HSAG HEALTH SERVICES ADVISORY GROUP

Memo

To: Centers for Medicare & Medicaid Services

From: Health Services Advisory Group, Inc.

CC: The Agency for Health Care Administration

Date: July 31, 2024

Re: Transition from Pre/Post MMA Program to Pre/Post MMA Renewal

Introduction

The evaluation design of the Florida Managed Medical Assistance (MMA) Section 1115 Demonstration Waiver is currently written from the perspective of assessing the impact of the MMA program, which began in 2014 (i.e., comparisons between a pre-MMA time period and post-MMA). However, as mentioned by the Agency for Health Care Administration (the Agency) in an email to Health Services Advisory Group, Inc. (HSAG), the pre/post MMA demonstration years have already been evaluated and provided to the Centers for Medicare & Medicaid Services (CMS) in the Final Draft Summative Report for state fiscal year (SFY) 2014/15–2019/20 (demonstration year [DY] 9–DY 14). The Agency has requested that HSAG focus the evaluation on the subsequent renewal period, which consists of SFY 2021–SFY 2030 (DY 15–DY 24).

Proposed Changes

There are three proposed changes to the current evaluation design described in this memo. These changes will be implemented in the first Interim Evaluation Report due to CMS on December 31, 2024, except for including an additional baseline year (SFY 2018) of data. This change will be implemented in subsequent evaluation reports due to CMS on December 31, 2026, December 31, 2029, and December 31, 2031. Additional changes may be requested with submission of a revised evaluation design in early 2025.

1. Changing the baseline period to compare pre-renewal to post-renewal outcomes and performance.
2. Refining Component 2 to better reflect the attributes of the MMA program.
3. Adjusting hypotheses to better align with expected MMA program impacts.

Baseline Comparison Period

The Agency has requested that HSAG focus the evaluation on the impact of the changes that were a part of the renewal period, which consists of SFY 2021–SFY 2030 (DY 15–DY 24) compared to the pre-renewal period rather than comparing pre-MMA outcomes to post-renewal outcomes.

The evaluation design generally describes comparing pre-MMA outcomes to post-MMA outcomes, although there is some ambiguity within the evaluation design. The proposed change will modify the approach of the evaluation to compare pre-renewal outcomes to post-renewal outcomes. Some hypotheses specifically mention the pre-MMA/post-MMA comparison, others are silent on the comparison period. This change will revise the baseline comparison period to SFY 2019 and SFY 2020 in the first Interim Evaluation Report due to CMS on December 31, 2024. Subsequent evaluation reports will utilize a baseline period extending from SFY 2018 to SFY 2020. This

change may also impact analyses of other components and comparisons beyond a pre/post-MMA comparison due to constraints in the data.

While it is not possible to determine how the results of the evaluation may be different from those of previous analyses prior to conducting the analyses, the effect will be a fundamental change in what is being measured. Under the previous Summative Evaluation Report, which examined the pre-MMA/post-MMA comparison, the evaluation largely assessed the impact of the implementation of MMA compared to the previous programmatic structure prior to 2014. The pre-renewal/post-renewal approach will evaluate the impacts of changes resulting from the renewal of the program along with any programmatic changes included in the renewal. Given that the pre-implementation period was over 10 years ago, the estimation of counterfactuals based on pre-MMA program performance will entail high variance and uncertainty, resulting in a substantially reduced probability of finding statistically significant impacts. Results of a pre-MMA/post-MMA analyses are also unlikely to provide useful data for the Agency in terms of measuring current program performance and identifying opportunities for improvement. Understanding how the current performance of the program compares to a system that has not been in place for 10 years will not provide useful data on the performance of the program and the impact of changes instituted with the renewal of the waiver and ultimately will not provide a useful picture of program impacts or performance.

HSAG expects that methodological changes resulting from the change in the baseline comparison period will be minimal. HSAG will continue to use the most rigorous method supported by the available data for each measure. Neither HSAG nor the Agency expects that shifting the baseline period to conduct pre-renewal/post-renewal comparisons will result in degradation of any of the expected data sources compared to the data from the pre-MMA period.

Component 2

Component 2 of the evaluation is focused on assessing “The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care.” However, customized benefit plans are not available currently nor have they been available historically. The previous independent evaluator had revised their evaluation to account for this by focusing the Component 2 evaluation on expanded benefits rather than customized benefit plans. HSAG proposes making similar changes by focusing on the impact of expanded benefits.

HSAG proposes evaluating the measures currently included in the evaluation design for Component 2 within the context of expanded services rather than customized plans as currently stated in the evaluation design. HSAG also proposes adding four additional measures to Component 2 to better align the evaluation with an analysis of the impact of expanded benefits:

- A descriptive analysis of the number and percentage of enrollees (demographics and case characteristics) who used expanded benefits.
- Analyze expanded benefit utilization by comparing and contrasting among the plans and/or plan types (as a replacement to Research Question 2.1.2 “How do plans tailor the types of expanded benefits to particular populations?”).
- Identifying which expanded benefits are the least commonly used.
- Include 30-day an analysis of all cause readmissions (along with emergency department and inpatient hospital utilization).

Hypothesis Adjustments

HSAG proposes adjusting a handful of hypotheses to better reflect the expected impacts from the MMA program and program changes associated with the renewal. Table 1 shows the original wording of the hypothesis as presented in the evaluation design along with the proposed wording for the hypothesis. Underlining has been added to highlight the proposed changes.

Table 1—Proposed Hypotheses Revisions

Original Hypothesis	Proposed Hypothesis
2.2: ED and IP hospital utilization for users of expanded benefits will not be greater than that of non-users.	**2.2**: ED and IP hospital utilization for users of expanded benefits will be lower than that of non-users.
7.5: There will be equal or fewer dental-related hospital events (e.g., ED, IP hospitalization) resulting from enrollee utilization of dental health services or utilization of expanded benefits offered by dental health plans.	**7.5**: There will be fewer dental-related hospital events (e.g., ED, IP hospitalization) resulting from enrollee utilization of dental health services or utilization of expanded benefits offered by dental health plans.
8.1: 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).	**8.1**: Eliminating retroactive eligibility will increase enrollment continuity and the health status of those subject to the new policy compared to those not subject to the new policy. Eliminating retroactive eligibility will have no effect on 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).
9.2: Avoidable hospitalizations and ED visits among enrollees with SMI who receive supportive housing assistance will be equal to or lower than similar Medicaid recipients prior to enrollment in the program.	**9.2**: Avoidable hospitalizations and ED visits among enrollees with SMI who receive supportive housing assistance will be lower than similar Medicaid recipients prior to enrollment in the program.

Note: ED: emergency department; IP: inpatient; LIP: low-income pool; SMI: serious mental illness; UCC: uncompensated care