RON DESANTIS
GOVERNOR

July 29, 2020

Secretary Alex Azar
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Azar:

Florida seeks to extend its Medicaid Medial Managed Assistance Research and Demonstration Waiver (CMS Project Number 11-W-00206/4). The Centers for Medicare and Medicaid Services approved this waiver for the period July 31, 2017 through June 30, 2022. Pursuant to application procedures required in 42 CFR 431.412(c) for Section 1115(a) waivers, the State requests an extension of the approval period from June 30, 2022 to June 30, 2024, under the same waiver and expenditure authorities as those approved in the current demonstration.

The demonstration objectives and financial eligibility criteria for waiver recipients remain largely unchanged since the Managed Medical Assistance program was approved June 31, 2017. The program is designed to provide primary and acute care to the majority of Florida Medicaid recipients without increasing costs.

Please find enclosed documentation as required in 42 CFR 431.412(c) to support this request. We appreciate your efforts in working with our State to extend the federal authorities necessary to maintain the waiver.

Sincerely,

[redacted]

Ron DeSantis
Governor

Enclosure

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249

Florida Managed Medical Assistance Program

(Project Number 11-W-00206/4)

Extension Request

July 29, 2020

1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration

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STATEMENT OF PURPOSE

The State of Florida (State) is seeking a two-year extension of the 1115 Managed Medical Assistance (MMA) Waiver, which would extend the waiver approval period through June 30, 2024. An extension of the MMA Waiver would allow the State to continue efficiently operating and evaluating all programs and pilots authorized under the current Special Terms and Conditions for an additional two-year period. Throughout this extension request, the State will highlight many of the successes that have been achieved under the 1115 Waiver thus far. **This extension request does not include any amendments to the current waiver design or the approved Special Terms and Conditions (STC), except STC 71 (LIP) to align with updates in Florida law adopted after the public comment period closed.**

Success of first five years of waiver lays foundation for further gains. Florida Medicaid serves more than 3.8 million recipients with an annual budget of over $29 billion. With the inception of Statewide Medicaid Managed Care through an 1115 waiver in 2013-14, the program shifted its focus from basic access to care and timely payment of claims to a focus on paying for improved health outcomes. The first five years of the program laid a solid foundation for this quality improvement work, emphasizing consumer satisfaction and improved access to care as measured by CAHPS and HEDIS. Consumer satisfaction with managed care has been consistently high, and the several dozen HEDIS measures Florida tracks improved from 41% being at or above the national average in 2013 to 58% being at or above the national average in 2018. The waiver program also began to bend the cost curve. Between FY 2009-10 and FY 2017-18, Florida Medicaid's per member, per year costs grew by 9 percent. In contrast, during the same period, the Consumer Price Index grew by almost 15 percent, and the Medical Consumer Price Index grew by more than 25 percent.

Building on success. In 2018-19, Florida implemented new health plan contracts that built on the success of the first five years of the program, setting targets to improve population health through evidence-based interventions implemented in collaboration with health plans, hospitals, physicians, and other stakeholders. The State has used a population health approach, bringing significant health concerns into focus and addressing ways that resources can be allocated to overcome the problems that drive poor health outcomes. The State is measuring results through reductions in potentially preventable hospital admissions, re-admissions, and emergency department visits and through improved birth outcomes. Stakeholders are highly engaged, pilots are starting around Florida, and dashboards are published to report results and ensure transparency across the program.

In order to accomplish these quality goals, the State convened health care providers and other community partners from across Florida to identify key strategies and evidence-based interventions that will improve health outcomes and facilitate paying for value over volume. The State (through the MMA plans) plans to deploy the following key initiatives related to potentially preventable healthcare events:

1. A hospital discharge planning pilot that focuses on connecting high-risk patients with the appropriate services and resources in the community to avoid re-admissions;
2. An emergency department (ED) diversion program which will address inappropriate use of the ED for ambulatory sensitive conditions as well as super utilizers of the ED (recipients with 12 or more ED visits in a year); and

3. A provider resource toolkit that targets outreach to providers with high rates of potentially preventable admissions.

The MMA plans will also be deploying the following initiatives related to improving birth outcomes:

1. Initiating a statewide awareness campaign to increase recipient education around preventative strategies, particularly focused on reducing unnecessary C-sections;
2. Increasing access to maternal home visits for high-risk mothers;
3. Expanding access to doula services;
4. Participating in statewide initiatives through the Florida Perinatal Quality Collaborative, which focus on increasing substance use screening, referral, and treatment for pregnant women and reducing lengths of stay for babies born with neonatal abstinence syndrome.

While each of these are separate initiatives, there is considerable overlap in the health systems involved (hospitals, physician groups, etc.) and community partners needed to address social determinants of health.

Driving to value-based care. The significant success Florida has achieved in increasing access to care and improving health outcomes only underscores the reality that population health will only be achieved when incentives in the health care system align to focus on individual and population outcomes through proven approaches to care delivery and management. Florida has made a start on value-based purchasing, requiring Medicaid health plans to contract with a percentage of their primary care providers through value-based purchasing arrangements, but more needs to be done. For example, the State is exploring maternity bundled payments in conjunction with the State's major commercial payers but needs the current system of payments authorized by the waiver to remain stable for two more years while the State continues this work. The State also intends to partner with private sector employers to maximize purchasing power in order to accomplish goals.

Hospital services, whether inpatient or outpatient, not only comprise a large percentage of health care costs, but are an area where significant opportunities exist to improve quality of care and drive system-wide quality improvement. Under the Medicare program, hospitals have been incentivized (both through value-based purchasing programs and financial penalties) to implement protocols that improve quality and reduce readmissions rates. These quality-driven process improvements made by hospitals should be evidenced regardless of payer, but the data does not reflect that when it comes to Florida Medicaid.

Redesign of Florida's hospital funding structure to incentivize quality outcomes rather than volume of services has the potential for systemic impact on the Medicaid program. Goals of hospital payment redesign are: 1) Payments are consistent with efficiency, economy, and quality of care, 2) Improved adequacy of rates across providers, and 3) Fiscal integrity of the Medicaid program.

