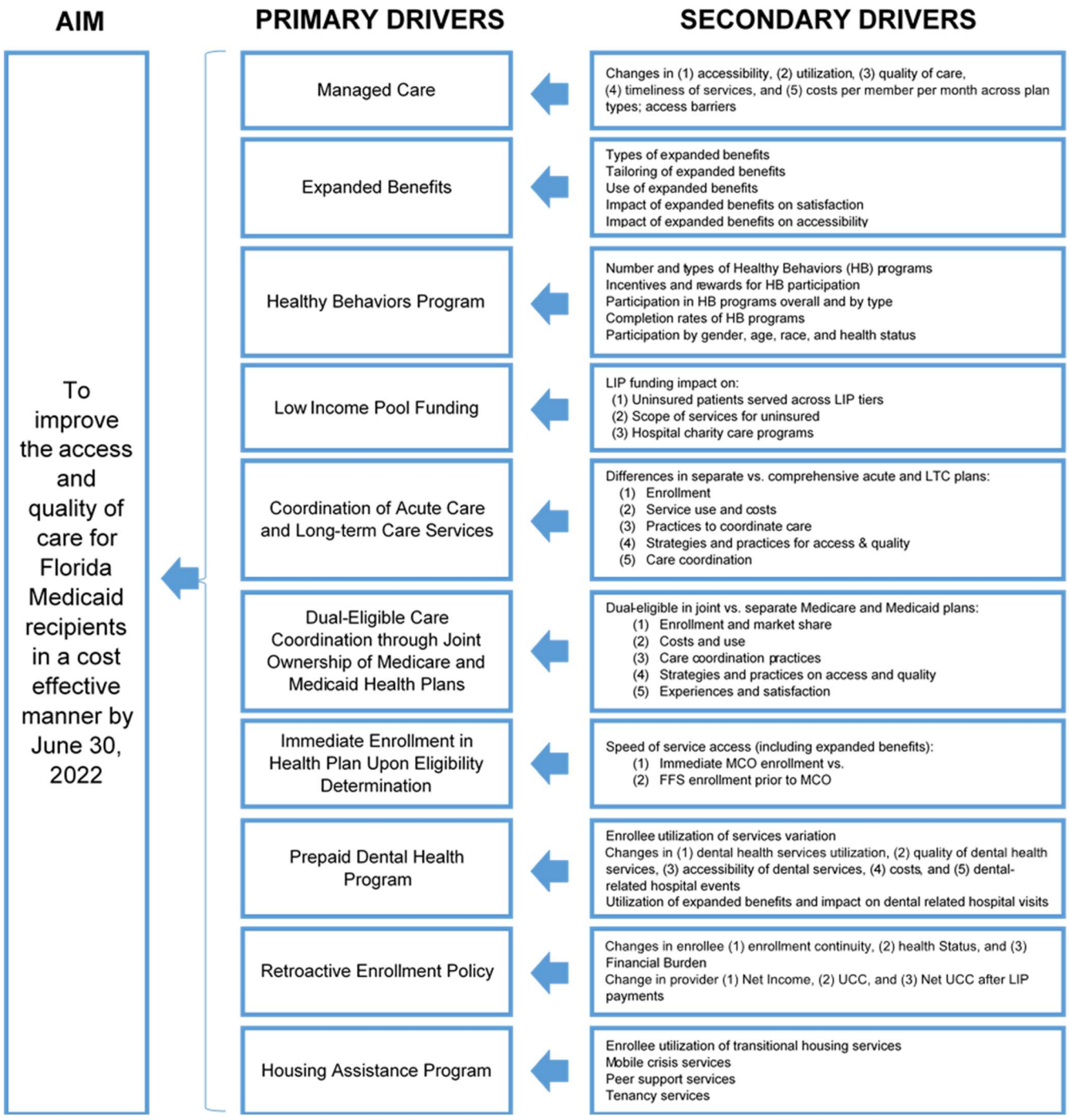
care plans has been for the plans to reach the National Medicaid 75th percentile on HEDIS measures. The managed care plans' HEDIS rates each year are compared to the previous year National Medicaid percentiles to measure the plans' (and MMA program's) progress toward reaching the 75th percentile. The 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.

Hypotheses in this report that describe outcomes as maintaining or improving will be tested using noninferiority testing. Other hypotheses that are stated in null form (i.e., hypothesizing no change) will be tested against a two-tailed alternative hypothesis (i.e., hypothesizing a non-zero, positive or negative change) using $\alpha \leq 0.05$ to denote statistical significance. Hypotheses making a prediction or directional outcome will generally be assessed through qualitative and descriptive data analysis.

The Driver Diagram 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



Goal: Improve 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.

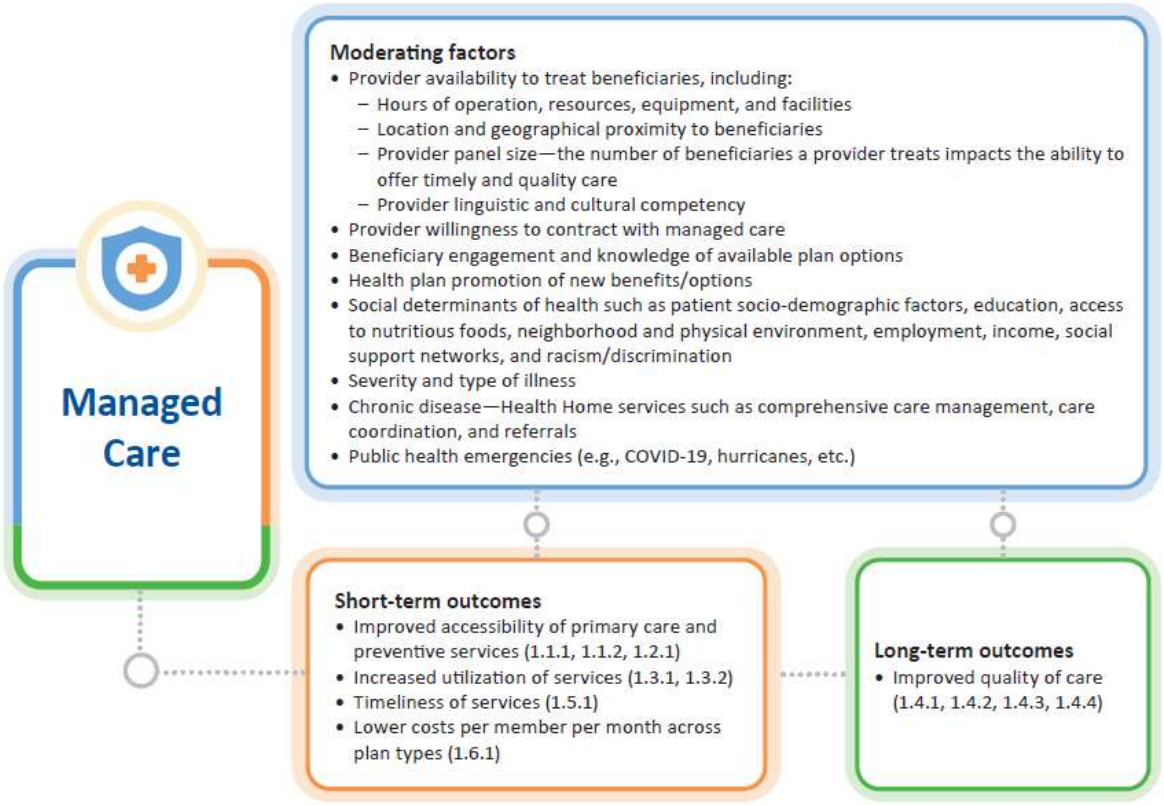
Component 1: The effect of managed care on access to care, quality and efficiency of care, and the cost of care.
Hypothesis 1.1: The MMA implementation will reduce barriers enrollees encounter when accessing primary care and preventative services.
RQ1.1.1: What barriers do enrollees encounter when accessing primary care services?
RQ1.1.2: What barriers do enrollees encounter when accessing preventive services?
Hypothesis 1.2: Accessibility of services in MMA plans will be equal to or better than pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).
RQ1.2.1: 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 1.3: There will be no change in the use of services for enrollees in the MMA period compared to the pre-MMA period; and 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.
RQ1.3.1: What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing 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?
RQ1.3.2: What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing 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 1.4: The quality of care for enrollees in MMA plans will be equal to or better than quality of care for enrollees in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); and 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.
RQ1.4.1: What changes in quality of care for enrollees are evident post-MMA implementation, comparing 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?
RQ1.4.2: What changes in quality of care for enrollees are evident post-MMA implementation, comparing 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)?
RQ1.4.3 What strategies are standard MMA and specialty MMA plans using to improve quality of care?
RQ1.4.4: Which of the strategies used by standard MMA and specialty MMA plans are most effective in improving quality and why?
Hypothesis 1.5: The timeliness of services in MMA plans is equal to or better than pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).

RQ1.5.1: 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 1.6: The per-enrollee cost by eligibility group in MMA plans will be no greater than pre-MMA implementation (FFS, Reform, and 1915 (b) waiver plans).

RQ1.6.1: 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)?

Figure 2. Logic Model for Component 1



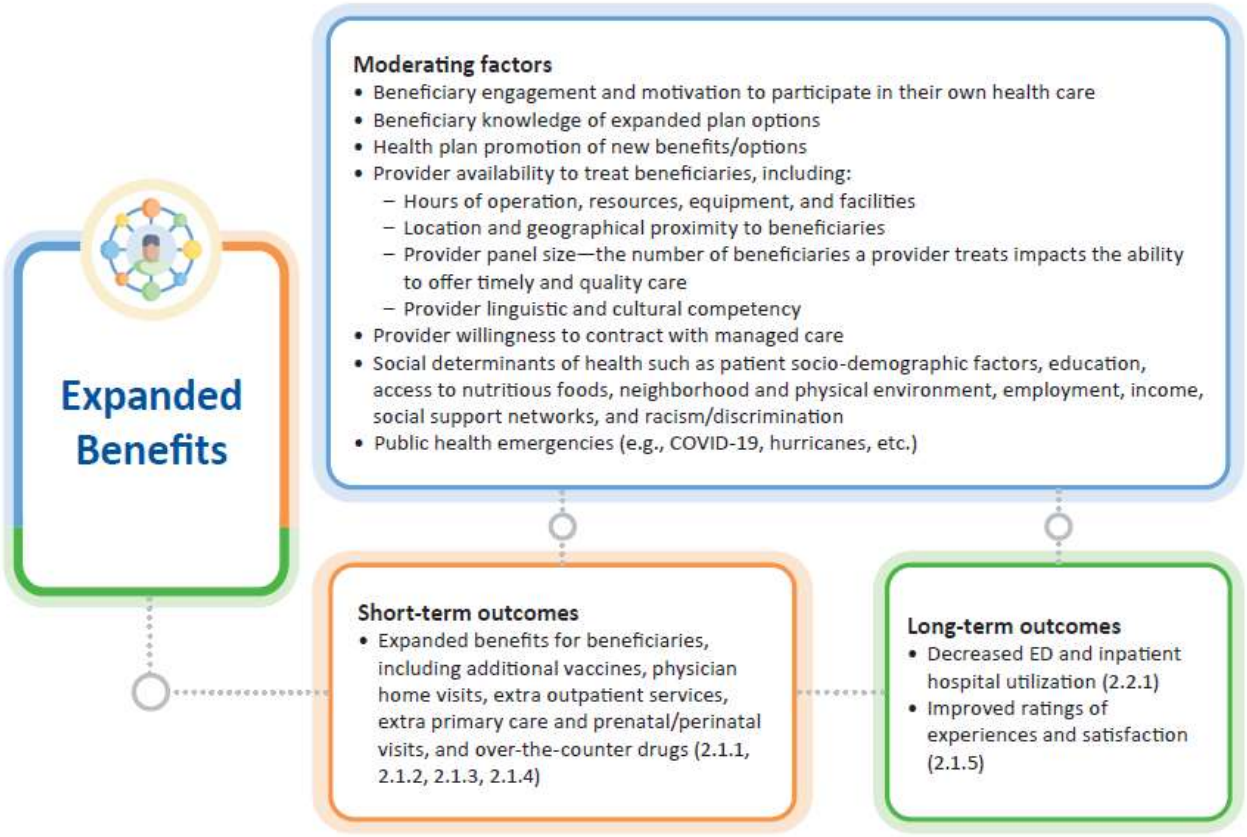
Goal: Improve program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care.

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

Hypothesis 2.1: Standard MMA and specialty MMA plans will offer expanded benefits.

RQ2.1.1: What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans?
RQ2.1.2: How do plans tailor the types of expanded benefits to particular populations?
RQ2.1.3: How many enrollees utilize expanded benefits?
RQ2.1.4: Which expended benefits are enrollees most commonly using?
RQ2.1.5: How do enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?
Hypothesis 2.2: ED and inpatient hospital utilization for users of expanded benefits will not be greater than that of non-users.
RQ2.2.1: 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) compared to those enrollees who do not?

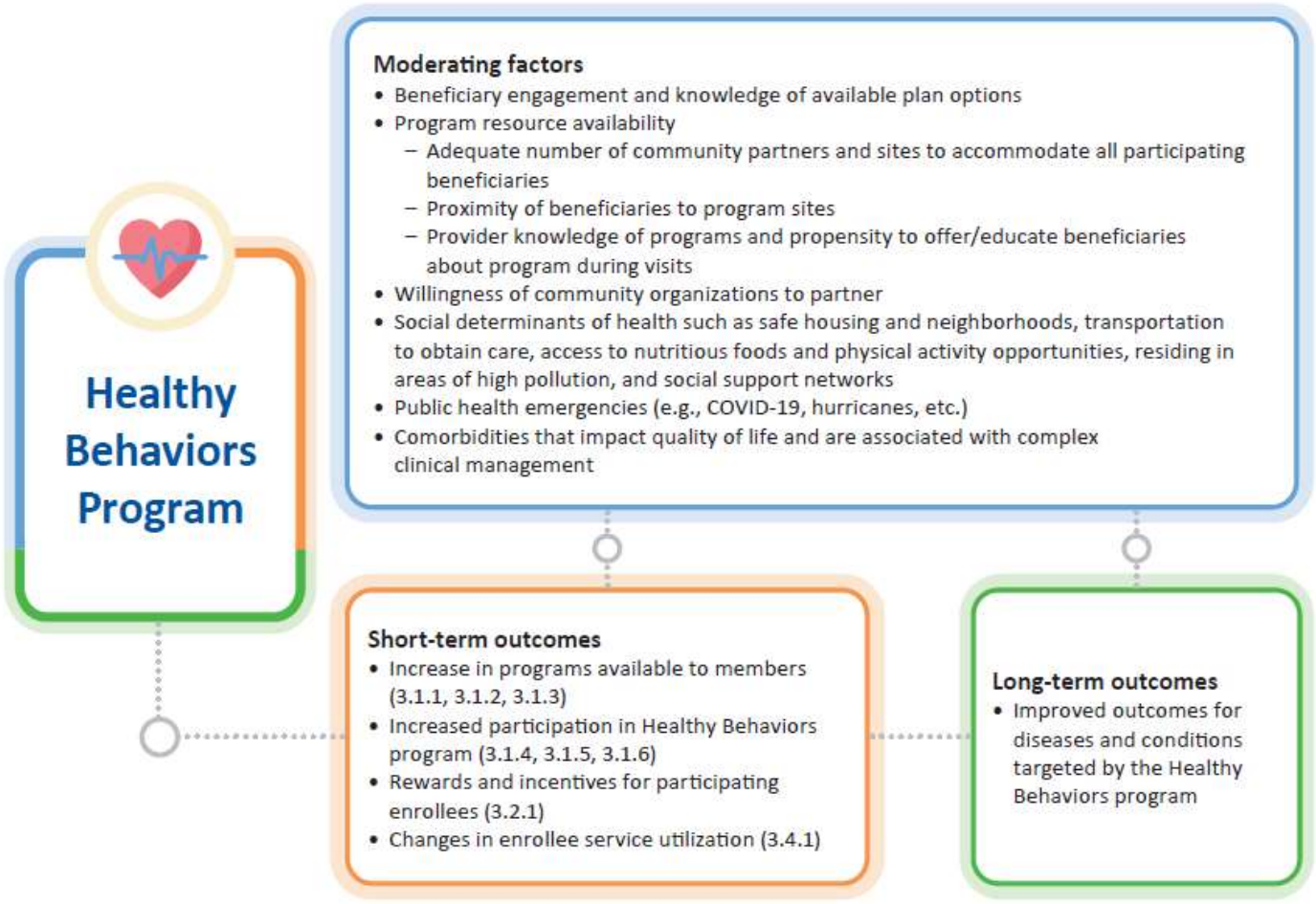
Figure 3. Logic Model for Component 2



Goal: Improve health outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility.

Component 3: Participation in the Healthy Behaviors programs and its effect on participant behavior or health status.
Hypothesis 3.1: MMA plans will offer Healthy Behaviors programs to enrollees; and enrollees will participate in and complete Healthy Behaviors programs.
RQ3.1.1: What Healthy Behaviors programs do MMA plans offer?
RQ3.1.2: What types of programs 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)?
RQ3.1.3: How many programs 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)?
RQ3.1.4: How many enrollees participate in each Healthy Behaviors program?
RQ3.1.5: How many enrollees complete Healthy Behaviors programs?
RQ3.1.6: Which types of Healthy Behaviors programs attract higher numbers of participants?
Hypothesis 3.2: MMA plans will offer incentives and rewards to encourage participation in Healthy Behaviors programs.
RQ3.2.1: What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs?
Hypothesis 3.3: Enrollees participating in Healthy Behaviors programs will reflect the gender, age, race/ethnicity, and health status diversity of Florida Medicaid recipients.
RQ3.3.1: How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees (DY13 and beyond)?
Hypothesis 3.4: Utilization of preventive services and outpatient services between enrollees participating in Healthy Behaviors programs will be equal to or better than enrollees not participating in Healthy Behaviors programs; and 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 will be reduced after enrolling in the Healthy Behaviors program.
RQ3.4.1: 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)?

Figure 4. Logic Model for Component 3

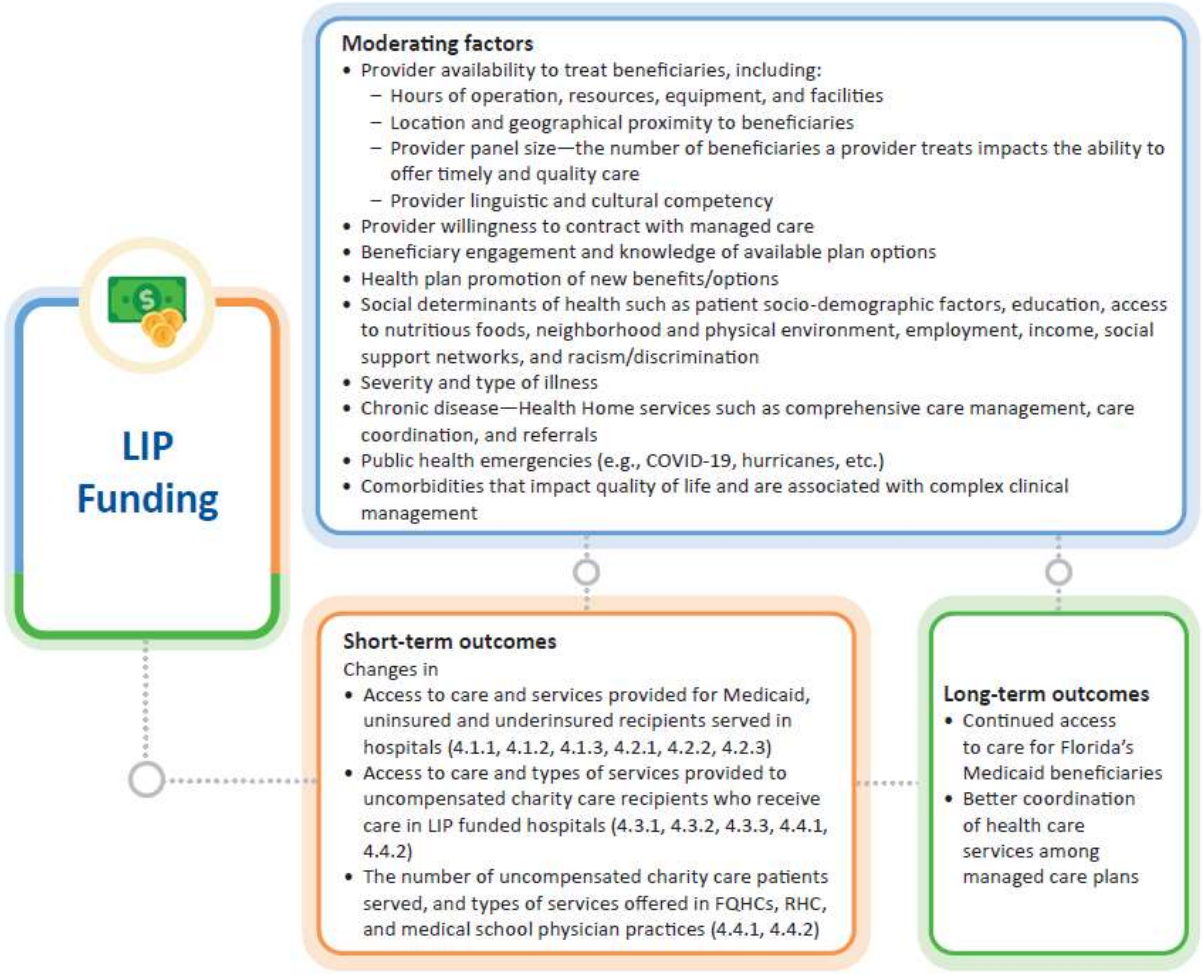


Goal: Increase access to, stabilize, and strengthen providers that serve uninsured, low-income populations in Florida by targeting Low-Income Pool (LIP) funding to reimburse charity care costs for services provided to low-income uninsured patients in hospitals, federally qualified health care centers, and rural health clinics that are furnished through charity care programs that adhere to the Healthcare Financial Management Association principles.

Component 4: The impact of LIP funding on hospital charity care programs.
Hypothesis 4.1: LIP funding will improve access to care for Medicaid, uninsured, and underinsured recipients served in hospitals.
RQ4.1.1: How many Medicaid recipients receive services in LIP funded hospitals?
RQ4.1.2: How many uninsured recipients receive services in LIP funded hospitals?
RQ4.1.3: How many underinsured recipients receive services in LIP funded hospitals?
Hypothesis 4.2: Services are being provided to Medicaid, uninsured, and underinsured recipients receiving care in LIP funded hospitals.

RQ4.2.1: What types of services are being provided to Medicaid recipients receiving care in LIP funded hospitals?
RQ4.2.2: What types of services are being provided to uninsured recipients receiving care in LIP funded hospitals?
RQ4.2.3: What types of services are being provided to underinsured recipients receiving care in LIP funded hospitals?
Hypothesis 4.3: The number of uncompensated charity care patients served will increase based on hospital access to LIP funding and different tiers of LIP funding; and there will be no change or an increase in the types of services or the number of services offered to uncompensated charity care patient in hospitals receiving LIP funding.
RQ4.3.1: How many uncompensated charity care recipients receive services in LIP funded hospitals?
RQ4.3.2: How does the number of uncompensated charity care recipients receiving services in LIP funded hospitals compare among hospitals in different tiers of LIP funding?
RQ4.3.3: What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals?
RQ4.3.4: What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?
Hypothesis 4.4: LIP funding will increase the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices.
RQ4.4.1: What is the impact of LIP funding on the number of uncompensated charity care patients served in FQHCs, RHCs, and medical school physician practices?
RQ4.4.2: What is the impact of LIP funding on the types of services provided for uncompensated charity care patients served in FQHCs, RHCs, and medical school physician practices?

Figure 5. Logic Model for Component 4



Goal: Improve health outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility.

Component 6: The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals.[2]
Hypothesis 6.1: Care coordination strategies and practices will ensure access to, satisfaction with, and quality of care for behavioral health services and non-emergency transportation services for dual-eligible enrollees is equal to or better than prior to implementation of care coordination.
RQ6.1.1: How many MMA enrollees are also Medicare recipients (dual-eligible)?
RQ6.1.2: To what extent do dual-eligible enrollees utilize behavioral health services?
RQ6.1.3: To what extent do dual-eligible enrollees utilize non-emergency transportation services?
RQ6.1.4: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services for dual-eligible enrollees?

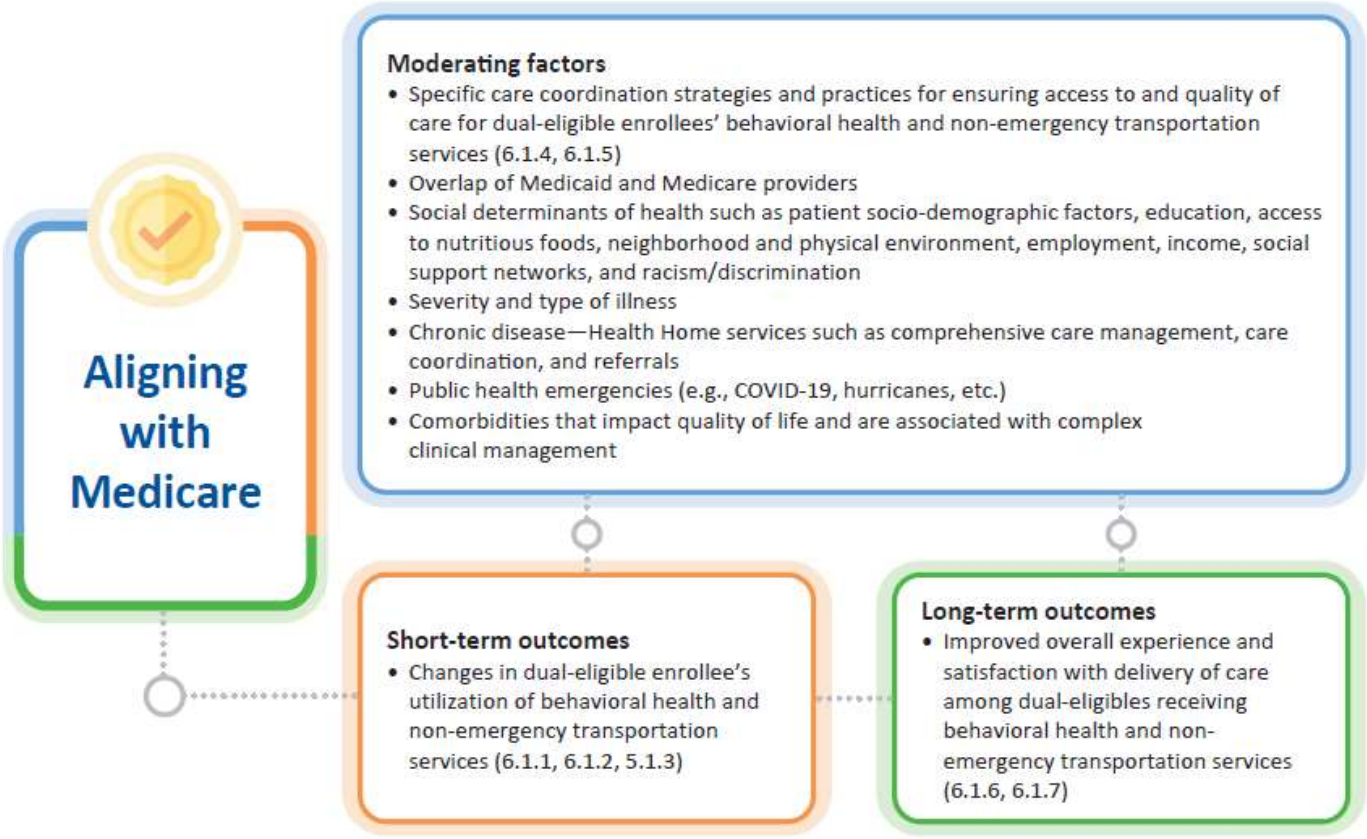
[2] Component 5 of the Demonstration is not included in this evaluation design.

RQ6.1.5: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for non-emergency transportation services for dual-eligible enrollees?

RQ6.1.6: How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health services?

RQ6.1.7: How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to non-emergency transportation services?

Figure 6. Logic Model for Component 6



Goal: Improve 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 exempt.

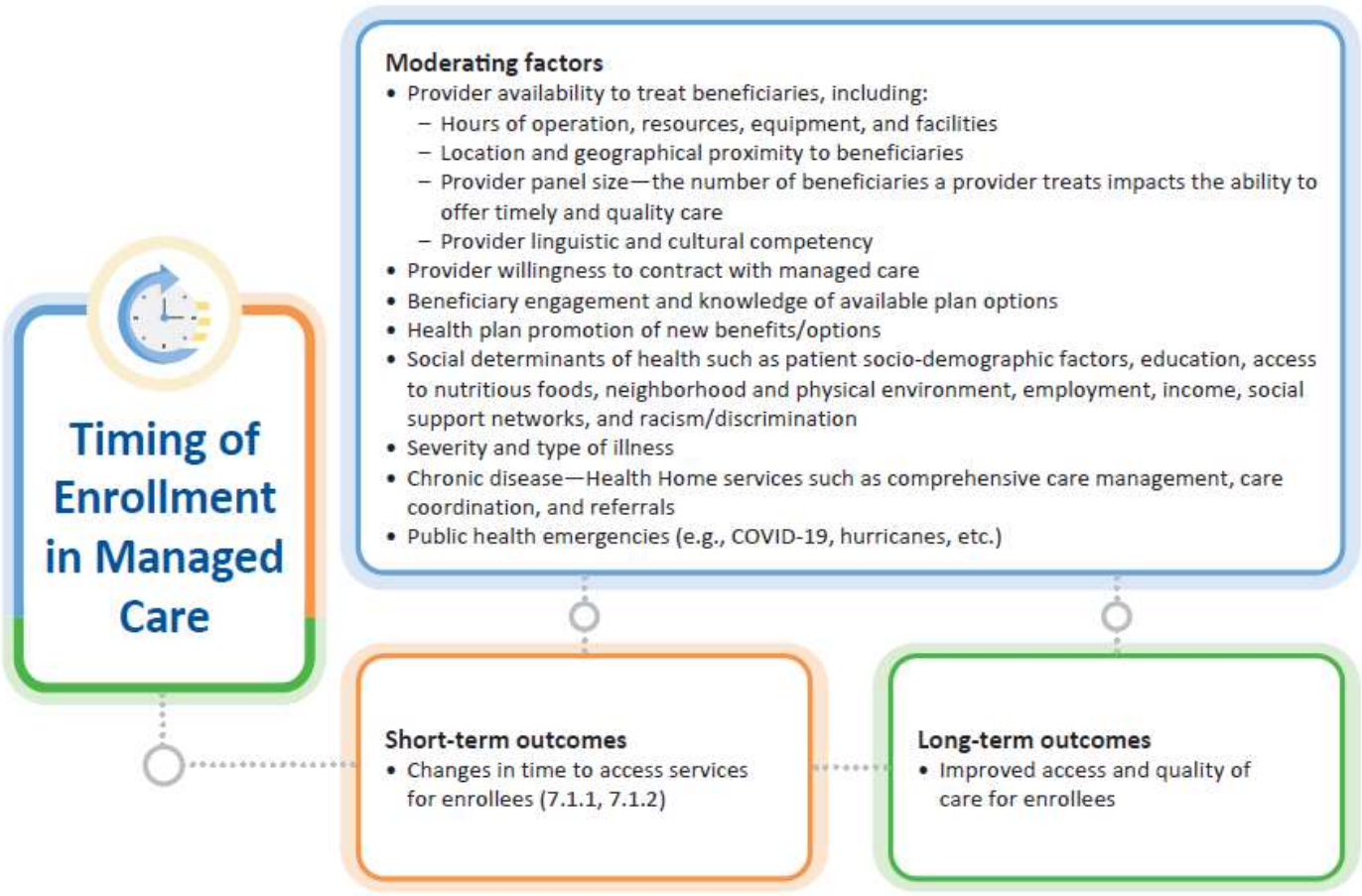
Component 7: The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner.

Hypothesis 7.1: Individuals newly enrolled into a managed care plan will experience timely access to services.

RQ7.1.1: 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?

RQ7.1.2: 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?

Figure 7. Logic Model for Component 7



Goal: Improve 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.

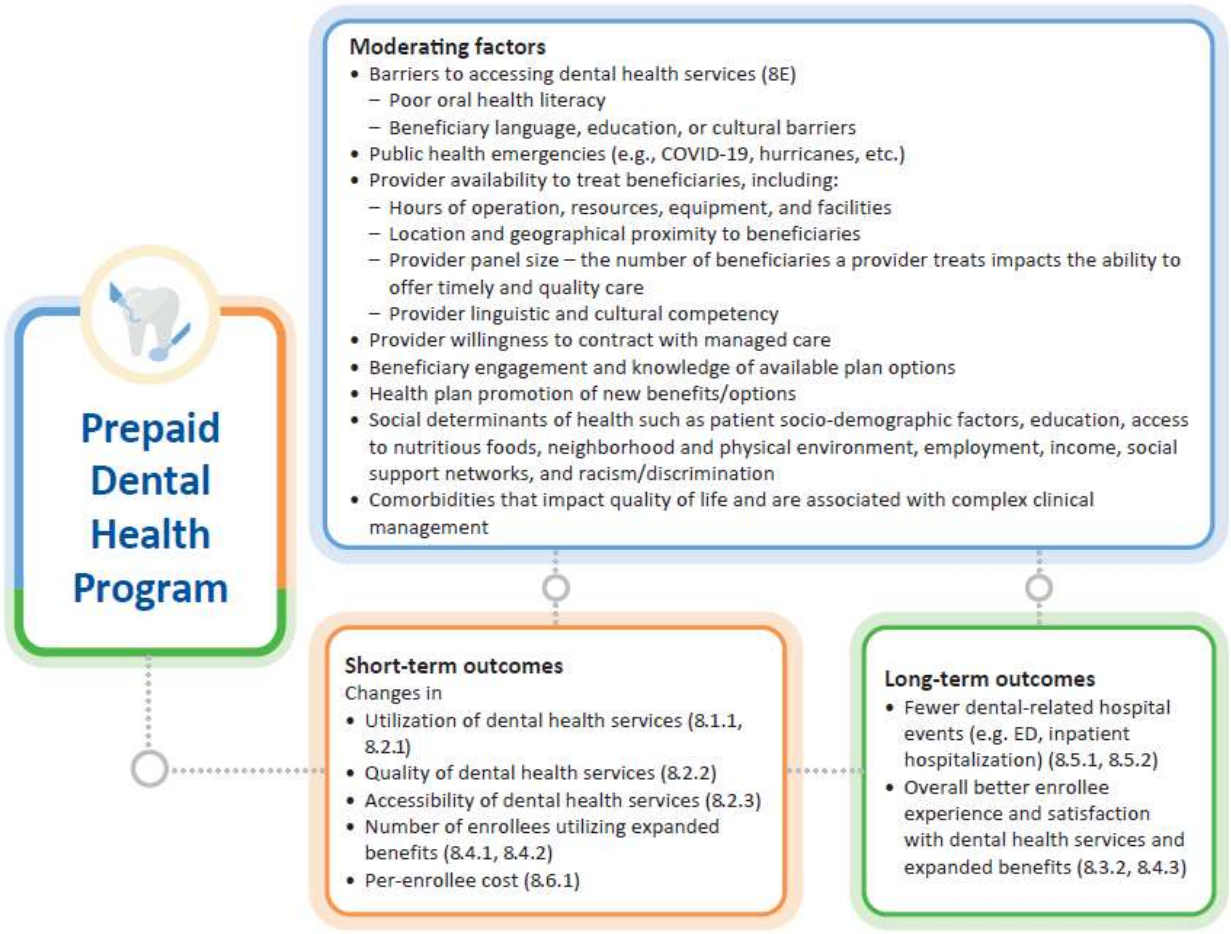
Component 8: The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services.