Other outcomes that the State would achieve through the redesign are:

- Aligning Incentives
  - Reward facilities that operate and provide care most efficiently
  - Increase reimbursement for difficult to treat populations

  - Create incentives to avoid performing unnecessary services
- Increasing Financial Predictability by establishing predictable rates for providers and the State
- Establishing Fair Practices
  - Provide the same payment for the same service across all facilities with similar characteristics
  - Align payments with the cost of care for different types of services

The State is also striving to align physician payment incentives with the Medicaid potentially preventable event and birth outcome quality goals. As the State identifies best practices and lessons learned through the quality initiatives, this information can be used to develop alternative payment arrangements with physician practices. Managed Medical Assistance plans have various incentive programs in place for physicians, but they do not all align directly with the State's initiatives. The State is driving MMA plans to engage their networks of providers in more shared risk payment arrangements. This is essential in achieving the State's triple aim and ensuring providers have shared responsibility in improving care and lowering costs.

While these more sophisticated risk-based payment models are developed, interim steps can help begin the alignment process. Plans need to equip physicians with data that helps them understand their performance in comparison to their peers and national benchmarks and to share data regarding patients with care gaps and real-time hospital encounters. Another opportunity is to create payment models that incentivize providers who are making significant strides related to electronic health information exchange within their region or those who are reserving capacity in their schedules to meet the urgent care needs that are contributing to unnecessary ED use.

In the discussions held with stakeholders, increasing the use of patient centered medical homes to serve members with complex medical and/or behavioral health needs is a growing need. Addressing this issue is a critical step in changing the trajectory related to unnecessary ED use and hospitalizations. Through the pilots, MMA plans are working collaboratively with hospital systems to identify medical homes for complex high-risk members that can provide the intense wrap around supports to meet the needs of the patient and financially incentivize these providers accordingly. While this is a step in the right direction, greater transparency is needed to ensure medical home providers are adhering to the fidelity of the model and can demonstrate success in improving health outcomes.

Recipient Engagement. The State continues to put meaningful facility-level and provider health care cost information into the hands of Florida consumers. This is critical in engaging recipients in the health care decision-making process and providing them with key information and the tools needed to make informed choices. Medicaid recipients have access to more information than ever before that will aid them in making the best health care decisions (e.g., choosing the right health plan, comparing re-admission and C-section rates of hospitals in their geographic area, etc.). There is, however, more than can be done to provide information to recipients that would assist in their selection of physicians that meet or exceed quality standards and those who routinely are rated highly for prescribing only necessary care based on clinical/evidenced based guidelines.

One area of focus in many of the quality initiatives is providing better patient education about available services and community resources and bringing greater awareness to recipients on how to

advocate for themselves to achieve the best health outcome (e.g., adoption of educational campaigns such as California's "My Birth Matters"). The MMA plans are also establishing multi-sector partnerships to meet the needs of members, including addressing social determinants of health. Historically, Medicaid payment for services provided through these types of partnerships was unavailable, but the State recently launched its Behavioral Health and Supported Housing pilot in two regions of the State. The authority for this initiative was granted through the 1115 MMA Waiver and has the potential to transform the lives of individuals contending with mental illness and/or substance use disorder.

Reason for the Extension Request. Through the MMA program, Florida has been embarking on transforming its delivery system in pursuit of the following three aims: improving the recipient's experience of care, improving the overall health of the Medicaid population, and continuing to bend the Medicaid cost curve. The State will continue to deploy this triple aim approach by creating innovative payment and financing approaches, promoting patient centered medical homes, achieving greater data and performance transparency, and implementing the State's quality Medicaid goals focused on reducing unnecessary and avoidable health care events/services. Extension of the 1115 MMA Waiver affords the time to test innovative pilots that will help the State meet its goals.

The State has already made strides in increasing the providers participating in value-based payment arrangements, but there are greater opportunities to align payment sources flowing to providers participating in the MMA program around goals that promote better health outcomes, incentivize providers to engage consumers actively in their health care, and ensure access to appropriate and timely care in the least costly setting. In order to fully maximize the impact and success of the quality initiatives that the State has undertaken related to PPEs and birth outcomes, provider payment reform must be a part of the equation. In addition, by aligning financial incentives, the State will be able to continue to bend the Medicaid cost curve and lower overall costs.

The reality, however, is that these efforts take time and, in order to successfully achieve these goals, the State needs stability in the authorities that govern the operation of the MMA program and other supplemental payment programs for a longer period than is currently authorized. With the extra time afforded through an approved two-year extension, the State would have the ability to evaluate and implement enhanced provider payment strategies, extend current program authorities and funding levels for programs like the Low Income Pool, and provide the stability needed to engage in meaningful stakeholder engagement and analytic work to achieve the State's goals.

The State recently received approval for two new components of the 1115 Waiver – a waiver of retroactive eligibility and the Behavioral Health and Supportive Housing Assistance pilot. The State is confident that both initiatives will achieve their intended purpose; however, this extension request will allow the State to fully demonstrate its efficacy in encouraging program enrollment for eligible recipients in order to reach the maximum number of Florida consumers in need of housing assistance.

Finally, it is critical to reflect on the impact of the 2019 novel coronavirus on the health care system and on the daily lives of the people Medicaid serves. At this time, we do not know the extent or duration of the changes this pandemic will cause to the overall health of the Medicaid population, the size and composition of the Medicaid rolls, the way that people access healthcare, and the impacts to Medicaid providers. Also unknown are the impacts to the state and federal economies and how Medicaid programs may have to adapt in response to any economic downturn. The state's Medicaid

program and the people we serve would benefit from stability in this program while we navigate the immediate crisis period, restore normal operations in the aftermath, and strategically assess any change in the waiver for the future.

1115 MANAGED MEDICAL ASSISTANCE WAIVER OVERVIEW

In 2011, the Florida Legislature directed the Agency for Health Care Administration (Agency) to create the SMMC program. At that time, the SMMC program had two key components: The MMA program and the Long-term Care program.

The State submitted an amendment request to CMS to amend the 1115 Reform Waiver to implement the MMA program. The State received approval from CMS on June 14, 2013 to terminate the Medicaid Reform program, implement the MMA program, and rename the waiver "Managed Medical Assistance." The Medicaid Reform program was terminated on August 1, 2014. On July 31, 2014, the State received approval from CMS to extend the MMA Waiver for the period July 31, 2014 through June 30, 2017. Subsequently, CMS re-authorized the MMA Waiver through another extension; the approval period began July 1, 2017 and is set to continue through June 30, 2022.

Florida's current 1115 MMA demonstration waiver allows the State to provide an array of health care services to Florida Medicaid recipients. The demonstration authorizes:

1. The delivery of medical and behavioral health services through a comprehensive managed care delivery system.
    - Medicaid recipients, who are mandatory for enrollment in the MMA program, are given the opportunity to select a health plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are automatically assigned into a health plan upon an affirmative eligibility determination and are subsequently provided with information about their choice of plan along with the automatically assigned plan.
    - Voluntary populations may choose to enroll with a health plan but are not automatically assigned to plans.

Health plans are able to provide customized benefits to their members that differ from, but are not less than, the Florida Medicaid State Plan benefits—and participating Medicaid-eligibles have access to Healthy Behaviors Programs that provide incentives for healthy behaviors.

2. The delivery of MMA dental services through the Prepaid Dental Health Program:
    - The majority of Medicaid recipients are required to receive their dental services (preventive, diagnostic, restorative care, etc.) through an MMA dental plan. Dental plans are required to cover the mandatory dental benefits approved in the Florida Medicaid State Plan, but they also offer their adult enrollees expanded benefit packages.
3. A Low-Income Pool that ensures continuing support for safety net providers who furnish charity care to the Medicaid, uninsured, and underinsured populations.
4. A pilot program that provides additional behavioral health services and supportive housing assistance services to 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.
5. A waiver of retroactive eligibility, which encourages Medicaid recipients 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). Other programs that have been vital in ensuring vulnerable populations, or those with complex medical needs, receive specialized care and services. These programs include:

- The Healthy Start program which provides outreach and case management services for eligible pregnant women and children.
- The MEDS AD program that provides Medicaid coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level.
- The Program for All-Inclusive Care for Children program that provides pediatric palliative care support services to children enrolled in the Children's Medical Services plan who have been diagnosed with potentially life-limiting conditions and were referred by their primary care provider.
- The Medicaid Comprehensive Hemophilia Management program, which operates statewide and provides pharmaceutical services and products for recipients who have a diagnosis of hemophilia or von Willebrand disease.
- The AIDS program, which provides additional services for recipients diagnosed with AIDS who are enrolled in a specialty health plan.

Through this demonstration, the State has aimed to achieve the following objectives:

1. **Improve health 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 benefit packages, top quality scores, and high rate of customer satisfaction. The State will provide oversight focused on improving access and increasing quality of care.
2. **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. A key objective of improved program performance is to increase patient satisfaction.
3. **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.
4. 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.
5. 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.

6. 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**.

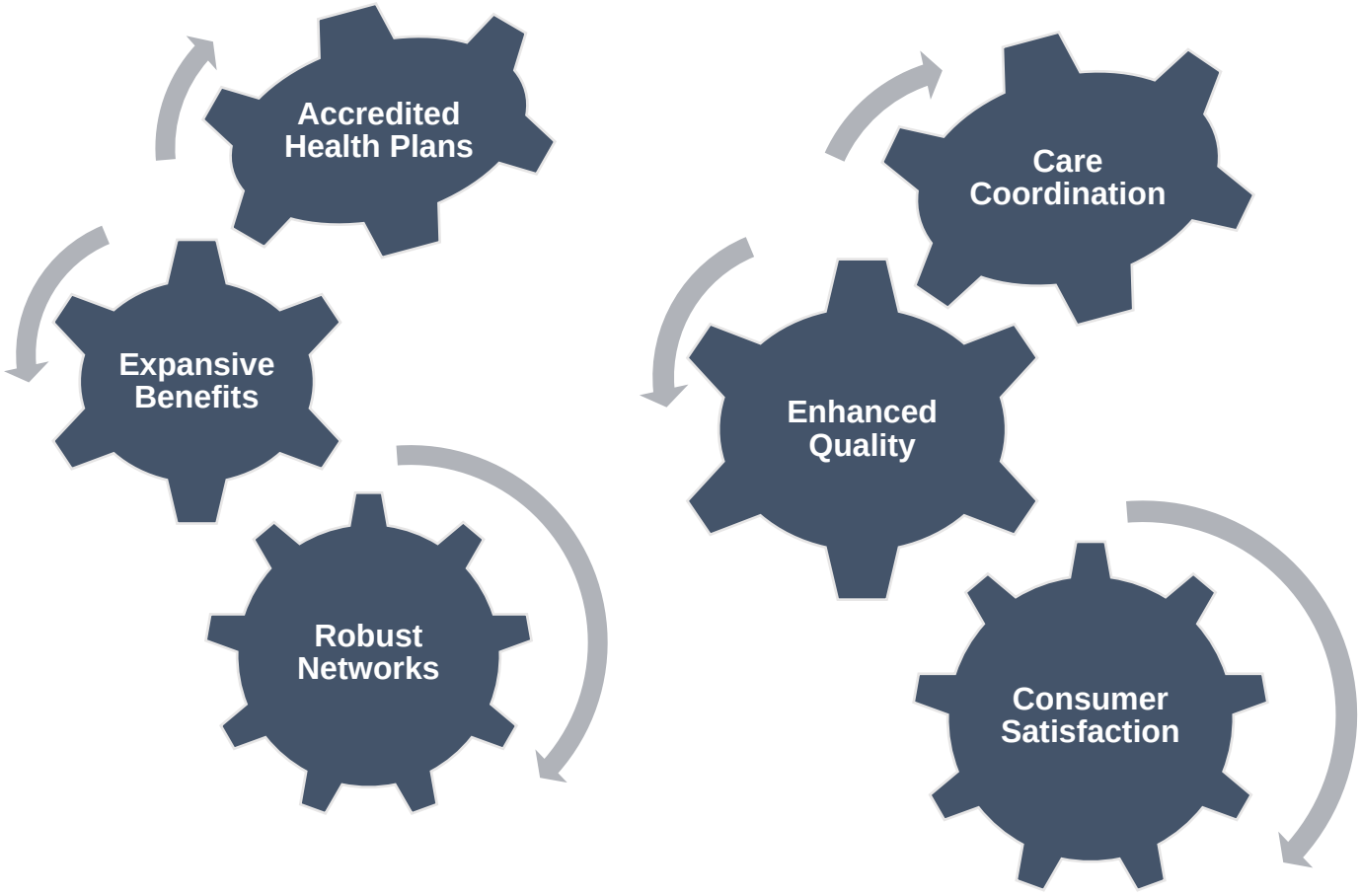
Florida has made substantial progress towards achieving these objectives and requests this waiver extension to build upon the work accomplished thus far and to further demonstrate program outcomes. The following section demonstrates how the State is meeting these objectives.

STATEWIDE MEDICAID MANAGED CARE PROGRAM

The strength of the program design along with the implementation of the Managed Medical Assistance and Prepaid Dental Health components of the Statewide Medicaid Managed Care program have been essential to the State's success in achieving the objectives of the demonstration.

IMPROVED HEALTH OUTCOMES

The foundation of the MMA health and dental programs are rooted in procuring contracts with high quality plans that offer expansive services with robust networks and who meet or exceed national performance benchmarks.