Hypothesis 8.1: Enrollee utilization of dental health services will reflect the age, gender, race/ethnicity, and geographic diversity of Florida Medicaid recipients.

RQ8.1.1: How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area?

Hypothesis 8.2: Access to, quality of, and utilization of dental health services will be equal to or better as a result of the implementation of the Statewide Medicaid Prepaid Dental Health Program.
RQ8.2.1: What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?
RQ8.2.2: What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?
RQ8.2.3: What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?
Hypothesis 8.3: Enrollees will encounter few barriers when accessing dental health services that will impact their experiences and satisfaction.
RQ8.3.1: What barriers do enrollees encounter when accessing dental health services?
RQ8.3.2: How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plans?
Hypothesis 8.4: Enrollees will utilize and be satisfied with expanded benefits .
RQ8.4.1: How many enrollees utilize expanded benefits provided by the dental health plans?
RQ8.4.2: Which expended benefits provided by the dental health plans are most commonly used by enrollees?
RQ8.4.3: How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?
Hypothesis 8.5: There will be equal or fewer 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.
RQ8.5.1: How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)?
RQ8.5.2: How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?
Hypothesis 8.6: Per-enrollee costs for dental health services will be less than or equal as a result of the implementation of the Statewide Medicaid Prepaid Dental Health Program.
RQ8.6.1: What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?

Figure 8. Logic Model for Component 8

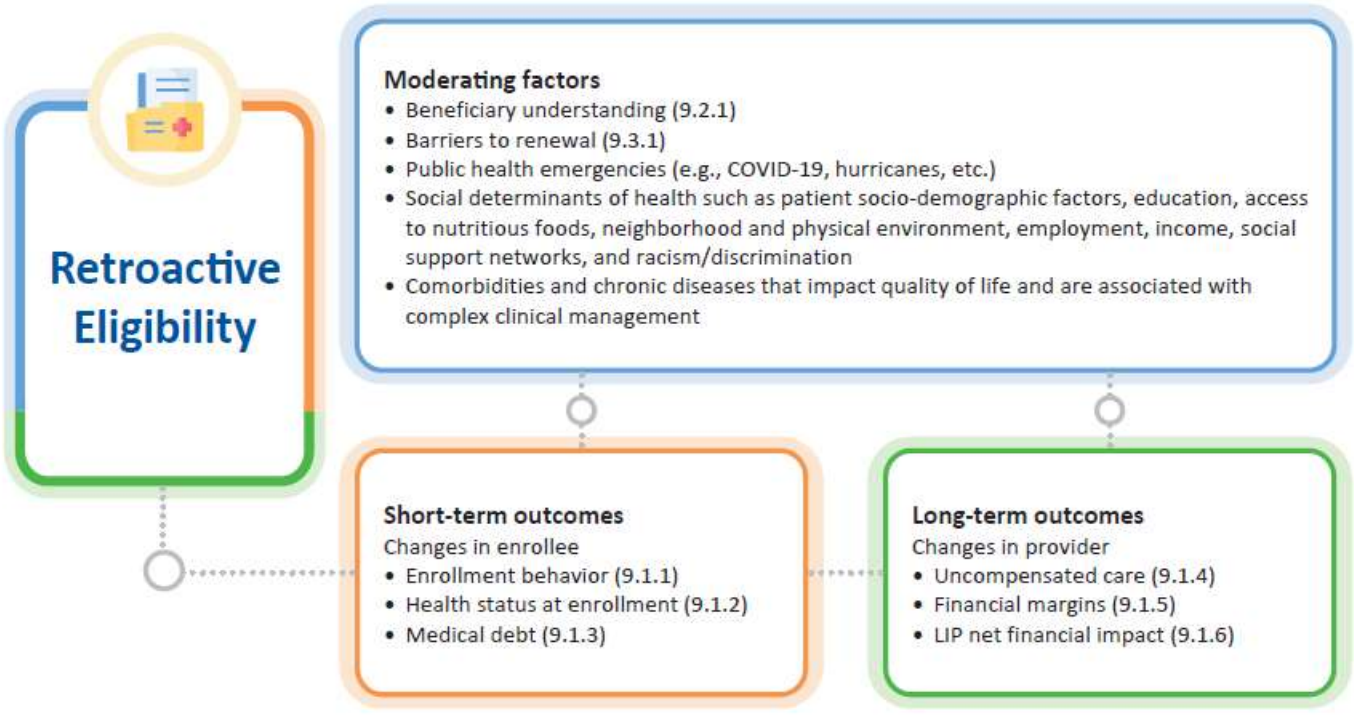


Goal: Improve continuity of coverage and care by encouraging the uptake of preventive services and/or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable; as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.

Component 9: The impact of the waiver of retroactive eligibility on beneficiaries and providers.
Hypothesis 9.1: Eliminating retroactive eligibility will have no effect on enrollment continuity, the health status of those subject to the new policy compared to those not subject to the new policy, new enrollee financial burden, provider uncompensated care amounts, provider financial performance (income after expenses), or the net financial impact of uncompensated care (UCC – LIP payments).
RQ9.1.1: How will eliminating retroactive eligibility change enrollment continuity?
RQ9.1.2: 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?
RQ9.1.3: How will eliminating retroactive eligibility affect new enrollee financial burden?
RQ9.1.4: How will eliminating retroactive eligibility affect provider uncompensated care amounts?

RQ9.1.5: How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?
RQ9.1.6: How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?
Hypothesis 9.2: Beneficiaries understand that they will not be covered during enrollment gaps.
RQ9.2.1: Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?
Hypothesis 9.3: Beneficiaries subject to retroactive eligibility encounter few barriers that impact timely renewal.
RQ9.3.1: What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?
Hypothesis 9.4: Eliminating prior quarter coverage will increase the likelihood and continuity of enrollment.
RQ9.4.1: Do eligible people without prior quarter coverage enroll in Medicaid at the same rates as other eligible people with prior quarter coverage?

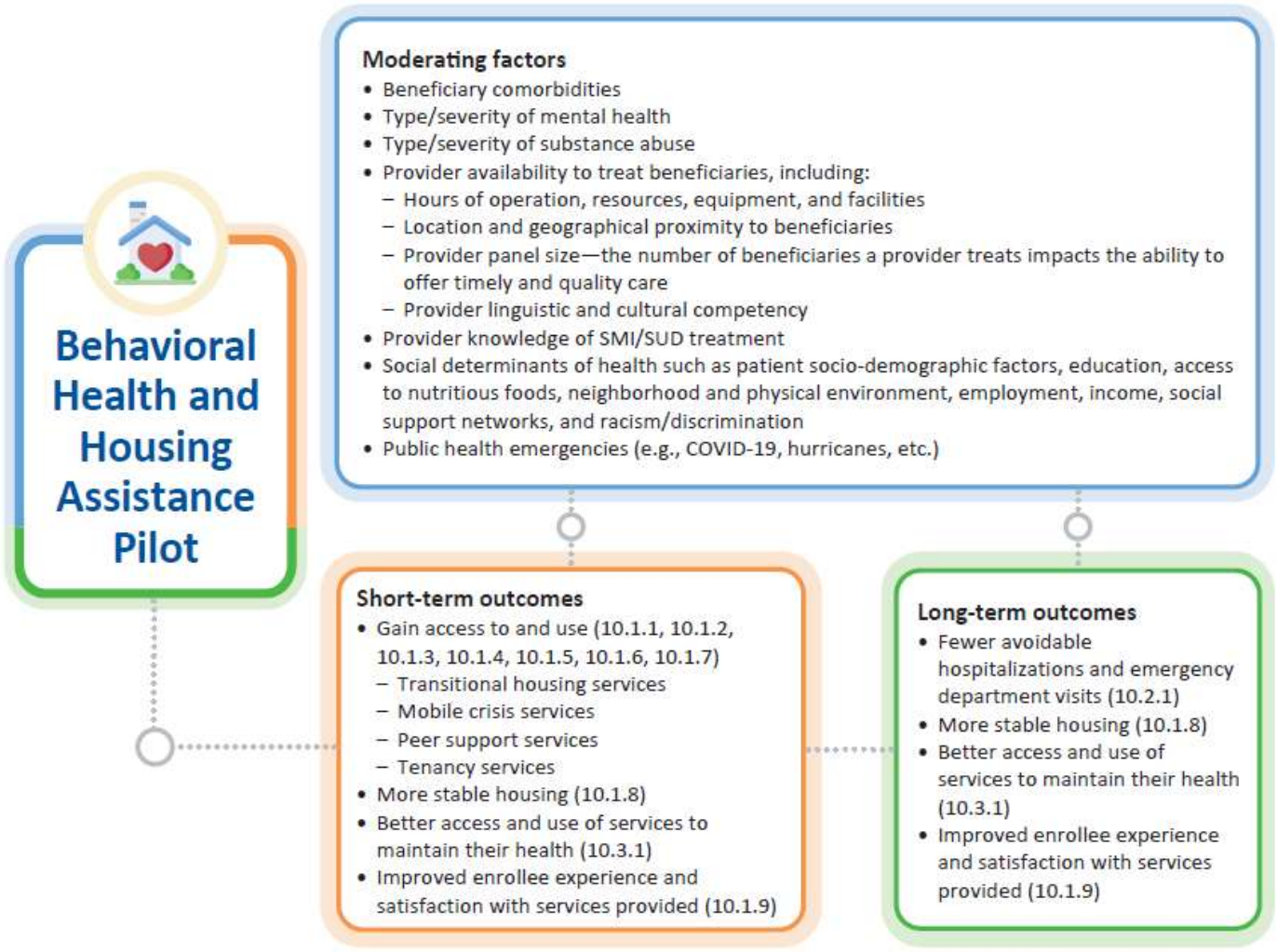
Figure 9. Logic Model for Component 9



Goal: Improve the integration of all services, increase care coordination effectiveness, increase individual involvement in their care, improve health outcomes, and reduce unnecessary or inefficient use of health 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.
Hypothesis 10.1: MMA plans and their enrollees will participate in the Housing Assistance Pilot Program and utilize the services offered (transitional housing services, mobile crisis services, peer support, tendency services).
RQ10.1.1: How many MMA plans participate in the Housing Assistance Pilot program?
RQ10.1.2: How many enrollees are participating in the Housing Assistance Pilot, by plan?
RQ10.1.3: How does participation in the Housing Assistance Pilot vary by gender, age, race/ethnicity and health status of enrollees?
RQ10.1.4: How did MMA plans implement the Pilot programs?
RQ10.1.5: What is the frequency of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan?
RQ10.1.6: What is the 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?
RQ10.1.7: What is the proportion of enrollees who are successfully discharged from the Pilot but subsequently become homeless again and resume using services?
RQ10.1.8: Is care coordination more effective for the study population as a result of the Pilot program?
RQ10.1.9: 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?
RQ10.1.10: What are the costs of the Pilot program, including the costs of services provided to enrollees and the costs to administer the program?
Hypothesis 10.2: Avoidable hospitalizations and emergency department visits among enrollees with SMI who receive supportive housing assistance will be equal to or less than similar Medicaid recipients prior to enrollment in the program.
RQ10.2.1: 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 10.3: There will be no difference or an increase 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.
RQ10.3.1: 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?

Figure 10. Logic Model for Component 10



Goal: Improve health outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility

Component 11: Investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

Hypothesis 11.1: Administrative costs incurred by the state to implement and operate the demonstration will be less than or equal to administrative costs prior to the waiver, or will be offset by savings under Hypothesis 11.2.

RQ11.1.1: What are the administrative costs incurred by the state to implement and operate the demonstration?

Hypothesis 11.2: The MMA eligibility and coverage policies will result in equal or lower Medicaid health services expenditures, provider uncompensated care costs, and combined total costs (administrative, health services, and provider uncompensated care costs.
RQ11.2.1: What are the short-term effects of eligibility and coverage policies on Medicaid health service expenditures?
RQ11.2.2: What are the long-term effects of eligibility and coverage policies on Medicaid health service expenditures?
RQ11.2.3: What are the impacts of eligibility and coverage policies on provider uncompensated care costs?
RQ11.2.4: What are the impacts of eligibility and coverage policies on combined total costs (administrative, health services, and provider uncompensated care costs)?

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.

Statistical testing for hypotheses that are stated such that the MMA program maintains or improves compared to pre-MMA renewal or out-of-state comparison groups (if available) will be conducted through noninferiority testing. In traditional null hypothesis statistical testing, a result of no significant difference would not necessarily indicate the MMA program maintained rates compared to pre-MMA renewal or an out-of-state group. This is because clinically significant differences could be found statistically insignificant due to low statistical power. Likewise, clinically irrelevant differences could be found to be statistically significant due to large sample sizes. Noninferiority testing is designed to address this limitation by testing directly whether the difference in rates fell within an equivalence interval that denotes the two groups are "close enough."[3] A prespecified fraction (δ) of the difference in rates will be used to define an "equivalence range" that would conclude MMA members performed as well as the comparison. Where possible, this equivalence range will be informed by clinical

[3] Streiner, D.L. (2003) "Unicorns Do Exist: A Tutorial on 'Proving' the Null Hypothesis," Can J Psychiatry, 48(11); Mascha, E. J., and Sessler, D. I., (2011) "Equivalence and Noninferiority Testing in Regression Models and Repeated-Measures Designs," Anesth Analg. 2011 Mar;112(3):678-87; Paiggio, G., et al. (2012) "Reporting of Noninferiority and Equivalence Randomized Trials: Extension of the CONSORT 2010 Statement" JAMA. 2012;308(24):2594-2604.

guidance. If clinical guidance is not feasible or applicable, δ will be determined through distribution-based methods such as effect size. While an effect size of 0.20 has commonly been deemed to represent a "small" effect as originally suggested by Jacob Cohen, Cohen writes, "the terms 'small,' 'medium,' and 'large' are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation" (p. 25).[4] Because the application of effect size in this context is to identify a minimum acceptable difference between proportions while still considering them "equal" for practical purposes, a stricter threshold than what may be typically used is appropriate. Therefore, δ for each measure will be calculated based off an effect size of 0.1.

Statistical testing for hypotheses not stated in this manner will use two-tailed significance testing 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 1.6.1, "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. Where the data allow, measures and analyses will be stratified by race/ethnicity and geography to identify any disparate impacts of the demonstration. The population foci of individual research questions are listed in ***Table 6*** below.

3. Evaluation Period

The current evaluation period began with SFY 2020-21 (DY15) and extends through SFY 2029-30 (DY24). The table below details the evaluation period that will be covered in each deliverable for the current demonstration approval period.

[4] Cohen, J. *Statistical Power Analysis for the Behavioral Sciences,* 2nd Ed. Hillsdale, N.J.: L. Erlbaum Associates; 1988:25.

Deliverable / Activity	Due Date	Evaluation Period
Interim Evaluation Report for DY 15-17 due to CMS	31-Dec-24	July 2020 – June 2023
Interim Evaluation Report for DY 15-19 due to CMS	31-Dec-26	July 2020 – June 2025
Draft Interim Evaluation Report for DY 15-22 due to CMS	31-Dec-29	July 2020 – June 2028
Draft Summative Report due to CMS	31-Dec-31	July 2020 – June 2030

Analysis for each interim and summative report will use the most rigorous analytic method for the data that is available. Determination of the final analytic method in each report and for each measure will be determined upon receipt of data to assess the quality, frequency, and availability of data, each of which will influence the analytic method. Moreover, the impact of COVID-19 in evaluation periods may influence the analytic method.

Generally, analyses that utilize an interrupted time series will likely not be able to be conducted until the DY 15-19 and DY 15-22 interim reports and the summative report since it is expected that there will likely be too few data points for a robust interrupted time series analysis. The synthetic control method, which depending largely on the availability of T-MSIS data, will likely not be viable until the summative report, due to the two-to-three-year lag in data availability. The next-best rigorous analytic approach will be used in lieu of the interrupted time series and synthetic controls.

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*
Care from Dentists and Staff	Percentage of respondents reporting their regular dentist usually or always explains things in a way that is easy to understand (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always listens to them carefully (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always treats them with courtesy and respect (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always spends enough time with them (vs. sometimes or never) 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) 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)

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey*
Access to Dental Care	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 appointment (vs. sometimes or never) 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")
Dental Plan Coverage and Services	Percentage of respondents reporting their dental plan usually or always covers all of the services they think are covered (vs. sometimes or never) Percentage of respondents reporting that the 800 number, written materials, or website usually or always provides the information they want (vs. sometimes or never) 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) Percentage of respondents reporting their dental plan's customer service staff usually or always treats them with courtesy and respect (vs. sometimes or never) 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") 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")
Patients' Rating	Percentage of respondents rating their regular dentist an 8, 9, or 10 on a scale of 0 (worst) to 10 (best) 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) 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) 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)
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 (Note – This measure will not be reported after CY 2016 data)	≥ 2 visits (182 days apart)	Agency-defined	--	--
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	--	--

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
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
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	--	

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
Medication Management for People with Asthma		NCQA HEDIS	--	1799
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
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, >= 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.