Nationally Accredited Plans

The State re-procured the health and dental plans in 2018, which resulted in the following plan contracts being awarded:

- **7 Comprehensive Plans** – This plan type provides both MMA services and Long-Term Care (LTC) services.
- **1 Long-Term Care Plus Plan** – This plan type provides MMA services and LTC services. (Recipients who only qualify for MMA services cannot enroll in this plan type.)
- **4 MMA-Only Plans** – This plan type provides MMA services. (LTC recipients are not eligible for this plan.)
- **5 Specialty Plans** – This plan type provides MMA services to recipients who qualify under a specialty population.
- **3 Dental Plans** - This plan type provides preventive and therapeutic dental services to all MMA recipients and all fully eligible fee-for-service individuals.

Through the re-procurement process, the State negotiated terms and conditions with selected plans that will provide greater consumer protections and managed care plan accountability, including but not limited to enhanced network standards, prior authorization requirements, expanded benefits, and advancements in value-based purchasing.

Robust Provider Networks

The State requires that the health plan enter into provider agreements with a sufficient number of providers to provide all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided to the enrollee with reasonable promptness. The State has established specific standards for the number, type, and regional distribution of providers in health plan networks. The health plans must maintain:

- A panel of preventive and specialty care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population.
- A provider network sufficient to serve a percentage of recipients in the region.
- Regional provider ratios based upon 120% of the health plan's actual monthly enrollment measured at the first of each month, by region, for all regions.

Table 1 illustrates examples of network adequacy requirements that are established for certain types of physicians. The State routinely reviews the standards to determine if changes are needed to facilitate timely access to care or to address a gap. As an example, there has been a heavy focus on addressing the opioid epidemic. In response, the State established minimum standards for medication assisted treatment. Additionally, in response to stakeholder feedback requesting more stringent standards to ensure children have access to therapy services, the State added requirements for pediatric therapists.

TABLE 1: Example of MMA Network Requirements					
Required Providers	Urban County		Rural County		Regional Provider Ratios
	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	
Primary Care Providers	30	20	30	20	1:750 enrollees
Specialists					
Allergy	80	60	90	75	1:20,000 enrollees
Cardiology	50	35	75	60	1:3,700 enrollees
Cardiology (PEDS)	100	75	110	90	1:16,667 enrollees
Gastroenterology	60	45	75	60	1:8,333 enrollees

Provider Network Verification

The State requires plans to submit their provider network files through the Provider Network Verification (PNV) system weekly to provide current information for Medicaid recipients when selecting a health plan. The State also uses this system to determine plan compliance with several provider network contractual requirements, in addition to ensuring that all network providers are appropriately licensed, have received a background screening, and are known to Florida Medicaid. Ensuring providers are properly licensed and have been through the background screening process is vital to ensuring access to qualified providers for all Florida Medicaid enrollees.

The PVN system produces reports that the State uses to analyze plan provider network files. The reports generated by the system contain plan contractual metrics, including:

- Each provider that is accepting new Medicaid patients,
- Each provider that offers after-hours care,
- The number of providers for each provider type/specialty compared with the plan membership (provider to member ratio reports), and
- Drive time and distance from each provider type/specialty specific to the location of the residence of plan members.
- For behavioral health, the requirement includes licensed mental health counselors for both child and adult psychiatrists.

The PNV system is also valuable when the Agency conducts network research. The system enables the Agency to run various queries to assist them in their research.

Through the State's efforts to ensure continuous quality improvement it has identified future improvements related to provider network oversight activities. For example, currently there is not a formal, systematic mechanism in place to interact with the State's behavioral health authority, the Department of Children and Families, and its behavioral health network to collect feedback on their experiences serving the Medicaid population. This can result in issues such as waitlist information not being reported to the Agency for review to ensure the plans' networks truly have enough providers to appropriately serve their Medicaid members.

The Agency monitors the PNV data weekly to ensure that each of the plans are meeting provider network ratios, time, and distance standards. The Agency issues compliance actions when deficiencies are identified. Most commonly, these compliance actions are monetary liquidated damages, but they can also include more significant actions including monetary sanctions and freezing enrollment. The State also deploys secret shopper techniques that validate the information provided through the PNV and to ensure enrollees have timely access to services.

Expansive Benefits

In addition to the standard benefit package that all MMA health and dental plans must provide, they also provide expanded benefits for their enrollees. Expanded benefits are services covered by the plans beyond the mandatory services contained in the Medicaid State Plan or that are in excess of the amount, duration, and scope specified in the State Plan. See **Attachment I** for required State Plan covered services. The State negotiated these additional benefits during the 2018 procurement cycle. Once a plan commits to the benefits, it must continue them for the life of the contract. The health and dental plans pay for the expanded benefits at no additional cost to the State.

Attachment I provides a comprehensive list of all the expanded benefit services health and dental plans may choose to cover. Plans are not required to offer all expanded benefits contained in **Attachment I**; each plan has covered expanded benefit service options, which are codified in their contract. Information about expanded benefits by plan is provided to recipients as part of the plan selection and choice counseling process, and plans distribute this information to their enrollees via an Enrollee Handbook.

The expanded benefits offerings have improved the array of services available to Medicaid recipients and enhanced recipient access to care. All health plans participating in the MMA program are offering the most robust expanded benefit packages since the inception of the program. Plans are offering over 50 services that exceed State Plan coverage for adults.

Many of the expanded benefits offered by the plans support the Agency's quality goals. Examples include:

- **Potentially Preventable Events:**
  - Primary care provider expanded after hours care and telemedicine services
  - Vaccines for adults
  - Alternative pain management, including acupuncture and massage services
  - Additional behavioral health assessment, day treatment, medication management, and psychosocial rehabilitation services
  - Behavioral health services for caregivers

- **Birth Outcomes:**
  - Doula services
  - Additional dental cleanings for pregnant women
  - Additional prenatal services

Under the new SMMC contracts, the State focused on fully integrating health care, and as such, health plans became responsible for providing services previously only available through the fee-for-service delivery system. These services include:

- Early Intervention Services
- Medical Foster Care
- Short-Term Nursing Facility Services
- Child Health Services Targeted Case Management

Continuity of care is always paramount when transitioning new services into managed care. The State enacted consumer protections codified in the SMMC contracts to ensure there was no disruption in care or need to change providers because of the transition. As a result, there were no gaps in the delivery of care and 100% of recipients continued to receive services.

Enhanced Quality and Health Outcomes

During the 2018 health plan re-procurement process, each of the health plans awarded a contract for the 2018-2023 contract term committed to higher performance standards, specifically in areas that would further the State's goals. The health plans committed to reducing potentially preventable events (PPE) such as hospital admissions, re-admissions, and emergency department visits as well as reducing primary Caesarean-section rates, pre-term deliveries, and the number of babies born with neonatal abstinence syndrome. Similarly, the dental plans committed to decreasing the dental emergency department visit rate, while increasing annual dental visit and preventive dental care visit rates.

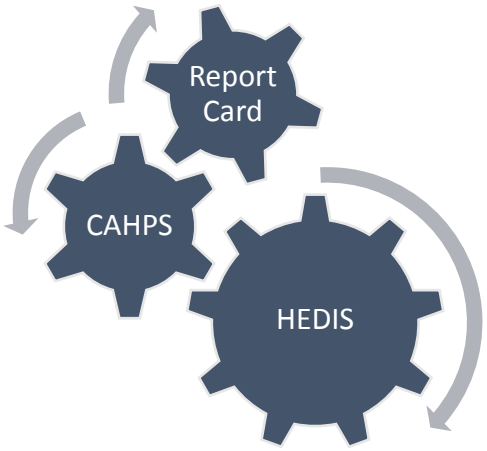
Table 2 located on the following page details the MMA health and dental plans' commitments for the new five-year contract period.

TABLE 2: MMA Health and Dental Plan Commitments			
Health Plans		**Dental Plans**	
Avg. Reduction	**Quality Outcome**	**Avg. Yearly Increase**	**Service Type**
22%	Preventable Admissions	3%	Annual Dental Visits-Above the Annual ITN Target
21%	Preventable Re-admissions	1%	Preventive Dental Care-Above the annual ITN Target
14%	Preventable Emergency Department Visits	**Reduction**	**Potentially Preventable Event**
12%	Primary C-section Rate	5%	Dental related emergency department visits within the first year
10%	Pre-term Deliveries	9%	Emergency Department Visits within the 5-year contract
15%	Babies Born with Neonatal Abstinence Syndrome		

The Agency has engaged in extensive work with stakeholders to develop initiatives that will aid in achieving these targets, such as emergency department diversion program pilots, discharge planning pilots, a C-section statewide educational campaign, intensive case management programs, and more. Stakeholders that have partnered with the State on these initiatives include the health and dental plans, the Florida Hospital Association, Safety Net Hospital Alliance of Florida, individual Florida hospitals in pilot regions, the Florida Association of Community Health Centers, the Florida Chapter of Emergency Physicians, the Florida Academy of Family Physicians, the Florida Perinatal Quality Collaborative, Florida Healthy Start Coalitions, the Florida Department of Health, the Florida Department of Children and Families, behavioral health providers, and more.

IMPROVED PROGRAM PERFORMANCE

The SMMC contracts include a robust array of performance measures and standards to evaluate health plan performance and consumer satisfaction.

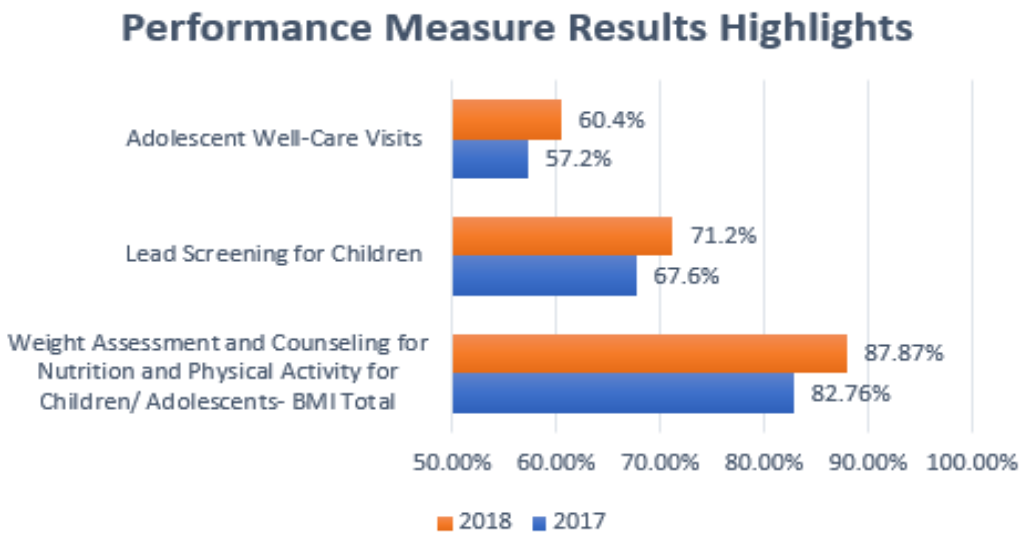


Performance Measures

The SMMC contracts include over 40 performance measures on which the plans report. The Health Effectiveness and Data Information System (HEDIS) is a set of nationally recognized and widely used performance measures designed to allow customers to compare health plan performance, both regionally and nationally. HEDIS was developed and is maintained by the National Committee for Quality Assurance. The Agency compares the HEDIS National Medicaid Means and Percentiles to the performance measures submitted by Florida's health plans. The State has continued to see a significant improvement in its Medicaid quality scores since the inception of the MMA program. The Agency posts detailed health plan scores on its website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.

The plan performance measure statewide average results for calendar years 2017 and 2018 demonstrate an upward trend for many of the performance measures. There are several measures during the calendar year 2018 where the statewide average results surpassed the 75th percentile of Medicaid plans nationally, and three that surpassed the 90th percentile. For calendar year 2018, 28 of the 48 statewide weighted means were at, or better than, the national mean and, of the 2018 statewide weighted means that were lower than the national mean, seven showed improvement from 2017.

The graph below illustrates notable performance measure improvements from 2017 to 2018, which are the most recent years for which the State has data available.



Prior to the June 2013 approval of the MMA program, which is structured substantially similarly to its current form, the State's HEDIS performance measures had remained stagnant and had significant room for improvement.