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,
- Enrollee participation and completion rates in Healthy Behaviors programs, and
- Enrollment.

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	1.1.1, 1.1.2
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)	1.1.1, 1.1.2
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	1.3.1, 1.3.2
Outpatient	PMPM average number of visits that a Medicaid enrollee had in a month	1.3.1, 1.3.2
ED	PMPM average number of visits that a Medicaid enrollee had in a month	1.3.1, 1.3.2
Professional Physician	PMPM average number of visits that a Medicaid enrollee had in a month	1.3.1, 1.3.2
Specialist	PMPM average number of visits that a Medicaid enrollee had in a month	1.3.1, 1.3.2
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 Outpatient Visits	Mean Service Use	10.3.1
Physician Primary Care Visits	Mean Service Use	10.3.1
Pharmacy Claims	Mean Service Use	10.3.1
Assisted Living	Mean Service Use	
Transitional Housing Services	Mean Service Use	10.1.5; 10.1.6; 10.1.7
Mobile Crisis Services	Mean Service Use	10.1.5; 10.1.6; 10.1.7
Peer Support Services	Mean Service Use	10.1.5; 10.1.6; 10.1.7
Tenancy Services	Mean Service Use	10.1.5; 10.1.6; 10.1.7
Potentially Preventable Hospitalizations	Mean Service Use	10.2.1
Potentially Preventable Emergency Department Visits	Mean Service Use	10.2.1
Behavioral Health Services	Mean Service Use	10.3.1
Average PCP Appointment Wait Times. Average appointment wait times. Data Source: Timely Access PCP Wait Times Report		
Urgent Care	Days	1F
Routine Sick	Days	1.5.1
Wellcare Visit	Days	1.5.1
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.		
Total MMA and LTC Costs Combined	Per Member Per Month Mean Cost	1.6.1

Measure	Description	Research Question(s)
Total MMA	Per Member Per Month Mean Cost	1.6.1
Hospital Inpatient	Per Member Per Month Mean Cost	1.6.1
Hospital Outpatient	Per Member Per Month Mean Cost	1.6.1
Physician Primary Visit	Per Member Per Month Mean Cost	1.6.1
Physician Specialist Visit	Per Member Per Month Mean Cost	1.6.1
Pharmacy Cost	Per Member Per Month Mean Cost	1.6.1
Emergency Dept. Cost	Per Member Per Month Mean Cost	1.6.1
Total LTC Costs	Per Member Per Month Mean Cost	1.6.1
Assisted Living Costs	Per Member Per Month Mean Cost	1.6.1
HCBS Costs	Per Member Per Month Mean Cost	1.6.1
Home Health Costs	Per Member Per Month Mean Cost	1.6.1
Hospice Costs	Per Member Per Month Mean Cost	1.6.1
Nursing Home Costs	Per Member Per Month Mean Cost	1.6.1
Supportive Housing Service Costs	Per Member Per Month Mean Cost	9.1.10
Expanded Benefits Offered by Plans		
Adult Dental Services	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Adult Influenza Vaccine	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Adult Pneumonia Vaccine	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Adult Shingles Vaccine	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Art Therapy	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Equine Therapy	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Hearing Services	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Home Health (non-pregnant adults)	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Medically Related Lodging & Food	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Newborn Circumcisions	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Nutritional Counseling	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Extra Outpatient Services	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Over-The Counter Drugs/ Supplies Aid	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Pet Therapy	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Physician Home Visits	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Post-Discharge Meals	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Extra Prenatal/ Perinatal Visits	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Extra Primary Care Visits	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Vision Services	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Waived Co-payments	Presence or Absence and Summary Counts	2.1.1, 2.1.2
Total Number of Expanded Benefits	Presence or Absence and Summary Counts	2.1.1, 2.1.2

Plan Interviews – Most Common Themes
(Subsequent year themes to be determined)

Quality of Care	% of content	1.4.3, 1.4.4
Behavioral Health	% of content	6.1.4, 6.1.5
Non-emergency Transportation	% of content	6.1.4, 6.1.5
Housing Assistance Pilot implementation	% of content	10.1.1, 10.1.2, 10.1.3, 10.1.4
Housing Services Care Coordination	% of content	10.1.8
Types of Healthy Behaviors Programs and Incentives **Data Source: Quarterly Healthy Behaviors Summary Reports**		
Medically Approved Smoking Cessation Program	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Medically Directed Weight Loss Program	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Medically Approved Alcohol or Substance Abuse Recovery Program	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Preventive Well Child Care	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Prenatal, Maternity, & Postpartum Visits	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Preventive Adult Care (PCP visits)	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Mammograms	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6
Cervical Cancer Screening	#, incentives and value	3.1.1, 3.1.2, 3.1.3, 3.2.1, 3.1.4, 3.1.5, 3.1.6

Enrollee Participation and Completion Rates in Healthy Behaviors Programs (Mandatory and Optional)		
Number currently enrolled	#	3.1.4, 3.1.5, 3.1.6
Enrollees who completed program	#	3.1.4, 3.1.5, 3.1.
Plans Offering Program	#	3.1.4, 3.1.5, 3.1.
Plan with Most Participants	#	3.1.4, 3.1.5, 3.1.
By Gender	# (Male, Female)	3.3.1
By Age Group	# (Age Grp 0-20, 21-40, 41-60, over 60)	3.3.1
Enrollment Measures		
Medicaid Enrollees by Eligibility Group Out of Estimated Eligible Recipients	The percentage of Medicaid enrollees by eligibility group out of estimated eligible Medicaid recipients.	9.4.1
Percentage of New Medicaid Enrollees by Eligibility Group, As Identified by Those Without a Recent Spell of Medicaid Coverage Out of Estimated Eligible Medicaid	The percentage of new Medicaid enrollees by eligibility group, as identified as those without a recent spell of Medicaid coverage out of estimated eligible Medicaid recipients.	9.4.1
Number of Medicaid Enrollees Per Month by Eligibility Group and/or Per-Capita of State	The number of Medicaid enrollees per month by eligibility group and/or per-capita of the state.	9.4.1
Number of New Medicaid Enrollees Per Month by Eligibility Group, as Identified by Those Without a Recent Spell of Medicaid Coverage	The number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage.	9.4.1

The following provides descriptions and numerators/denominators for the four evaluator-defined measures shown above in ***Table 4***:

Medicaid Enrollees by Eligibility Group Out of Estimated Eligible Recipients

Description: The percentage of Medicaid enrollees by eligibility group out of estimated eligible Medicaid recipients. Data for this measure will be sourced from the Integrated Public Use Microdata Series American Community Survey.

Denominator: Number of individuals likely eligible for Medicaid last year based on IPUMS survey data on family income (FTOTINC), number of own children in household (NCHILD), and disability (DIFFREM, DIFFCARE, DIFFPHYS, DIFFMOB, DIFFSENS).

Numerator: Number of beneficiaries covered by Medicaid (HINSCAID)

Percentage of New Medicaid Enrollees by Eligibility Group, As Identified by Those Without a Recent Spell of Medicaid Coverage Out of Estimated Eligible Medicaid

Description: The percentage of new Medicaid enrollees by eligibility group, as identified as those without a recent spell of Medicaid coverage out of estimated eligible Medicaid recipients. Data for this measure will be sourced from the Integrated Public Use Microdata Series American Community Survey.

Denominator: Number of individuals likely eligible for Medicaid based on IPUMS survey data on family income (FTOTINC), number of own children in household (NCHILD), and disability (DIFFREM, DIFFCARE, DIFFPHYS, DIFFMOB, DIFFSENS).

Numerator: Number of beneficiaries beginning enrollment in Medicaid.

Number of Medicaid Enrollees Per Month by Eligibility Group and/or Per-Capita of State

Description: The number of Medicaid enrollees per month by eligibility group and/or per-capita of the state. Data for this measure will be sourced from the Integrated Public Use Microdata Series American Community Survey.

Denominator: Estimated current year population of Florida.

Numerator: Number of beneficiaries beginning enrollment in Medicaid.

Number of New Medicaid Enrollees Per Month by Eligibility Group, as Identified by Those Without a Recent Spell of Medicaid Coverage

Description: The number of new Medicaid enrollees per month by eligibility group, as identified by those without a recent spell of Medicaid coverage. Data for this measure will be sourced from the Integrated Public Use Microdata Series American Community Survey.

Denominator: N/A

Numerator: Number of beneficiaries beginning enrollment in Medicaid who did not have Medicaid coverage for at least six months prior.

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 Decision Support System (DSS) database. The evaluation team conducts numerous checks related to data integrity upon receipt of the DSS 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. Duplicate records are deleted to eliminate redundant encounter records resulting from multiple submissions from providers.

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
Medicaid claims, eligibility, enrollment and encounter data	Pre-MMA MMA	Pre-MMA Inclusion criteria ▪ 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. Exclusion criteria ▪ All groups explicitly excluded from MMA program participation. Demographic and health status characteristics MMA Inclusion criteria ▪ 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. Exclusion criteria ▪ All groups explicitly excluded from MMA program participation. Demographic and health status characteristics
Consumer Assessment of Health Care Providers and Systems (CAHPS)	Pre-MMA MMA	See Table 2 above for a complete listing of the proposed CAHPS measures for this evaluation.
CAHPS Dental Plan Survey	MMA	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.

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	Case file audit reviews to determine the timeliness of enrollee assessments performed by case managers Reviews of the consistency of enrollee service authorizations performed by case managers Development and implementation of continuous improvement strategies to address identified deficiencies
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	All available data related to each Healthy Behaviors program Caseloads (new and ongoing) for each Healthy Behaviors program at the individual recipient level Amount and type of rewards/incentives provided for each Healthy Behaviors program
Annual Milestone Statistics and Findings Report Data	MMA	LIP Payments by provider (hospital and non-hospital) Number of individuals served (hospital providers) including Medicaid, Uninsured, Total all unduplicated, Inpatient, Outpatient, and Inpatient/ Outpatient combined Average number of individuals served (hospital providers) Growth in the number of individuals served (hospital

Data Source	Time Period*	Variables
		providers) 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)
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
Qualitative interviews of state staff	DY15-DY22	Qualitative interviews by evaluators may also help to systematically gather information on administrative costs, particularly for understanding the allocation of state staff time required to launch and then maintain demonstration operations. Depending on the role of managed care plans in implementing the demonstration policies, states may also need to include managed care administrative costs, gathering information through interviews and potentially through secondary data sources.

Provider surveys	DY15-DY22	State-specific provider surveys, which could provide information about uncompensated care costs incurred by hospital and nonhospital providers, such as federally qualified health centers. States should field such a survey at baseline to understand changes after demonstration implementation.
Enrollee satisfaction surveys: - 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,
Integrated Public Use Microdata Series (IPUMS) American Community Survey	DY11-DY22	ACS HINSCAID, HIUIR, HIURULE, INCTOT, AGE, DIFFREM, DIFFCARE, DIFFPHYS, DIFFMOB, DIFFSENS
Transformed Medicaid Statistical Information System (T-MSIS)	DY9-DY22	If available, T-MSIS data will be used for out of state comparison groups. Variables will include all data necessary for identifying outcomes of interest (e.g. diagnosis and procedure codes) and confounding factors.
Healthcare Cost Report Information System (HCRIS)	Pre-MMA MMA	Variables of interest include data on total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs; cost of charity care; and difference between net revenue and costs for Medicaid program.

Florida Hospital Uniform Reporting System (FHURS)	Pre-MMA MMA	Variables of interest include data on charity care, Medicaid revenue, total revenue, and operating expenses.

*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, strong evaluation designs that address the limitations of pre-post and post-only designs such as difference-in-differences and propensity-score matching are not viable for evaluating Florida's MMA program. The exceptions where this approach may be used include 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). These stronger evaluation designs are not viable for much of the MMA program primarily due to the fact that Florida's statewide transition to the MMA program took place over a three-month period[5] 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. Comparison groups outside of Florida Medicaid provide the next-best approach for establishing causal inferences. Where possible, out-of-state data will be used to serve as comparison groups. While an out-of-state comparison group can provide a counterfactual design, the granularity of the data available may not allow for strong statistical controls over differences across the populations. Additionally, it is unlikely the independent evaluator will be able to control for additional quality improvement programs that may impact a comparison group population.

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

Out-of-State Comparison Groups

Identifying Comparison States

The selection of states used for an out-of-state comparison group will be based on similarities to Florida Medicaid members in terms of overall demographics as well as state Medicaid programs and policies. In addition, comparison states should not have a major change in Medicaid policies during either the baseline or evaluation periods. Selection of states will be conducted on a measure-by-measure basis depending on available data. The independent evaluator will assess the feasibility of utilizing out-of-state comparison groups based on the criteria for identifying comparison states and data availability.

The menu of analytic methods generally depends on two factors related to availability of data:

1) Level of data granularity
2) Number of time periods prior to intervention

Level of Data Granularity

Beneficiary-Level Data

Data at the beneficiary-level would allow for a selection of individuals who are similar to MMA beneficiaries which would serve as a comparison group. This would provide the most flexibility in identifying a suitable comparison group for a wide selection of measures. Such data may be obtained through the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF). Due to the two-to-three year lag, with only preliminary data for 2020 available as of this writing, the T-MSIS data is expected to be feasible for only the summative evaluation report. Depending on access fees and the restrictions around using the T-MSIS data, the independent evaluator will determine the most cost-effective and feasible approach for developing a comparison group. With beneficiary-level data supplied through T-MSIS, the independent evaluator expects to be able to apply individual level propensity scoring adjustments.[6]

Moreover, with access to beneficiary-level Medicaid data, the independent evaluator can calculate rates for customized or non-standardized measures as opposed to relying on aggregate data for established quality metrics.

Aggregate Data

If beneficiary-level data are not available or are not cost-effective, established quality metrics such as measures that follow CMS Core Set specifications can utilize aggregate data in the form of benchmark information or data from out-of-state health plans. The level of granularity of the benchmark data and available time periods will dictate the type of statistical testing possible. For instance, some methods such as difference-in-differences require distributional measures of the data such as standard deviation or variance, and/or sample sizes. If these data are not available, it will not be possible to calculate the standard errors necessary for making statistical inferences. It is possible, however, to implement other methods such as interrupted time series or synthetic controls with aggregated rate data, but as described

[6] Bradley, K., J. Heeringa, R.V. Pohl, J.D. Reschovsky, and M. Samra. “Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations.” Washington, DC: Mathematica, revised October 2020.

below, require sufficient number of data points prior to intervention.

Pre-Intervention Data Availability

If the source of out of state data are limited to few data points prior to implementation, then the independent evaluator will apply a difference-in-differences approach, which can be conducted on as little as one baseline data point.[7] If additional but limited data points are available (for example between 3 and 6 data points), then the independent evaluator will explore either an interrupted time series approach with comparison group(s) or synthetic controls. With additional data points, the likelihood of successfully applying the synthetic control methods increases.

Certain components of the evaluation, however, may be able to utilize an in-state comparison group. For example, 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 may serve as controls, which may allow for standard and/or modified difference-in-differences analysis of the Housing Assistance Pilot. While there are no members on the waitlist at time of writing, this approach may be used for late interim reports or the summative report if the program has reached its capacity and there are individuals on the waitlist.

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 the best approach given constraints on available data and/or as dictated by the research question under study. In general, a pre-post perspective (e.g., ITS with or without comparison group, difference-in-differences, or synthetic controls) 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, including propensity scoring adjustments, will be used whenever feasible to control for other factors that might influence the outcome.

Propensity Score Matching

Propensity score matching will be used to identify a subset of the eligible comparison group that is most similar to the intervention population based on observable characteristics,

[7] Pohl, K. R., and Bradley, K. "Selection of Out-of-State Comparison Groups and the Synthetic Control Method." Washington, DC: Mathematica, October 2020.

including demographic factors and health conditions prior to implementation of the demonstration.[8] Propensity score matching has been used extensively to match individuals from an eligible comparison group to individuals in the intervention group.[9] However, there are several risks to the use of propensity scores and subsequent matching on the propensity score .

Propensity Score Risks

Risk	Description
Insufficient coverage	Not enough individuals in the eligible comparison group similar enough to intervention population for 1:1 matching
Unbalanced groups	Observable characteristics of the intervention and comparison groups after matching are not balanced

When confronted with insufficient coverage, the independent evaluator will first explore alternative specifications in either the propensity score model and/or the matching algorithm before moving to alternative approaches. For example, instead of a typical 1:1 greedy matching algorithm, the independent evaluator will explore matching with replacement or optimal matching algorithms.[10] If alternative matching algorithms do not yield a matched comparison group with sufficient coverage and balance, then propensity score weighting will be explored as the next step. Propensity score weighting utilizes the full eligible comparison group and assigns a higher statistical weight to beneficiaries who are predicted to be part of the intervention but were not. A risk of this methodology is that the analysis may be dominated by a handful of beneficiaries with extremely high weights.

Balance between the matched comparison and intervention groups will be assessed using a three-pronged approach to evaluate the similarity between the intervention group and comparison groups across observable characteristics, or covariates. The **Error! Reference source not found.** summarizes each of the three prongs.

Assessment Approaches

Assessment Approach	Advantage	Cautionary Note
Covariate-level statistical testing	Provides quantitative evidence, or lack thereof, of significant differences between matched groups	Susceptible to false positives for large sample sizes and false negatives for small sample sizes
Standardized differences	Does not rely on sample size	No universal threshold to indicate balance or unbalance
Omnibus test	Provides a single quantitative assessment of balance across all covariates as a whole	Susceptible to false positives for large sample sizes and false negatives for small sample sizes

Each of these approaches ultimately assesses the similarity of the *mean* of the distribution for each covariate. Additional metrics pertaining to the distribution should also be considered as part of the balance assessment, such as reporting the standard deviations.[11]

[8] See, e.g., Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations" for a detailed discussion of appropriate evaluation designs based on comparison group strategies (https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-evaldsgn.pdf).

[9] Guo, S., and Fraser, M.W., (2010) *Propensity Score Analysis: Statistical Methods and Applications,* SAGE Publications, Inc., Thousand Oaks, CA; or Austin, P. C. (2011). An Introduction to Propensity Score Methods for Reducing the Effects of Confounding in Observational Studies. *Multivariate behavioral research*, *46*(3), 399–424. doi:10.1080/00273171.2011.568786; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144483/.

[10] See, e.g., Austin P. C. (2014). A comparison of 12 algorithms for matching on the propensity score. *Statistics in medicine*, 33(6), 1057–1069. doi:10.1002/sim.6004; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4285163/.

[11] Austin P. C. (2011). An Introduction to Propensity Score Methods for Reducing the Effects of Confounding in Observational

These categories represent a starting place for building the comparison group and may not reflect the final selection identified by the independent evaluator.

Similarities in observable characteristics between the intervention population and those meeting exemptions will be assessed and if systematic differences are found, propensity score matching, or weighting, will be used to normalize the comparison group to match the intervention group.

Identifying and Accounting for Impacts of the COVID-19 Public Health Emergency

The COVID-19 public health emergency (PHE) impacted Medicaid programs, enrollment, utilization patterns, state expenditure patterns in unprecedented ways in terms of scope, magnitude, and duration. The resulting impacts, particularly for CY 2020, generally dominate any programmatic impacts, particularly for program elements that may have been scheduled for implementation during the PHE. Separating PHE and demonstration effect is particularly challenging for this evaluation since DY 15-17 (the years most impacted by the PHE) primarily represent continuations of previous programmatic elements.

Impacts from the PHE vary by state, but *generally*, CY 2019 and early Q1 2020 represent negligible or very small PHE impacts. Beginning in late Q1 and through Q2 of 2020, the data reflect the maximum impact resulting from the PHE and the PHE effects dominate most demonstration waiver program impacts, particularly for demonstrations, such as this, where few if any programmatic changes were implemented during this period. Beginning in Q3 and Q4 of 2020, the PHE impact diminished but remained significant. During this period, PHE impacts can still dominate program effects, but the exact trajectory of the PHE impact, including its degree of persistence over time are not currently well understood, particularly with regional variations in subsequent spikes in COVID cases and the emergence of COVID variant strains.

Beginning in CY 2021 fewer PHE impacts are generally observed; however, as with the previous period, the exact trajectory of the PHE impacts, including their degree of persistence and the effects of subsequent infection rate spikes and COVID variants may still drive significant impacts that could be confounded with or mistaken for demonstration effects, such as an increase in utilization resulting from pent-up demand for services. Additionally, the PHE has resulted in fundamental changes across a wide range of health care, including the widespread adoption and availability of telehealth services; changes which may not be the result of a demonstration.

The independent evaluator will employ a range of approaches to adjust or account for PHE impacts throughout the course of the evaluation. The specific approach used for a given measure will depend on several factors that will not be known until the evaluation activities covered by this design are underway. Some of these factors include:

- The quality and availability of data pertaining to specific measures in the evaluation design and the appropriateness of the data for the PHE adjustment method;
- The availability and reliability of PHE-related data such as COVID infection rates as well as measures of hospital and emergency department capacity; and,
- The availability and quality of multiple-state data covering a sufficient baseline period

Studies. *Multivariate behavioral research*, *46*(3), 399–424. doi:10.1080/00273171.2011.568786; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144483/.

through at least CY 2021.

Once the data have been collected, validated, and reviewed, the independent evaluator will determine and employ the most rigorous method based on the content of the measure, any observable PHE impacts, and available data.

A brief overview of the range of methods that may be implemented are described below, ranging from the least to the most complex/rigorous.

- Dropping observations for periods in which the PHE impacts dominate demonstration effects to such a degree that no method can reliably or accurately separate demonstration effects from the PHE impacts.
- Adjust baseline periods, where appropriate, from pre-PHE period to a post CY 2020 period, ensuring that demonstration effects are measured and tested against a baseline period that more accurately reflects the post-PHE changes in the provision and utilization of health care.
- Restrict the analyses to beneficiaries who were continuously enrolled in Medicaid before the PHE through the evaluation period.
- Implement case mix (or risk) adjustments across the entire PHE trajectory to account for variations in Medicaid enrollment resulting from the PHE.
- Develop a composite measure of PHE impact based on available measures of "COVID intensity", such as COVID case rates, including variations over time and across geographic regions. This will allow for a proxy measure of the PHE impact across time and geographic regions.
- Employ an event study method, estimating impacts for each year in the demonstration rather than across the entire duration of the demonstration.
- Estimate alternative counterfactuals, using interrupted time series.
- Leverage multiple-state data, such as T-MSIS, combined with time-series data and geographic measures of PHE intensity, such as COVID infection rates, measures of hospital/ED capacity, and other relevant PHE policies across several comparison state to develop a high frequency (e.g., quarterly or monthly) estimate of the PHE impact trajectory over demonstration years possibly impacted by the PHE. In conjunction with a multiple-state control/comparison group, this approach would allow the independent evaluator to estimate a PHE-only counterfactual against which to test the presence and magnitude of demonstration effects.

Each approach has unique strengths and weaknesses that will vary by measure, data source, and the degree of the PHE impact. The independent evaluator will provide a complete description of the methods used as well as a justification for its use across all measures included in the evaluation. Additionally, the independent evaluator will conduct sensitivity analyses across all measures and methods used to separate PHE and demonstration effects to determine the extent to which the particular PHE adjustment may have changed the outcome of the measure

Statistical Testing and Modeling

The independent evaluator will utilize the best analytic approach given the type of measure, research question, and available data.

Multivariable statistical models, including propensity score matching, 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).

Synthetic Control Method

If data are available from a large number of other states and for sufficient number of pre-intervention time periods, the independent evaluator will first seek to implement the synthetic control method prior to conducting alternative analyses. This method, as described in CMS' guidance on Section 1115 demonstration evaluations, "involves constructing a single comparison group from a pool of potential comparison states (the "donor pool") by combining them so that the newly constructed (synthetic) comparison group resembles the treatment group as closely as possible on levels and trends in preintervention outcomes."[12] Although this approach is the most restrictive in terms of requiring the most number of comparison states and pre-intervention data points, it is flexible in terms of level of data necessary. For example, if the independent evaluator cannot obtain beneficiary-level data or measures of uncertainty in aggregate data are not available, aggregate data in the form of statewide or plan-level rates may still be used.

Interrupted Time Series

When a suitable comparison group cannot be found and data can be collected at multiple points in time before and after the implementation of the program, an ITS methodology can be used. This analysis is quasi-experimental in design and will compare a trend in outcomes between the baseline period and the evaluation period for those who were subject to the program.

In ITS, the measurements taken before the demonstration will be used to predict the outcome as if the demonstration did not occur. The measurements collected after the demonstration are then compared to the predicted outcome to evaluate the impact the demonstration had on the outcome. The ITS model is:

$$Y_t = \beta_0 + \beta_1 time_t + \beta_2 post_t + \beta_3 time \times post_t + \mu_t$$

where Y_t is the outcome of interest for the time period *t*, *time* represents a linear time trend, *post* is a dummy variable to indicate the time periods post-implementation, and *time×post* is the interaction term between time and post. The coefficient, β_0, identifies the starting level of outcome *Y*, β_1 is the slope of the outcome between the measurements before the program, β_2 is the change in the outcome at a various point in time, and β_3 is the change in the slope for the measurements after the program.

Assuming that the measurements taken after the implementation of the demonstration would have been equal to the expectation predicted from the measurements taken before the demonstration in the absence of the intervention, any changes in the observed rates after implementation can be attributed to the program.

A limitation of interrupted time series is the need for sufficient data points both before and after program implementation.[13] To facilitate this methodology, the independent evaluator may consider additional baseline data points using prior year calculations, and/or calculating quarterly rates where feasible, if multiple years both pre-and post-implementation are

[12] Pohl, K. R., and Bradley, K. "Selection of Out-of-State Comparison Groups and the Synthetic Control Method." Washington, DC: Mathematica, October 2020.

[13] Baicker, K., and Svoronos, T., (2019) "Testing the Validity of the Single Interrupted Time Series Design," *NBER Working Paper 26080,* https://www.nber.org/papers/w26080.pdf; Bernal, J.L., Cummins, S., Gasparrini, A. (2017) "Interrupted time series regression for the evaluation of public health interventions: a tutorial," *International Journal of Epidemiology,* 46(1): 348-355, https://doi.org/10.1093/ije/dyw098; Penfold, R. B., Zhang, F. (2013) "Use of Interrupted Time Series Analysis in Evaluating Health Care Quality Improvements," *Academic Pediatrics*, 13(6): S38 - S44, https://doi.org/10.1016/j.acap.2013.08.002.

available to control for seasonality in quarterly data.

If out-of-state data are available, a variation of the ITS approach to include a comparison group can be implemented.[14]

Comparison to National Benchmarks

The independent evaluator will compare rates using statistical testing (e.g., chi-square, t-tests) for established quality metrics to national benchmarks or national surveys where available but cannot implement more robust methods such as interrupted time series, synthetic controls, or DiD.

Medicaid Expenditures

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: given month, while ln (PMPM $) is the natural log of expenditures by an individual in any given month given that they incurred any expenditures.

$$\ln\left(\frac{(any\ \$ = 1)}{p(any\ \$ = 0)}\right) = MMA \cdot \beta 1 + \text{Age} \cdot \beta 2 + \text{Gender} \cdot \beta 3 + \text{Race} \cdot \beta 4 + \text{RiskScore} \cdot \beta 5 + \varepsilon \text{it}$$

$$\ln(PMPM\ \$)_{it} = MMA \cdot \beta 1 + \text{Age} \cdot \beta 2 + \text{Gender} \cdot \beta 3 + \text{Race} \cdot \beta 4 + \text{RiskScore} \cdot \beta 5 + \varepsilon \text{it}$$

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-

[14] Contreary, K., K. Bradley, and S. Chao. "Best Practices in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations." Oakland, CA: Mathematica Policy Research, June 2018

differences approach will also be employed to study the impact of the retroactive enrollment policy change on new enrollee financial burden (see Research Question 9.1.3).

Qualitative Analyses

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

- ***RQ 1.4.3****: What strategies are standard MMA and specialty MMA plans using to improve quality of care?*
- ***RQ 1.4.4****: Which of the strategies used by standard MMA and specialty MMA plans are most effective in improving quality and why?* ***RQ 2.1.5****: How do enrollees rate their experience and satisfaction with the expanded benefits that are offered by their health plan?*
- ***RQ 6.1.4****: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services for dual-eligible enrollees?*
- ***RQ 6.1.5:*** *What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for non-emergency transportation services for dual-eligible enrollees?*
- ***RQ 6.1.6:*** *How do dual-eligible enrollees rate their experience and satisfaction with* the *delivery of care they receive related to behavioral health services?*
- ***RQ 6.1.7****: How do dual-eligible enrollees rate their experience and satisfaction with* the *delivery of care they receive related to non-emergency transportation services?*
- ***RQ 8.4.3****: How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?*
- ***RQ 9.1.1****: How will eliminating retroactive eligibility change enrollment continuity?*
- ***RQ 9.2.1:*** *Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?*
- ***RQ 9.3.1:*** *What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?*
- ***RQ 10.1.4****: How did MMA plans implement the Pilot program?*
- ***RQ 10.1.8****: Is care coordination more effective for the study population as a result of the Housing Assistance Pilot Program?*
- ***RQ 11.1.1:*** *What are the administrative costs incurred by the state to implement and operate the demonstration?*
- ***RQ 11.2.3:*** *What are the impacts of eligibility and coverage policies on provider uncompensated care costs?*

Methods

Qualitative interviews with MMA plan experts. Experts in quality of care (RQs 1.4.3, 1.4.4), care coordination (RQs 6.1.4, 6.1.5, RQ 10.1.8), and program implementation (10.1.1, 10.1.2, 10.1.3, 10.1.4) 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 1.4.3, 1.4.4, 6.1.4, 6.1.5, 10.1.1, 10.1.2, 10.1.3, 10.1.4 and 10.1.8, respectively, which will be asked of all MMA plans for RQs 1.4.3, 1.4.4, 5.1.4 and6.1.5, and for MMA plans participating in the Housing Pilot for 10.1.1, 10.1.2, 10.1.3, 10.1.4 and 10.1.8. 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 (6.1.4, 6.1.5) 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 (1.4.3, 1.4.4) or coordination of behavioral health services and non- emergency transportation services (6.1.4, 6.1.5); 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 1.4.3, 1.4.4, 6.1.1, 6.1.2, and 6.1.3, 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 (2.1.5), coordination of behavioral health and non-emergency transportation for dual-eligible members (6.1.6, 6.1.7), expanded benefits offered by prepaid dental health plans (8.4.3), new enrollee health status (9.1.2), enrollee understanding of retroactive enrollment changes and barriers to enrollment renewal (9.2.1and 9.3.1), 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 (10.1.9). The surveys will be administered to MMA and prepaid dental plan members (2.1.5, 8.4.3), dual-eligible MMA plan members (5.1.6, 6.1.7) who were enrolled in an MMA standard or MMA specialty plan in the last 12 months, MMA new enrollees (9.1.2), MMA enrollees subject to the new retroactive enrollment policy (9.2.1 and 9.3.1), and plan members who participated in the Housing Assistance Pilot (10.1.9). 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.

Four measures utilize CAHPS beneficiary surveys. The independent evaluator will use existing and/or historic CAHPS data administered by health plans in the analysis of these measures, depending on data availability. As these surveys have already been fielded and the data already exist, the independent evaluator will have limited influence over the sample sizes of these surveys. These previously administered CAHPS surveys (as well as future surveys) have followed (and will follow) the standard National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Specifications for Survey Measures, which requires a sample size of 1,350 beneficiaries for the CAHPS 5.0 Adult Medicaid Health Plan Survey and 1,650 for the CAHPS 5.0 Child Medicaid Health Plan Survey[15,16].

For the measures that rely on customized survey questions, a separate power calculation was conducted to determine the required sample sizes to assess various effect sizes; we chose to compare a 3 percent, 5 percent, and 10 percent proportional difference, which corresponds to 1.5, 2.5, and 5 percentage point change from 50 percent, respectively. Using a standard power level of 0.80, an alpha level of 0.05 and a two-sided test, we calculated the required sample sizes using both a chi-square test and z-test for difference in proportions.

Proportion Difference	Chi-square n	Z-test n
0.015	17,437	17,438
0.025	6,274	6,276

[15] HEDIS is a registered trademark of NCQA.
[16] National Committee for Quality Assurance. *HEDIS® 2021, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

Proportion Difference	Chi-square n	Z-test n
0.05	1,565	1,566

A sample size that is powered to detect a proportional difference of 5 percent, a value that is appropriate given the proposed measures is ideal. However, this would require a total number of surveys of 41,861 (6,276 * 6.67), assuming a 15 percent response rate. However, since budgetary constraints are a concern, then 10,446 (1,566 * 6.67) total surveys will likely be used to detect a 10 percent proportional difference.

The State and its independent evaluator will seek to streamline survey administration across evaluations to minimize the number of separate survey rounds required, thereby minimizing the burden on beneficiaries and maximizing the response rate.

Provider surveys. It is expected that FHURS and HCRIS data will be available and sufficient to investigate RQ 11.2.3. However, provider surveys may be administered to answer RQ 11.2.3, if FHURS and/or HCRIS data are not available or do not sufficiently address the research question. In that event, provider surveys will be developed by the independent evaluator and power calculations provided in the interim and summative reports.

Qualitative issues and approaches for specific questions.

Research Questions 1.4.3 and 1.4.4
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 2.1.5
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 Questions 6.1.6, 6.1.7, and 10.1.8
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 Questions 1.5.6 and 1.5.7
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 questions 1.5.6 and 1.5.7 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 8.4.3
Sampling and other survey methods specific to RQ 8.4.3 will likely be similar to those used for RQs 2.1.5, 1.5.6 and 1.5.7and will be determined after more information on the operation and utilization rates of the prepaid dental health program becomes available.

Research Question 9.1.1
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 8.1.1 will likely be similar to those used for RQs 1.4.3 and 1.4.4.

Research Question 9.1.2
RQ 9.1.2will 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 9.2.1
RQ 9.2.1 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 9.2.1 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 9.3.1
RQ 9.3.1 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 9.3.1 will be the same as for RQ 9.2.1.

Research Questions 10.1.1, 10.1.2, 10.1.3, and 10.1.4
RQs 10.1.1, 10.1.3, 10.1.3, and 10.1.4 examine 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 10.1.8
RQ 10.1.8 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.

Research Question 11.1.1
Research Question 11.1.1 examines administrative costs incurred by the state to implement and operate the demonstration. Qualitative interviews will systematically gather information on administrative costs, particularly for understanding the allocation of state staff time required to launch and then maintain demonstration operations. They state may also conduct data collection through interviews and secondary sources on managed care administrative costs.

Research Question 11.2.3
Research Question 11.2.3 examines the impacts of eligibility and coverage policies on provider uncompensated care costs. The state-specific provider survey, will provide information about uncompensated care costs incurred by hospital and nonhospital providers, such as federally qualified health centers. The state will field surveys at baseline to understand changes after demonstration implementation.