Comparing calendar year 2018 to calendar year 2013, the last full measurement year prior to MMA implementation, there were 36 HEDIS performance measures reported in both years. The statewide weighted means improved in calendar year 2018 for 30 of the 36 measures, while three measurers were maintained at the same rate. Measures with notable improvements from 2013 to 2018 include:

- Adolescent Well-Care Visits: increased from 50% to 60%.
- Adults' Access to Preventive Care (65+ Years group): increased from 73% to 90%.
- Adult BMI Assessment: increased from 82% to 89%.
- Annual Dental Visit: increased from 40% to 50%.
- Hemoglobin A1c Testing for people with Diabetes: increased from 80% to 86%.
- Eye Exams for People with Diabetes: increased from 49% to 56%.
- Medical Attention for Nephropathy for People with Diabetes: increased from 80% to 92%.
- Follow-up after Hospitalization for Mental Illness within 30 Days: increased from 45% to 51%.
- Immunizations for Adolescents – Combo 1: increased from 63% to 74%.
- Lead Screening in Children: increased from 60% to 71%.
- Timeliness of Prenatal Care: increased from 71% to 83%.
- Postpartum Care: increased from 51% to 63%.
- Well-Child Visits in the First 15 Months – 6 or more: increased from 54% to 70%.

The performance measures with a ten-percentage point increase or more had dedicated performance improvement projects under the MMA program:

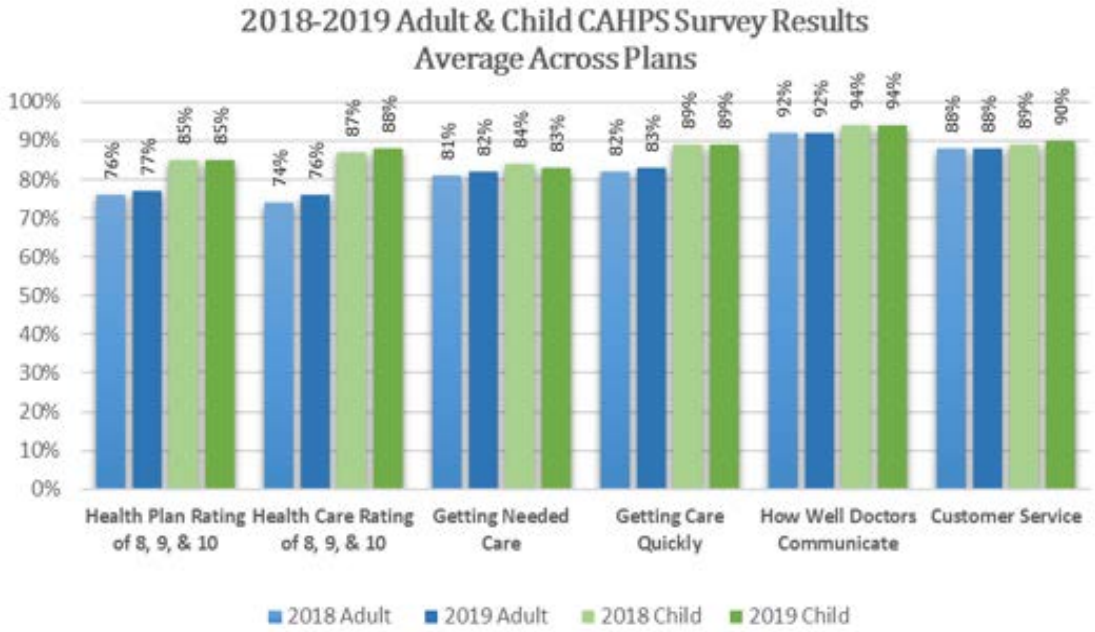
- Focus on preventive dental services for children led to overall performance improvement in dental visits.
- Focus on prenatal care and well-child visits in the first 15 months resulted in performance improvements in the prenatal care and postpartum care measures and the well-child visits measure.

Enrollee Satisfaction Surveys Results

The health plans are required to contract with a certified survey vendor to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey each year. The surveys must be conducted according to the National Committee for Quality Assurance's (NCQA) mixed mode protocols, and health plans must conduct both adult and child surveys. The health plans are required to report their certified results to both the Agency and NCQA annually; NCQA includes the results in the national Medicaid means and percentiles.

Overall, the MMA CAHPS survey results for 2018 and 2019 showed health plans consistently having high enrollee satisfaction rates. Health plan enrollees reported having positive experiences with getting care quickly, getting needed care, customer service, and communicating with their providers.

In 2018, 76% of adult members and 85% of parents of child enrollees rated their health plans an 8, 9, or 10. In 2019, 77% of adult members and 85% of parents of child enrollees rated their health plans an 8, 9, or 10. Please see the chart below for additional detail.



The above chart contains the 2018 and 2019 Adult and Child CAHPS survey results, showing the average across health plans.

Rates in the above chart indicate the percentage of survey respondents giving an 8, 9, or 10 rating; a usually or always rating; or a very good or excellent rating.

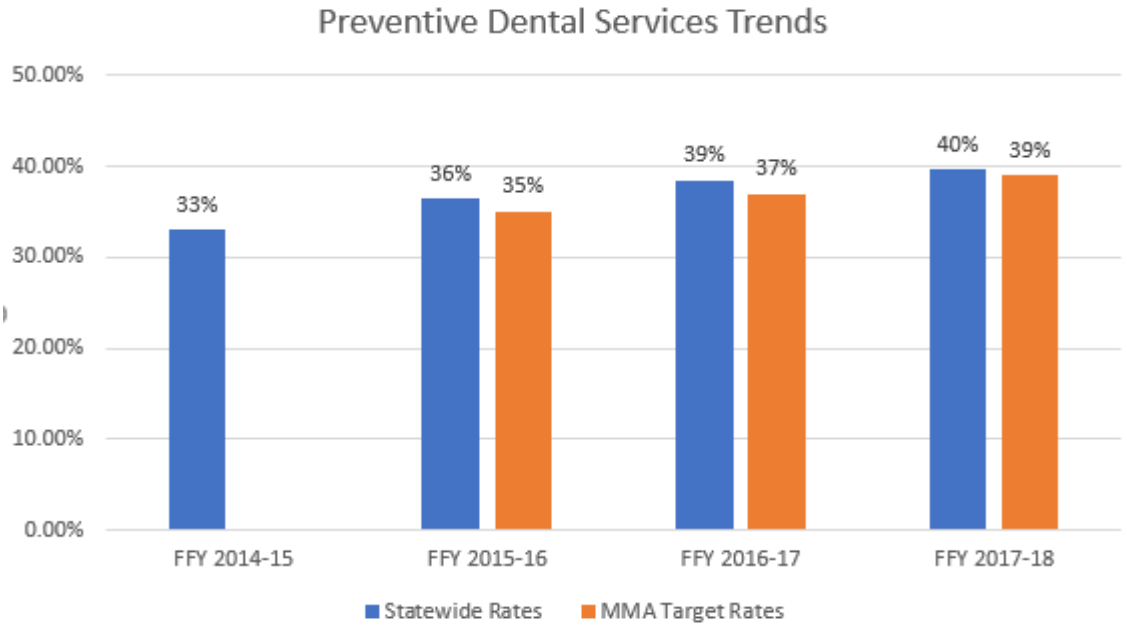
CMS-416 Results

The MMA program has allowed the State to set incremental target measures to improve the rate at which children access services. The measures are reported annually within the CMS-416 Well-Child Visit Report that is submitted to CMS for the Federal Fiscal Year (FFY). The health plans may be assessed liquidated damages if they do not achieve the set target measures on this, as well as on the dental preventive and treatment services rates. Health plans must achieve at least 80% for those enrollees who are continuously enrolled in the health plan for at least eight months for the Florida Screening Ratio measure. The plans far exceeded this for FFY 2017-2018, achieving a Screening Ratio across the health plans of 93.7%.

In FFY 2017-2018, nine health plans met or exceeded the 39% target rate for preventive dental services. Preventive dental has been the subject of a targeted, mandatory performance improvement project. The 39% target was Florida Medicaid's highest performance rate set to date for preventive dental services and represents a 25-percentage point increase over the State's FFY 2011 rate of 14%. Since the inception of MMA in FFY 2014-2015, the health plans have been trending above the contractual targets for this measure. Failure to meet preventive dental services

rates may result in the State requiring plans to implement corrective action plans, in addition to imposing liquidated damages.

The statewide rates for each FFY, and corresponding target rates, are outlined in the following chart. The Agency did not have target rates for FFY 2014-2015 as this was within the MMA and SMMC transition period.



Medicaid Health Plan Report Card

The Agency, in its efforts to promote transparency, publishes a Medicaid Health Plan Report Card, which highlights key performance measures in a consumer-friendly format. The Report Card is updated annually and illustrates HEDIS scores utilizing a five-star rating system, grouping HEDIS measures into related and understandable categories, such as Keeping Kids Healthy and Pregnancy-Related Care. The Medicaid Health Plan Report Cards are available online at the Agency's award-winning Consumer Health Care Transparency website, www.FloridaHealthFinder.gov.

The State is developing other transparency tools to assist in driving improvements in health care outcomes. This includes more frequently updated dashboards that will allow the State, the plans, and its stakeholder partners to measure the impact of the interventions being implemented to drive to the quality improvement goals. Six dashboards displaying data about potential preventable hospitalizations, re-admissions, and emergency department visits and for neonatal abstinence syndrome, preterm births, and C-sections are live and being used by the quality improvement workgroups. For the potentially preventable hospital events, the dashboards are interactive, and users can display data by year, region, health plan, and recipient gender, race/ethnicity, and age group. The dashboards are on the Agency's Quality Initiatives Dashboard website, available at:

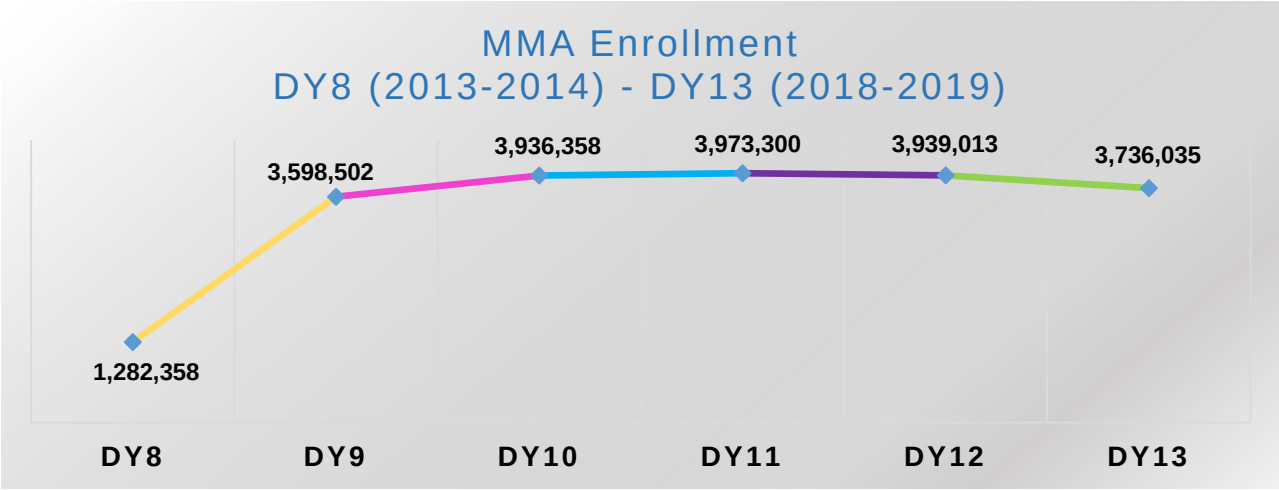
https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityandPerformanceMeasuresDashboardSeries-20190923/SwitchboardMain?iframeSizedToWindow=true&:embed=y&:showAppBanner=false&:display_count=no&:showVizHome=no

IMPROVED ACCESS TO COORDINATED CARE

The MMA program promotes coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner.

Enrollment

Since the statewide rollout of the MMA program in DY9, the average yearly enrollment figure has been 3,836,642. The MMA program's enrollment has remained consistent with minor fluctuations from year to year. The trend since DY9 indicates that the MMA program has matured and stabilized, operating smoothly and efficiently. The decline in enrollment is DY13 is consistent with an overall decline in Medicaid enrollment.