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				
Q1.1.1: What barriers do enrollees encounter when accessing primary care services? Q1.1.2: What barriers do enrollees encounter when accessing preventive services?	-Frequencies of complaints, grievances, and appeals related to access to care	-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	-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data -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
Q1.2.1: 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?	**-Standard measures and composites of the CAHPS survey:** -Getting Needed Care -Getting Care Quickly -Rate the Number of Doctors -Health Plan Information and Customer Service **- MMA program weighted HEDIS**	-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data -MMA program weighted HEDIS means compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of	-CAHPS, HEDIS, encounter data as necessary -NCQA Quality Compass Benchmarks -T-MSIS (for MMA program weighted HEDIS means measures)	-Synthetic controls -ITS -Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	means: - 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) 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 ≥182 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 (≥ 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	the MMA program		services
Q1.3.1: What changes in the utilization of services for enrollees are evident post-	Utilization: - Inpatient -Outpatient -ED -Professional	-Pre-MMA vs. MMA periods -Enrollees eligible for enrollment in a	-Medicaid claims, eligibility, enrollment, encounter data	-Synthetic controls -ITS

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
MMA implementation, comparing 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 ? Q1.3.2: What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing 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?	(Physician, Specialist)	specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans	-NCQA Quality Compass Benchmarks -T-MSIS	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity
Q1.4.3: What strategies are standard MMA and specialty MMA plans using to improve quality of care? Q1.4.4: Which of the strategies used by standard MMA and specialty MMA plans are	-Descriptions of Performance Improvement Projects (PIPs), including their objectives, interventions, and outcomes -Themes from qualitative interviews with plan experts on quality of care	-Standard plan populations -Specialty plan populations -Populations outlined in PIPs -Representatives of MMA and MMA specialty plans	-EQRO reports and plan PIPs as available. -Qualitative Interviews	-Descriptive analyses -Qualitative analyses (interviews with health plan Quality Improvement contacts)

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
most effective in improving quality and why?				
Q1.5.1: 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?	-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)	-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	-CAHPS (Adult and Child): Getting Care Quickly survey measure -Timely Access PCP Wait Times report -HEDIS measures related to timeliness of services -Non-Emergency Transportation Timeliness Report -NCQA Quality Compass Benchmarks -T-MSIS (for PPC measure)	-Synthetic controls -ITS -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)
Q1.6.1: 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-member per-month expenditures as measured by monthly risk-adjusted capitated payment to plans	-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	-Medicaid FFS and capitation claims, Medicaid eligibility data	-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 standard MMA and specialty MMA plans. Evaluators will examine trends in PMPM expenditures over time. Multivariate controls will include age,

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
				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				
Q2.1.1: What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? Q2.1.2: 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
Q2.1.3: How many enrollees utilize expanded benefits? Q2.1.4: Which expended benefits are enrollees most commonly using?	-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
Q2.2.1: 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) compared to those enrollees who do not?	-ED utilization -Inpatient hospitalizations	-Users of expanded benefits vs non-users of expanded benefits	-Encounter data	-ITS with comparison group -Multivariate analyses, when applicable & to the extent possible
Beginning with the evaluation of DY11 (SFY 2016-17) Q2.1.5: How do	-Enrollee satisfaction with expanded benefits	-Health plan enrollees	-Surveys	-Qualitative analyses

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?				
Component 3: Participation in the Healthy Behaviors programs and its effect on participant behavior or health status				
Q3.1.1: What Healthy Behaviors programs do MMA plans offer? Q3.1.2: What types of programs 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	-Descriptive analyses
Q3.2.1: What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs?	-Incentives and rewards offered by the plans to enrollees participating in HB programs.	-MMA standard and specialty plans	-MMA managed care reports on healthy behaviors	-Descriptive analyses

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Q3.1.4: How many enrollees participate in each Healthy Behaviors program? Q3.1.5: How many enrollees complete Healthy Behaviors programs? Q3.1.6: Which types of Healthy Behaviors programs attract higher numbers of participants? Q3.4.1: 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)?	-Healthy Behaviors enrollees (gender, age) -Healthy Behaviors enrollees (race/ethnicity, health status beginning with the evaluation of DY13 – SFY 2018-19) -Healthy Behaviors program types - Service utilization (evaluation of DY13 and beyond)	-Healthy Behaviors program enrollees	-Healthy Behaviors plan summary reports, quarterly -Individual data, DY13 and beyond	-Descriptive analyses -Multivariate analyses for 3E, DY13 and beyond
Component 4: The impact of LIP funding on hospital charity care programs				
For the evaluation of DY10 (SFY 2015-16) only Q4.1.1: How many Medicaid recipients receive services in LIP funded hospitals? Q4.1.2: How many uninsured recipients receive services in LIP funded hospitals? Q4.1.3: How many underinsured recipients receive services in LIP funded hospitals?	-Number of uninsured/underinsured patient served in LIP funded hospitals in DY10	-Hospitals that received LIP funding in DY10	-LIP providers -Payment amounts and type of payments (category) made to each provider. -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured	-Descriptive statistics and univariate analyses as applicable and to the extent possible

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
For the evaluation of DY10 (SFY 2015-16) only Q4.2.1: What types of services are being provided to Medicaid recipients receiving care in LIP funded hospitals?	-Number and types of services provided to uninsured/underinsured patients served in LIP funded hospitals in DY10	-Hospitals that received LIP funding in DY10	- LIP providers -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured	-Descriptive statistics and univariate analyses as applicable
Beginning with the evaluation of DY11 (SFY 2016-17) Q4.3.1: How many uncompensated charity care recipients receive services in LIP funded hospitals? Q4.3.2: How does the number of uncompensated charity care recipients receiving services in LIP funded hospitals compare among hospitals in different tiers of LIP funding? Q4.3.3: What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals? Q4.3.4: What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?	-Volume of services provided to uninsured patients: adjusted days (total inpatient days adjusted by patient-care revenues for outpatient services) -Dollar amount of charity care provided: gross revenue, net revenue, operating expense	-All organizations receiving LIP funding beginning with the evaluation of DY11	-FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net revenues for uncompensated care patients, and operating expenses) -LIP data: LIP providers -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	-Descriptive statistics and univariate analyses as applicable

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
			--DSH reporting data as available - Information on hospital charity care programs (policies, procedures, descriptions etc.)	
Beginning with the evaluation of DY12 (SFY 2017-18) Q4.4.1: What is the impact of LIP funding on the number of uncompensated charity care patients served in FQHCs, RHCs, and medical school physician practices? Q4.4.2: What is the impact of LIP funding on the types of services provided for uncompensated charity care patients served in FQHCs, RHCs, and medical school physician practices?	-Number of uncompensated charity care patients served -Types of services provided for each provider within each provider type category	-LIP funded FQHCS, RHCs, and medical school physician practices	-Number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices -FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net 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	-Descriptive and univariate analyses, to the extent possible

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
			uncompensated care services and encounters provided to the uninsured - Medicare cost reports - DSH reporting data as available	
Component 6: The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals				
Q6.1.1: How many MMA enrollees are also Medicare recipients (dual-eligible)? Q6.1.2: To what extent do dual-eligible enrollees utilize behavioral health services? Q6.1.3: To what extent do dual-eligible enrollees utilize non-emergency transportation services? Q6.1.4: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services for dual-eligible enrollees? Q6.1.5: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for non-emergency transportation	-Enrollee counts (6A) -Content analysis results for plans' care coordination practices related to behavioral health and non-emergency transportation services -Qualitative themes from interviews with plan experts on care coordination -CAHPS measures of experience and satisfaction with delivery of non- emergency transportation services; and ECHO measures of experience and satisfaction with behavioral health services	-Representatives of MMA and MMA specialty plans (care coordination experts) -Dual-eligible members in MMA and MMA specialty plans	-Medicaid encounter, eligibility, and enrollment data -Florida Health Data Center hospital and emergency department encounter data for dual-eligibles receiving care under Medicare auspices -MMA and MMA specialty plan P&P documents on coordination of behavioral health and non-emergency transportation services - Follow up Qualitative Interviews - Medicaid eligibility and enrollment data for telephone interview-eligible sample pool of dual-eligibles - Telephone survey results (frequencies for response categories for	-Descriptive analysis -Qualitative analysis using Atlas Ti, grounded theory and content analysis for plan care coordination experts -Descriptive analysis of telephone interview data

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
services for dual-eligible enrollees? Q6.1.6: How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health services? Q6.1.7: How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to non-emergency transportation services?			each question)	
Component 7: The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner				
Q7.1.1: 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? Q7.1.2: 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?	-Time to access services from enrollment date to date of first service use	New MMA enrollees (7.1.1, 7.1.2) New Medicaid enrollees in pre-MMA HMO and PSN plans in DY7 (7.1.2) -New MMA enrollees who selected their MMA plan (7.1.1) -New MMA enrollees who were auto-enrolled in an MMA plan (7.1.1) -New MMA enrollees who switched plans within 120 days of initial enrollment (7.1.1)	-Eligibility and Encounter data -Enrollment data that indicates auto- enrolled vs. enrollee-selected and whether the enrollee switched plans within 120 days	-Descriptive statistics and t-tests as applicable

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
		-New MMA enrollees who did not switch plans within 120 days of initial enrollment (7.1.1)		
Component 8: The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services				
Q8.1.1: How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area? Q8.2.1: What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Dental Utilization: - Inpatient -Outpatient -ED -Professional (Physician, Specialist)	-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	-Medicaid claims, eligibility, enrollment, encounter data for dental services	-ITS -Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.
Q8.2.1: What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	**-Dental performance measures listed in Table 3:** -Annual Dental Visit -Dental Treatment Services -Sealants for 6–9-Year-old Children at Elevated Caries Risk -Preventative Dental Services **The following four performance measures were not reported by plans prior to PDHP:** -Oral Evaluation -Topical Fluoride for Children at Elevated Caries Risk -Ambulatory Care Sensitive Emergency Department Visits for	-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	-PDHP performance measure reports to the Agency	-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			
Q8.2.3: 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 appointment (vs. sometimes or never) - 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.	-PDHP program CAHPS access to care results examined over time	-CAHPS data described in Table 3 -NCQA Quality Compass benchmarks	-ITS -Comparison to benchmarks -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
	"somewhat no" or "definitely no")			
Q8.3.1: 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
Q8.4.1: How many enrollees utilize expanded benefits provided by the dental health plans? Q8.4.2: Which expended benefits provided by the dental health plans are most commonly used by enrollees?	- 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
Q8.5.1: How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)? Q8.5.2: How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?	-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 utilization and associated dental-related hospitalizations	-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 extent possible), and race/ethnicity
Q8.6.1: What changes in per-enrollee cost for dental health services occur with	-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	-Medicaid FFS and capitation claims related to dental services	-Univariate analysis -Multivariate regression and

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
the implementation of the Statewide Medicaid Prepaid Dental Health Program?		at any point in time during pre-PDHP period -PDHP beneficiaries in dental plans following PDHP roll-out	-Medicaid and dental eligibility data	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
Q8.3.2: 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 8.2.3	-PDHP program child enrollees	-CAHPS Dental Services Survey -NCQA Quality Compass benchmarks	-Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of Services -ITS -Comparison t benchmarks
Q8.4.3: How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?	-Enrollee satisfaction with expanded benefits	-PDHP plan enrollees	-Surveys	-Qualitative analyses
Component 9: The impact of the waiver of retroactive eligibility on beneficiaries and providers.				
Q9.1.1: 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	-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.	-ITS -Pre-post logistic regressions of enrollment renewal controlling for demographics (age and sex), eligibility group, health status (Clinical Risk Group), and retroactive

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	or in anticipation of the policy change			enrollment policy.
Q9.1.2: 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. (See Appendix II, Table A-1) **NOTE: To the best of the evaluation team's knowledge, there does not exist a source for self-assessed health status or SF-12 scores from new Medicaid enrollees prior to the policy change. This precludes our ability to address this research question.**	-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
Q9.1.3: How will eliminating retroactive eligibility affect new enrollee financial burden?	-(1) Individual new enrollee medical debt verified by collection agencies prior to the new enrollee's application date.	-New Medicaid enrollees	Credit reporting data on new Medicaid enrollee medical and non-medical debt immediately prior to enrollment in Medicaid. Data obtained via contract from TransUnion LLC	-(1) Modified difference-in-differences models (as explained in Attachment 6) or interrupted time-series models of total and medical debt credit reporting data
Q9.1.4: How will eliminating retroactive eligibility affect provider uncompensated care amounts? Q9.1.5: How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?	-Hospital and SNF Uncompensated Care Expenditures -Hospital and SNF net income and rates of return -Hospital net change impact of UCC: UCC – LIP payments Hospital and SNF Uncompensated Care Expenditures	- Florida hospital and SNFs serving Medicaid enrollees	- CMS Healthcare Cost Report Information System (HCRIS) Hospital and Skilled Nursing Facility datasets (when available for 2019) - Florida Hospital Uniform Reporting System (FHURS) (if HCRIS data post policy change is	-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

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Q9.1.6: How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?	-Hospital and SNF net income and rates of return -Hospital net change impact of UCC: UCC – LIP payments		unavailable) - Florida Low Income Pool expenditure reports **Note: FHURS data is available approximately 180 days (or 6 months) after the fiscal year ends for each hospital.**	
Q9.2.1: Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps? Q9.3.1: What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?	-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	-Random telephone sample of Medicaid enrollees subject to the new retroactive enrollment policy (i.e., male and non-pregnant women)	-Beneficiary Survey #2 dealing with understanding of the policy change and common barriers to timely renewal. -Beneficiary Survey #2 is under development and will be submitted to CMS for review and approval prior to fielding.	-Descriptive tabulations and cross-tabulations of question responses by sex, age group, and enrollment length.
Q9.4.1**:** Do eligible people without prior quarter coverage enroll in Medicaid at the same rates as other eligible people with prior quarter coverage?	- Percentage of Medicaid Enrollees by Eligibility Group Out of Estimated Eligible Medicaid Recipients -Percentage of New Medicaid Enrollees by Eligibility Group, As Identified by Those Without a Recent Spell of Medicaid Coverage Out of Estimated Eligible Medicaid -Number of Medicaid Enrollees Per Month by Eligibility Group and/or Per-Capita of State -Number of New Medicaid Enrollees Per Month by Eligibility Group, as Identified by Those Without a Recent Spell of Medicaid Coverage	Medicaid Eligibility Groups as identifiable in ACS data and MMIS data	Integrated Public Use Microdata Series American Community Survey	-ITS -Difference-in-differences (if out-of-state or multiple state data are available) -Pre-test and post-test -Descriptive time series

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
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. (This component will begin with DY 14 through DY 19 unless CMS grants an extension of the housing pilot.)				
Q10.1.1: How many MMA plans participate in the Housing Assistance Pilot program? Q10.1.2: How many enrollees are participating in the Housing Assistance Pilot, by plan? Q10.1.3: How does participation in the Housing Assistance Pilot vary by gender, age, race/ethnicity and health status of enrollees? Q10.1.4: How did MMA plans implement the Pilot programs?	-Total number of participating MMA plans -Total number of enrollees receiving housing assistance services per plan -Total number of enrollees receiving housing assistance services by gender, age, race/ethnicity -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 - Implementation processes used by participating MMA plans	-MMA enrollees receiving housing assistance services -MMA program staff involved with the implementation process	-Enrollee Roster Report submitted by MMA plans -Qualitative interview to assess implementation	-Descriptive statistics (means, medians, standard deviations, etc.) -Descriptive tabulations of question responses from qualitative interviews
Q10.1.5: What is the frequency of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan? Q10.1.6: What is the 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? Q10.1.7: What is the proportion of enrollees who are successfully	-Total number of enrollees using transitional housing services -Total number of enrollees using mobile crisis services -Total number of enrollees using peer support -Total number of enrollees using tenancy services	-MMA enrollees receiving housing assistance services	-Enrollee Roster Report submitted by MMA plans	-Descriptive statistics (means, medians, standard deviations, etc.)

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
discharged from the Pilot but subsequently become homeless again and resume using services?				
Q10.2.1: 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?	-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	-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 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
Q10.3.1: 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?	-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	-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
Q10.1.8: Is care coordination more effective for the study population as a result of the Pilot program?	-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 reduced	-MMA plan staff with knowledge of care coordination conducted by the plan -Pilot Participants	-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
	-Percentage of participants diagnosed with a substance use disorder receiving medication assistance treatment -percentage of participants with serious mental illness who are compliant with medication management requirements			
Q10.1.9: 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
Q10.1.10: 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.
Component 11: Investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.				
Q11.1.1: What are the administrative costs incurred by the state to implement and operate the demonstration?	-Administrative costs associated with (1) implementation and (2) operation of the demonstration	-No comparison group per CMS guidance	-Current and past Agency budgets. Statewide Medicaid Monthly Enrollment Reports. Qualitative interviews of state agency staff.	-Estimates of fixed and variable administrative costs based on statistical models related administrative costs to enrollment levels.
Q11.2.1: What are the short-term effects of eligibility and coverage policies on Medicaid health service expenditures?	-Longitudinal health services expenditures per member per month (PMPM) for pre-MMA and MMA periods	-Medicaid enrollees assigned to the demonstration and those who would have been assigned to the demonstration in the pre-MMA period.	-Amount paid to providers from Medicaid claims and encounter files during pre-MMA and MMA periods, respectively.	-Two-part cost PMPM regression models controlling for enrollee sociodemographics, risk score, and the presence of the demonstration.

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Q11.2.2: What are the long-term effects of eligibility and coverage policies on Medicaid health service expenditures?				
Q11.2.3: What are the impacts of eligibility and coverage policies on provider uncompensated care costs?	-Uncompensated care costs for hospitals and nursing homes in Florida by year for the pre-MMA and MMA periods.	-Florida hospital and nursing home providers in the FHURS and HCRIS.	-Florida Hospital Uniform Reporting Systems (FHURS) and Healthcare Cost Report Information System (HCRIS). Provider surveys.	-Statistical cost models examining provider uncompensated care costs as a function of patient and hospital characteristics.
Q11.2.4: What are the impacts of eligibility and coverage policies on combined total costs (administrative, health services, and provider uncompensated care costs)?	-Outcome measures for 11.1.1, 11.2.1, 11.2.2, and 11.2.3, i.e., administrative and health services expenditures as well as provider uncompensated care costs.	-Annual Medicaid enrollee and user cohorts along with annual Medicaid hospital and nursing home providers	-Agency budgets Medicaid encounters FHURS and HCRIS	-Accounting tallies and analyses will be applied to the results of RQ 11.1.1-11.2.3 to reach a conclusion about the overall impact of the demonstration on combined total costs.

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 were available beginning with the evaluation of DY13. However, the lack of individual level Healthy Behaviors data for the evaluations of DY10, DY11 and DY12 was a limitation because service utilization patterns will not be known for specific enrollees. For example, it was not 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.

- Dental CAHPS became available in July 2021 and will be used to address RQ 8.2.3 (What changes in the accessibility of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?) and/or RQ 8.3.2 (How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plan?)

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 significant 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 non-pregnant Medicaid enrollees qualified for retroactive enrollment prior to the policy change. Consequently, the statistical precision of any effect of the policy change on current new enrollees who would have qualified for retroactive enrollment under the previous policy will likely be reduced by the presence of the large number of current new enrollees who would have been ineligible for retroactive enrollment under the previous policy.

E. Attachments

1. Independent Evaluator.

In 2022, the Agency contracted with Health Services Advisory Group, Inc. (HSAG) to conduct the independent evaluation of the MMA program. The Agency provided HSAG with a description of the objectives and have approved the evaluation design. The principal investigator is Paul Niemann, PhD, whose contact information is provided below:

Paul Niemann, PhD
Director
Data Science & Advanced Analytics
Health Services Advisory Group, Inc.
303-570-2588 | pniemann@hsag.com

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 costs presented in the table below include the total estimated cost, as well as a breakout of estimated staff, administrative, and other costs for each aspect of the evaluation. The following describes the activities that will be performed under each activity description.

- Key Informant Interviews – costs include protocol development, outreach to potential interviewees, conducting interviews, and synthesis of results.
- Provider Focus Groups/Surveys – similar to key informant interviews, costs include protocol development, outreach to potential interviewees, conducting interviews, and synthesis of results.
- Member/Beneficiary Surveys – ***Staff/Administrative*** costs include development of survey instruments, sampling protocols, monitoring response rates, and high level synthesis of results. ***Other*** costs include direct costs of conducting the survey (e.g., printing, postage, and computer-assisted telephone interviewing).
- Measure Calculation – costs include development of detailed measure specifications, data acquisition and validation, as well as measure coding, calculation, and validation.
- Analysis and Reporting – ***Analysis*** costs include synthesis of qualitative and quantitative data and results, statistical analyses, and hypothesis testing, as well as triangulation of results across all data sources, measures, and hypotheses. ***Reporting*** costs include drafting the interim and summative draft and final reports, in addition to the annual monitoring reports.

Evaluation Area/Task	Interim Report 1	Interim Report 2	Interim Report 3	Final Summative Report
Key Informant Interviews				
Staff Costs	$ 53,295	$ 43,605	$ 43,605	$ 53,295
Administrative Costs	$ 40,205	$ 32,895	$ 32,895	$ 40,205
Other Costs	$ -	$ -	$ -	$ -
Total Costs	**$ 93,500**	**$ 76,500**	**$ 76,500**	**$ 93,500**
Provider Focus Groups/Surveys				
Staff Costs	$ 53,295	$ 43,605	$ 43,605	$ 53,295

Evaluation Area/Task	Interim Report 1	Interim Report 2	Interim Report 3	Final Summative Report
Administrative Costs	$ 40,205	$ 32,895	$ 32,895	$ 40,205
Other Costs	$ -	$ -	$ -	$ -
Total Costs	**$ 93,500**	**$ 76,500**	**$ 76,500**	**$ 93,500**
Member/Beneficiary Surveys				
Staff Costs	$ 56,100	$ 45,900	$ 45,900	$ 56,100
Administrative Costs	$ 42,075	$ 34,425	$ 34,425	$ 42,075
Other Costs	$ 182,325	$ 149,175	$ 149,175	$ 182,325
Total Costs	**$ 280,500**	**$ 229,500**	**$ 229,500**	**$ 280,500**
Measure Calculations				
Staff Costs	$ 319,770	$ 261,630	$ 261,630	$ 319,770
Administrative Costs	$ 241,230	$ 197,370	$ 197,370	$ 241,230
Other Costs	$ -	$ -	$ -	$ -
Total Costs	**$ 561,000**	**$ 459,000**	**$ 459,000**	**$ 561,000**
Analysis and Reporting				
Staff Costs	$ 479,655	$ 392,445	$ 392,445	$ 479,655
Administrative Costs	$ 361,845	$ 296,055	$ 296,055	$ 361,845
Other Costs	$ -	$ -	$ -	$ -
Total Costs	**$ 841,500**	**$ 688,500**	**$ 688,500**	**$ 841,500**
Total	**$ 1,870,000**	**$ 1,530,000**	**$ 1,530,000**	**$ 1,870,000**

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.

Table 7. MMA Evaluation Activities, December 31, 2017-December 31, 2030

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

Deliverable / Activity	Due Date
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
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

Deliverable / Activity	Due Date
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
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

Deliverable / Activity	Due Date
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	October 1, 2020
DY13 and DY14 Health Plan Qualitative Administrative Interview Materials	October 1, 2020
MMA Interim Report – Project 6 – Component 9 (Waiver of Medicaid Retroactive Eligibility) DYs 13-14	October 15, 2020 (draft) December 1, 2020 (Final)
DY14 MMA Program Component 10 (Housing Assistance Pilot) Data Request and Verification	December 15, 2020
MMA Interim Report- Project 3 DYs 13 and 14- Component 4 (LIP)	February 1, 2021 (draft) March 1, 2021 (final)
MMA Interim Report- Project 2 DYs 13 and 14- Component 3 (Healthy Behaviors)	February 15, 2021 (draft) March 15, 2021 (final)
MMA Interim Report-Project 4 DYs 14 and 14- Component 6 (Dual-Eligibles)	February 15, 2021 (draft) March 15, 2021 (final)
MMA Interim Report – Project 1 DYs 13 and 14 – Components 1, 2, and 7 (Access, Quality, Cost)	March 1, 2021 (draft) April 1, 2021 (final)
MMA Interim Report- Project 5 - DY 14- Component 8 (Pre-paid Dental Health Program)	April 1, 2021 (draft) May 15, 2021 (final)
MMA Preliminary Report – Project 7 – DY14 – Component 10 (Housing Assistance Pilot)	May 5, 2021

Deliverable / Activity	Due Date
Draft Evaluation Design due to CMS*	July 18, 2021
MMA Final Report – DY14 – Project 7 – Component 10 (Housing Assistance Pilot)	August 16, 2021
Annual Monitoring Report due to CMS*	September 30, 2021
DY15* MMA Program Medicaid Data Request and Verification	October 1, 2021
Summative Evaluation Report (DYs 9-14) due to Agency	November 1, 2021 (draft) April 1, 2022 (final)
DY15 Enrollee Satisfaction Survey Materials	December 3, 2021
DY15 Health Plan Qualitative Administrative Interview Materials	December 3, 2021
MMA Interim Report – Project 6 – Component 9 (Waiver of Retroactive Eligibility) DYs 13-15	December 15, 2021 (draft) February 15, 2022 (final)
MMA Interim Report – Project 3 DY15 – Component 4 (LIP)	February 1, 2022 (draft) March 15, 2022 (final)
MMA Interim Report – Project 2 DY15 – Component 3 (Health Behaviors)	March 1, 2022 (draft) April 15, 2022 (final)
MMA Interim Report – Project 1 DY 15 Components 1, 2, 5, and 7 (Access, Quality, Cost)	April 1, 2022 (draft) May 16, 2022 (final)
MMA Interim Report – Project 4 DY 15 – Component 6 (Dual Eligibles)	April 15, 2022 (draft) May 31, 2022 (final)
MMA Interim Report – Project 5 - DY15- Component 8 (Pre-paid Dental Health Program)	April 30, 2022 (draft) June 4, 2022 (final)

Deliverable / Activity	Due Date
Summative Evaluation Report (DYs 9-14) due to CMS*	June 30, 2022
Annual Monitoring Report due to CMS*	September 30, 2022
Annual Monitoring Report due to CMS*	September 30, 2023
Interim Evaluation Report for DY 15-17 due to CMS*	December 31, 2024
Interim Evaluation Report for DY 15-19 due to CMS*	December 31, 2026
Draft Interim Evaluation Report for DY 15-22 due to CMS*	December 31, 2029
Draft Summative Report due to CMS*	December 31, 2031

*Deliverables due to CMS.

5. 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

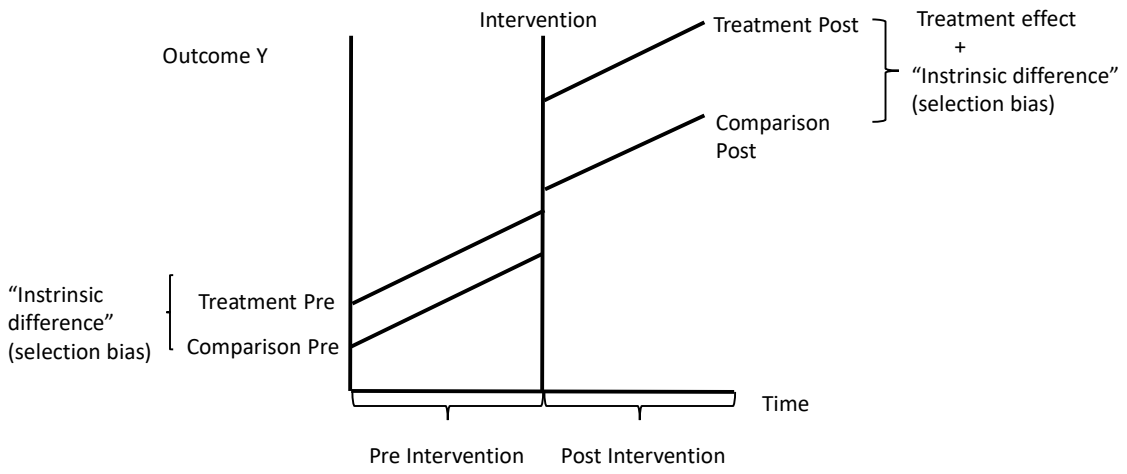
comparison group only receives usual care. The difference in outcomes between the treatment and comparison groups is then taken as an estimate of the treatment effect. The most common problem here is that treatment and comparison groups may differ from one another in unobserved ways that influence both 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 2[17] 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 in 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



Treatment effect = (Treatment Post – Comparisonl Post) – (Treatment Pre – 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 difference-in differences) gives the true treatment effect alone.

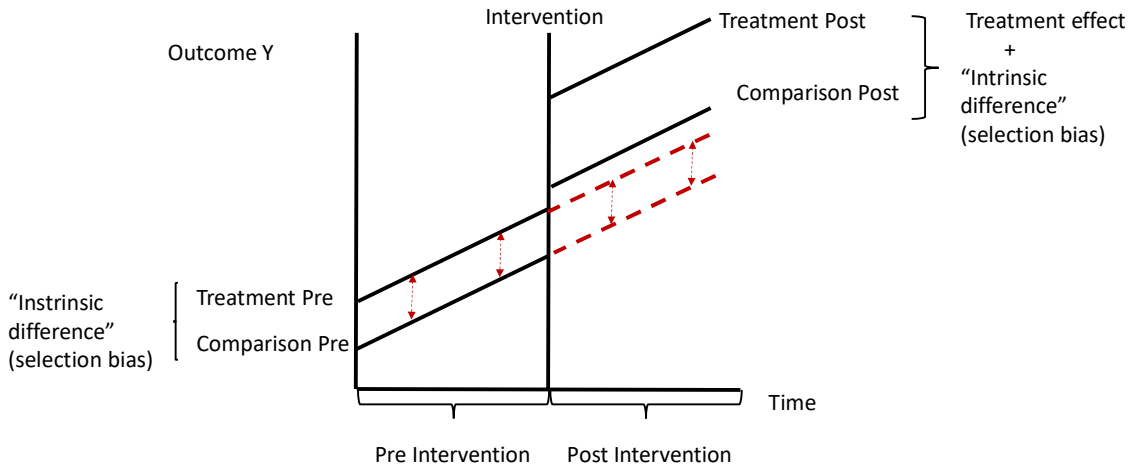
Assumes Equal Time Trends

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

[17] Figure 1 has been omitted from this attachment for purposes of brevity.

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



Treatment effect = (Treatment Post – Comparson Post) – (Treatment Pre – Comparison Pre)

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

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

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

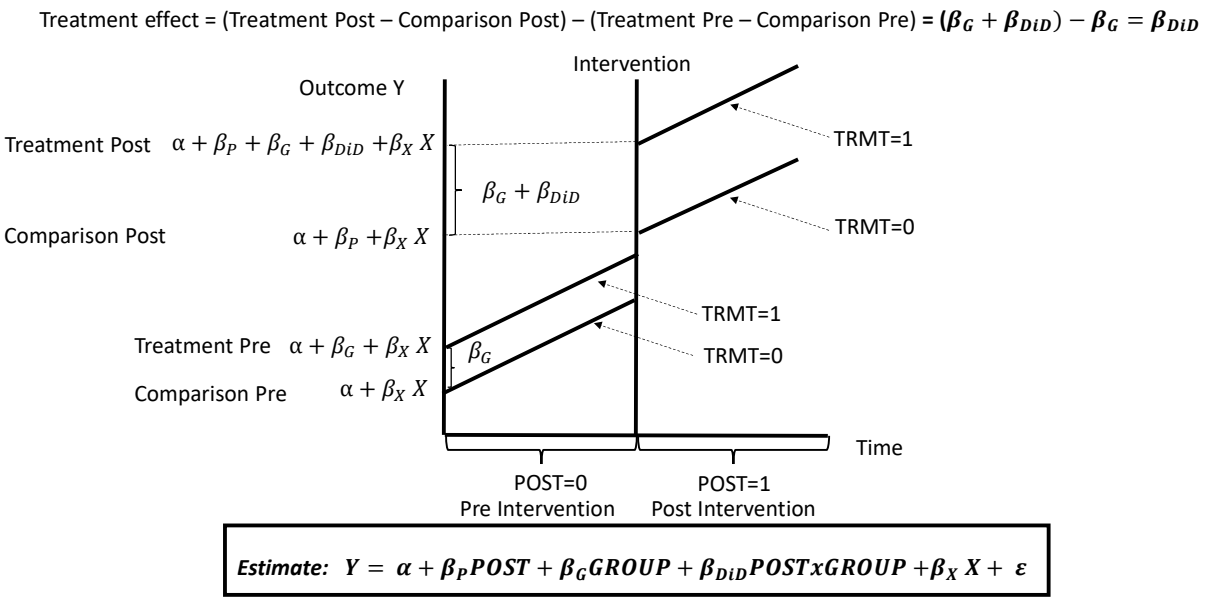
Figure 4 shows graphically the way D-i-D works based on the D-i-D statistical model. In Figure 4, the outcome Y is on the vertical axis and time is on the horizontal axis. The horizontal axis is divided into pre- and post-intervention segments. The four straight lines in Figure 4 correspond to the treatment 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?



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

One approach for testing and relaxing the strict assumptions of D-i-D is to introduce 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 as specified in the following equation (Harman, Lemak, Al-Amin, Hall, & Duncan, 2011):

$$Y = \alpha + \beta_t time + \beta_P POST + \beta_G GROUP + \beta_{Pt} POSTxtime + \beta_{Gt} GROUPxtime + \beta_{DiD} POSTxGROUP + \beta_{DiDt} POSTxGROUPxtime + \beta_X X + \varepsilon$$

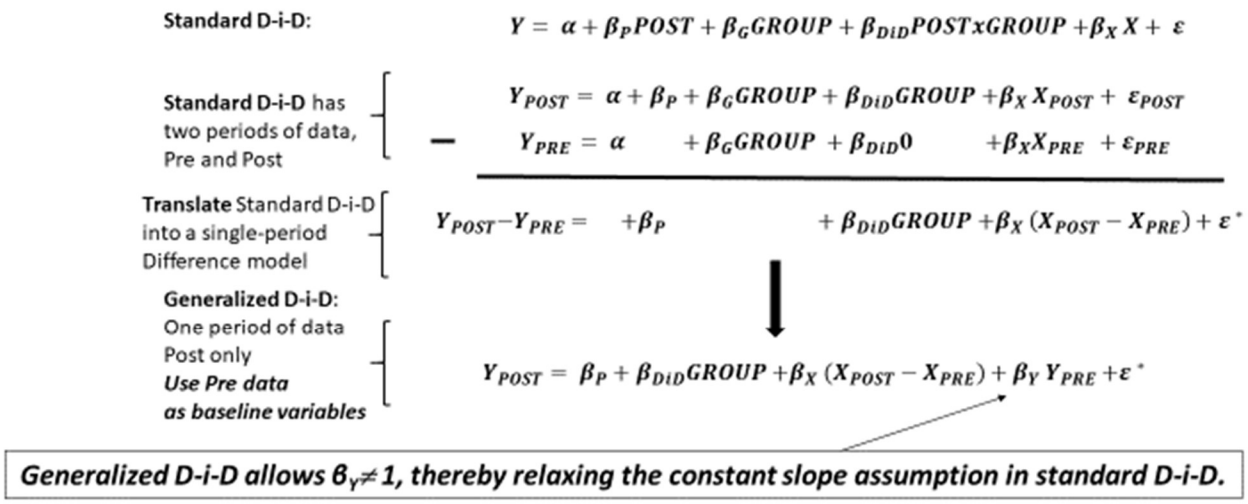
Even when the number of time periods in the pre and/or post periods preclude estimating time trends, the standard D-i-D assumptions can be relaxed. University of Florida faculty member Keith Muller has observed that the standard D-i-D model can be translated from a two period, pre/post model into a single 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: $\beta_Y\neq1$ 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



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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F. Appendix

Florida Responses to "CMS Implications of COVID-19 for Section 1115 Demonstration Evaluations: Considerations for States and Evaluations"[18]

A. Introduction

This section presents the Florida MMA evaluation team's comments and responses to the issues and questions raised by CMS concerning the impact of COVID-19 on the MMA evaluation. The comments and responses are in italics following the relevant CMS material.

B. Documenting demonstration implementation and evaluation changes

The COVID-19 pandemic is likely to affect demonstration implementation in multiple ways, including by changing provider and beneficiary behavior and rapidly increasing the pool of Medicaid beneficiaries enrolled in demonstrations. For example, providers may have adopted telehealth strategies, changing service delivery and potentially health outcomes for demonstration beneficiaries in ways that might persist in the long term. In addition, the pandemic has caused some states to pause or delay implementation of approved section 1115 demonstration policies, such as monthly payment requirements. These implementation changes, in turn, may necessitate adjustments to evaluations.

Comment: We agree that the COVID-19 pandemic will have widespread impacts on Florida Medicaid and on the Florida MMA program in particular. The impacts on the MMA program specifically should be centered on the ongoing MMA program since no new MMA program implementations have been paused or delayed by the COVID-19 pandemic. Nevertheless, the changes stemming from COVID-19 are

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profound and will likely limit the comparisons of evaluation results prior to, during, and following COVID-19. In addition, the three most recent components of the MMA evaluation (the prepaid dental and supportive housing programs and the retroactive enrollment policy changes) were implemented within one to two years of the start of the COVID-19 pandemic. Consequently, COVID-19 may delay the maturation of those components. Caution will be needed in interpreting early year-to-year changes in the evaluation results for those recently implemented programs.

Suggested topics and questions for state consideration. The following questions may be useful as states think through evaluation challenges caused by COVID-19 and engage with their evaluators:

- How will changes to the demonstration affect the logic models or driver diagrams that guide the evaluation? Are all expected demonstration outcomes the same as before the pandemic? What new modifying or confounding factors, such as use of telehealth, might change expected outcomes? Which of these new factors are likely to be temporary, and which are likely to be persistent?

  Response: We do not believe that COVID-19 will directly affect our logic models or driver diagrams, but COVID-19 will undoubtedly independently influence many of the outcomes examined in the MMA evaluation. In particular, the likely reduction in face-to-face utilization and the associated increase in telehealth services bear close scrutiny. The magnitudes of these utilization changes need to be measured initially and monitored over time to gauge any lasting impacts stemming from COVID-19.

- In what ways will demonstration implementation changes affect planned evaluation activities?

  Response: We do not believe that COVID-19 will change any demonstration implementations since all the MMA evaluation components were implemented prior to the COVID-19 pandemic.

- How can states keep evaluators informed about demonstration changes? Are evaluators able to document changes to demonstration implementation so they can (1) consider how to amend planned evaluation activities and (2) use that information to interpret outcomes?

  Response: The evaluation team is currently relying on and will continue to rely on the Agency's website that chronicles changes stemming from the COVID-19 emergency, "Brief Description of Changes During the State of Emergency", at https://ahca.myflorida.com/COVID-19_Medicaid.shtml#alerts .

- How does the timing of the demonstration approval period interact with the timing of the pandemic? That is, did the demonstration start before, during, or after the pandemic, and what does that mean for the evaluation design? Are there opportunities to observe demonstration outcomes before the pandemic began?

  Response: All the MMA evaluation components were implemented prior to the COVID-19 pandemic. Consequently, baseline data are available for all MMA components. As discussed above, the greater concern may be about observing the evolution of the initial impacts of the more recent MMA components (i.e., prepaid dental, supportive housing, and retroactive enrollment) into longer term, steady-state impacts.

- How can evaluators account for large numbers of new demonstration beneficiaries? Are new demonstration beneficiaries likely to differ from previously enrolled beneficiaries in systematic ways, and if so, should evaluators conduct subgroup analyses to understand how these beneficiaries interact with demonstrations?

Response: We recognize that there are likely to be many new people enrolled in Medicaid due to the pandemic and they will likely differ somewhat from other enrollees. We view subgroup analyses defined by pre-post COVID-19 changes in enrollment by eligibility group as the best way to address this.

C. Collecting primary data

The pandemic is likely to affect primary data collection—both interviews and surveys—in multiple ways. States may decide to update data collection plans to reflect respondent availability, the need to avoid in-person data collection, the need to update survey instruments to reflect changes to demonstration policies or the health care or economic landscape (for example, changes to employment opportunities given furloughs and layoffs), the likelihood of confounded responses (that is, different responses during the pandemic), and/or the need to update sample designs to account for newly enrolled beneficiaries or subgroups with disproportionately high pandemic impacts. Some states may experience high survey response rates because beneficiaries are easier to reach at home. However, beneficiaries' responses will undoubtedly be affected by the pandemic. Providers may be relatively difficult to survey or interview if they are busy with the pandemic response, although providers' availability and responsibilities are also changing rapidly.

States that planned to collect primary data in 2020 may decide to postpone it because of the factors noted above. Whether it is possible to postpone primary data collection and still use it as a data source for a given evaluation depends on the timing of the demonstration period—for example, it would not be possible to postpone a planned 2020 survey until 2021 and still use it for the evaluation of a current demonstration period that ends in 2020. In addition to timing considerations, states making the decision to postpone, change, or move forward with primary data collection must balance the budgetary impacts of changes, the usefulness of data collected, the burden to respondents, and the importance of primary data for the evaluation.

Comment: The MMA evaluation team has already begun to modify survey and interview content as well as the timing of data collection to reflect the broad reach of COVID-19. We expect these modifications to content and timing to continue as needed as the pandemic evolves. To date, these adjustments have only had minimal impacts on our primary data collection, but this will likely change as COVID-19 evolves and as our data collection efforts move past the first few months of 2020.

Suggested topics and questions for state consideration. Primary data collection requires a significant investment of evaluation resources. CMS encourages states to discuss the need to update data collection plans and the impact that might have on evaluation budgets with their evaluators. The following questions may be useful:

- What is the advice of evaluators on whether and how to postpone primary data collection? Does this vary by respondent type? Can data collection reasonably be postponed given unknown timing of the pandemic and the timing of the demonstration period? What are the cost implications of timing changes and what priority should be placed on making such changes?

  Response: The evaluation team has coordinated and will continue to coordinate adjustments to the MMA primary data collection efforts with the Agency moving forward. These adjustments do vary by the nature of the intended respondents, the importance of the evaluation topic, and the likely impact of COVID-19 on the topic, so answers must be tailored to the specific circumstances at hand. At this point, we do not foresee any changes in costs stemming from any potential postponements.

- Do survey instruments or interview discussion guides require updates to reflect changes to

demonstration implementation or the health care or economic landscape (such as employment opportunities)? When will changes to demonstration activities be settled enough to redesign instruments? What are the cost implications of instrument changes and what priority should be placed on making such changes?

Response: To date, we have identified required updates for specific instruments prior to their fielding and plan to continue this process in the future. We will confer with the Agency on a case-by-case basis when significant redesign and adaptation become necessary.

- How important is it to update survey samples to support subgroup analyses of newly enrolled beneficiaries and/or those with disproportionate pandemic impacts? How can evaluators define subgroups with disproportionate pandemic impacts for the purposes of changing the sample? What are the cost implications changing the sample design and what priority should be placed on making such changes?

  Response: We are in the process of monitoring changes in enrollments across eligibility groups as COVID-19 progresses to identify important subgroups based on the individual questions that comprise the MMA evaluation. Identifying specific subgroups with disproportionate pandemic impact on a per enrollee basis is especially challenging and will likely come as a result of a focused, in-depth evaluation of COVID-19 alone.

D. Using time trends and comparison groups

All time trends—meaning changes in observed demonstration outcomes over time—will be affected by the pandemic, to varying degrees. Evaluation designs that use comparison groups, such as difference-in-differences and regression discontinuity designs, will be more robust than trends and time series designs because they help to adjust for changes brought about by the pandemic. However, strong comparison groups must be similar to demonstration groups, including in terms of their COVID-19 impacts. CMS recognizes that states and their evaluators may be unable to assess the similarity of COVID-19 impacts on demonstration and comparison groups because the full extent of these impacts is still unknown and the best ways to measure impacts are not yet settled. CMS further recognizes that some states using designs without a comparison groups may be unable to introduce one to their approved designs.

In some cases, using interrupted time series analysis may be a relatively robust approach, because this design uses many observations over a long period and does not require (1) a known trajectory for the pandemic or its effects or (2) a similar comparison group. CMS recommends that states avoid using pre/post designs, if possible.

Comment: The MMA evaluation team agrees with the above comments. We believe it will be close to impossible to separate out COVID impacts using difference-in-difference since COVID is impacting everyone (i.e., no comparison group is available). While it's possible that some Medicaid enrollees will be more affected than others, that will be very hard to determine. Interrupted time series that accounts for the period coinciding with the pandemic is probably the most feasible approach.

Suggested topics and questions for state consideration. The following questions may be useful as states think through evaluation challenges caused by COVID-19 and engage with their evaluators:

- Which components of the planned evaluation design use comparison groups? Can evaluators feasibly assess the similarity of COVID-19 impacts on demonstration and comparison groups?

Response: The MMA evaluation has not relied on comparison groups because the entire MMA implementation was universal and was implemented over a short three-month period. This has made it impossible to identify a truly comparable in-state comparison group for the MMA evaluation and is the major reason that the MMA evaluation has relied on interrupted time-series analyses.

- If the evaluation design includes time-based designs, would evaluators recommend changing them to better account for the pandemic? How many observation periods can be included?

  Response: Yes. The MMA evaluation team is considering the use of pre-MMA, MMA pre-COVID, MMA during COVID, and MMA post-COVID periods.

- Are there any opportunities to strengthen planned evaluation designs to account for the pandemic? If the evaluation design includes more than one analytic approach, should certain approaches receive greater focus?

  Response: In addition to the four-period time construct described in the answer to the previous question, the MMA evaluation team is considering whether geographic-specific monthly COVID-19 incidence rates might be a useful control variable for those observed outcomes which are likely to vary directly with COVID incidence rates.

E. Isolating demonstration effects

Because of the magnitude of the changes brought about by the pandemic, it will be challenging to isolate demonstration effects from pandemic effects. CMS acknowledges that, for some demonstration outcomes, pandemic effects will be much larger than demonstration effects were expected to be, making any demonstration effects impossible to observe. In those cases, states and their evaluators may judge that some planned impact analyses—depending on the timing of the pandemic during the demonstration approval period—are unlikely to produce viable evidence about demonstration effects and are not worth the resource investment. States and their evaluators should identify such demonstration outcomes and keep CMS informed with explanations of any corresponding modifications to planned evaluation activities. In such scenarios, states are still encouraged to provide data or trends that show changes to expected demonstration outcomes even if those outcomes are not attributable to demonstration policies.

Comment: We agree that disentangling COVID-19 impacts from changes in the demonstration impacts may be difficult or impossible in some cases. However, most MMA components have several years of pre-COVID MMA estimated impacts to serve as a baseline for evaluating COVID period changes.

Isolating demonstration effects may also be difficult if the beginning of the demonstration period coincides with the beginning of the pandemic. In that case, it will be unclear whether states should attribute observed changes to the demonstration or to the pandemic. Conversely, demonstrations ending in 2020 or those spanning 2020—for example, if data collection is planned for 2019 through 2021—may be able to exclude some months in 2020 from analyses of demonstration outcomes, or to conduct robustness checks to explore the effects of including peak pandemic months. Exact months to exclude may not be clear until more information about the trajectory of the pandemic becomes available.

Comment: Fortunately, the MMA program has no component whose beginning or ending coincides with the start of the COVID-19 period.

Suggested topics and questions for state consideration. The following questions may be useful as states think through evaluation challenges caused by COVID-19 and engage with their evaluators:

- What is the relative expected magnitude of demonstration and pandemic effects for demonstration outcomes? Does it make sense to try to observe all planned demonstration outcomes, or only some?

  Response: This is difficult if not impossible to determine in the absence of information about the impact of COVID-19. However, given the relatively stable early MMA impacts as a baseline, it should be possible to highlight where either temporal changes in COVID-19 main effects or COVID-19 interactions with the MMA program have an outsize net impact.

- Do evaluators expect to be able to isolate demonstration effects to support conclusions about demonstration policies, and if so, how do they plan to do this?

  Response: Yes. In addition to pre-COVID-19 MMA impacts, we expect to control for MMA impacts during and after the COVID-19 pandemic. Also, as discussed above, we plan to use geographic-specific COVID-19 incidence rates as a control variable where feasible to help disentangle COVID-19 and MMA impacts.

- What covariates (measures) might be related to the pandemic, but not to the demonstration, and therefore appropriate to use as controls?

  Response: We believe that geographic-specific COVID-19 incidence rates is one important such covariate.

- If evaluators expect to proceed with planned analyses, is it feasible to drop certain months from those analyses, or to conduct robustness checks that assess the effect of including or excluding them?

  Response: At a minimum, it should be possible to conduct sensitivity tests by alternately including and excluding those months where COVID-19 incidence rates changed dramatically to measure the sensitivity of the estimated MMA impact to these changes.

F. Interpreting findings

Finally, even if states and their evaluators can adjust evaluation approaches in some of the ways suggested above, the severity of pandemic impacts will require cautious interpretation of observed outcomes. CMS requests that all interim and summative evaluation reports include discussions of potential confounding from the pandemic for each observed outcome or set of findings. Careful interpretation of findings is especially important because best practices for isolating demonstration effects in the context of the pandemic are not settled and because isolating demonstration effects may not be feasible for all demonstrations.

Comment: We agree with this assessment and plan to use extreme caution in interpreting any dramatic change in the estimated MMA impact that coincides with substantial changes in COVID-19 incidence rates.

Appendix II. Data Sources Examined for New Medicaid Enrollee Health Status for Research Question 8.1.2

Table A1. Data Sources Examined for Retroactive Enrollment Evaluation Question 8.1.2

Data Source	Frequency	Owner	Medicaid Coverage?	Enrollment Length?	Health Status?	State of Residence?	Remarks
Current Population Survey (CPS)	Monthly	U.S. Departme nt of the Census	Yes	No	Yes	Yes	
National Health Interview Survey (NHIS)	Annual	National Center for Health Statistics (NCHS)	Yes	No	Yes	Yes	
Medical Expenditure Panel Survey (MEPS)	Annual	Agency for Healthcare Research and Quality (AHRQ) /NCHS	Yes	Yes	Yes	Yes	MEPS provides in-depth information on a limited national sample. The likely sample size for *new* Florida Medicaid enrollees, however, is likely in the single digits.
National Health and Nutrition Examination Survey (NHANES)	Annual	NCHS	Yes	No	Yes	Yes	
American Community Survey (ACS)	Annual	Urban Institute	Yes	No	Yes	Yes	
Behavioral Risk Factors Surveillance Survey (BRFSS)	Annual	Census	Yes	No	Yes	Yes	
National Ambulatory Medical Care Survey (NAMCS)	Annual	Centers for Disease Control (CDC)	Yes	No	Yes	Yes	
National Survey of Family Growth	5 year cycle	CDC/NCHS	Yes	No	No	Yes	
National Immunization Survey	Annual	National Center for Immunization and Respiratory Diseases (NCIRD)/ CDC	Yes	No	No	Yes	
National Survey of Children's Health	Annual	Health Resources	No	No	Yes	No	

Data Source	Frequency	Owner	Medicaid Coverage?	Enrollment Length?	Health Status?	State of Residence?	Remarks
		and Services Administration / Maternal and Child Health Bureau (HRSA/ MCHB)					
National Home and Hospice Care Survey	Conducted periodically; not conducted since 2007	CDC	Yes	No	No	Yes	Conducted in 1992, 1993, 1994, 1996, 1998, 2000, 2007
Medicare Current Beneficiary Survey	3 data releases annually	Office of Enterprise Data and Analytics (OEDA) / Centers for Medicare and Medicaid Services (CMS)	As a source of payment	No	Yes	No	
CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)	Continuous	CDC	No	No	No	No	
CMS Chronic Conditions Public Use Files	Annual	CMS	No	Yes (for Medicare)	No	No	
Dartmouth Health Care Atlas	Annual	The Dartmouth Institute of Health Policy and Clinical Practice	No	No	No	No	Based on aggregate data
Healthcare Cost and Utilization Project (HCUP) – Nationwide Inpatient Sample (NIS) and State Inpatient Databases (SID)	Annual	AHRQ	Yes	No	No	Yes	Inpatient discharge data record from community hospitals in the state
Medicare and Medicaid Statistical Supplement	Annual	CMS	Aggregate information on Medicaid payments	No	No	No	
National Healthcare Quality and Disparities Report	Annual	AHRQ	No	No	No	Report on performance of healthcare system	

Data Source	Frequency	Owner	Medicaid Coverage?	Enrollment Length?	Health Status?	State of Residence?	Remarks
National Vital Statistics System	Continuous	NCHS	No	No	No	Yes	Data on births and deaths
Youth Risk Behavior Surveillance System	Every two years	CDC	No	No	No	No	