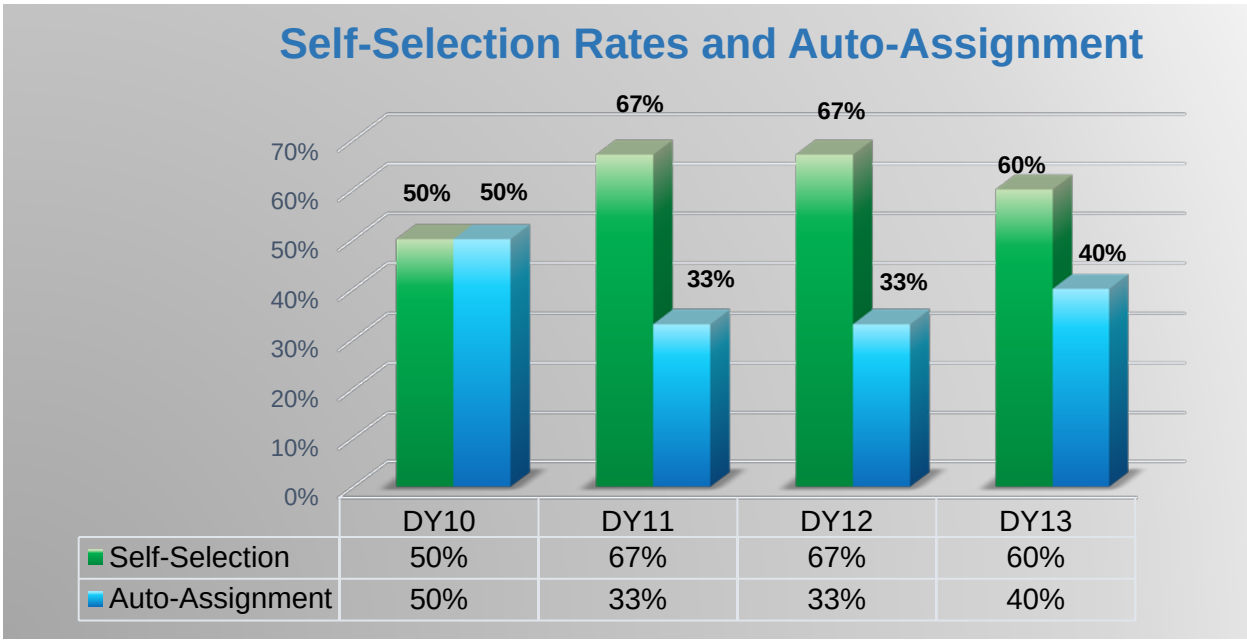
Auto-Assignment and Self-Selection

To facilitate early enrollment and earlier access to the benefits of the managed care delivery system for Medicaid eligible recipients, the State has been:

- Automatically enrolling new Florida Medicaid eligible recipients into a managed care plan immediately upon eligibility determination since 2015.
  - Florida encourages individuals to take an active role in the health plan selection process prior to or upon their eligibility determination. Information regarding the health plan enrollment process, as well as plan availability in their area, is provided upon submission of their Florida Medicaid eligibility application.
  - If the individual does not select a health plan prior to becoming Medicaid eligible, the State utilizes an algorithm to select a health plan that best fits their needs, and immediately assigns them to that plan. This assignment process ensures there is no lag time between an individual's eligibility determination and health plan enrollment, which grants recipients immediate access to care. All individuals enrolled have an open enrollment window of 120-days during which they are permitted to change their health plan.

- Permitting recipients under the age of 21 years who are receiving Prescribed Pediatric Extended Care services and recipients residing in group-home facilities licensed under section 393.067, Florida Statutes (F.S.), to voluntarily enroll into the MMA program.

The State's efforts to engage individuals by providing extensive information upon their application for Florida Medicaid, which encourages them to take an active role in their health care by selecting a health plan prior to their eligibility determination or during the 120-day post enrollment change period, have been successful. As the following chart illustrates, the percentage of recipients selecting their health plan was increased and stabilized prior to DY13, indicating that the State's efforts have been successful.

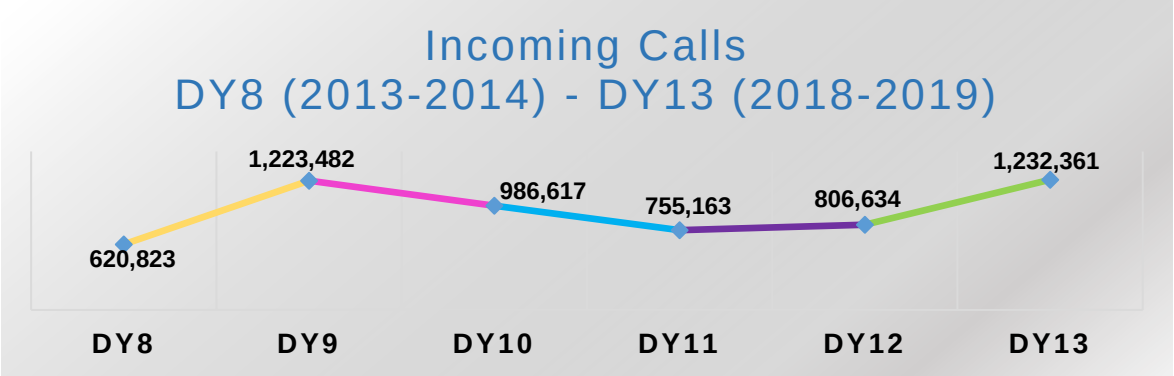


	DY10	DY11	DY12	DY13
Self-Selection	50%	67%	67%	60%
Auto-Assignment	50%	33%	33%	40%

There was a 7-percentage point decrease in the self-selection rate from DY12 to DY13. This was due to the health plan procurement process. Individuals whose health plans were no longer going to be contracted with the State or were no longer going to be covering the individual's Medicaid region after the end of the 2014-2018 contract period received a health plan auto-assignment followed by an open choice period upon the expiration of the contract.

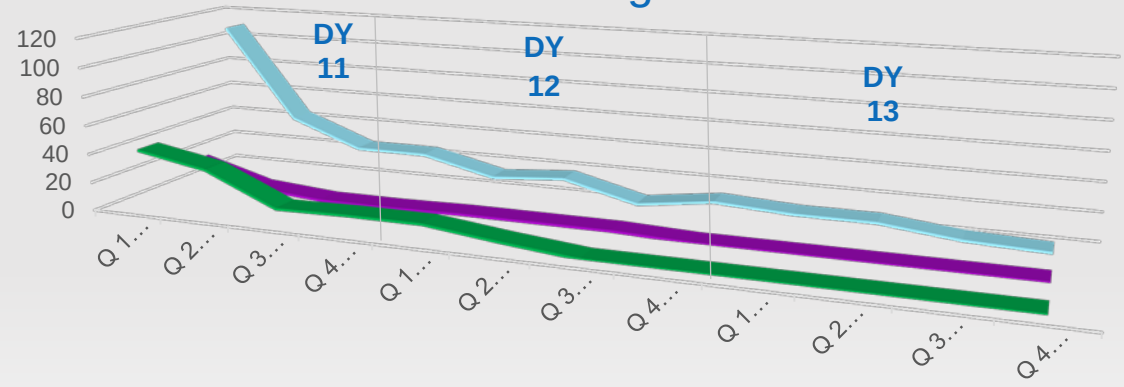
Choice Counseling Activities

The Agency contracts with an enrollment broker/choice counseling vendor to manage Florida Medicaid recipients' enrollment in, and disenrollment from, managed care plans. This also includes the operation of the call center and other outreach activities such as mailings. The following chart details the choice counseling center's call volume from DY8 to DY13.



As illustrated above, DY9 and DY13 had the highest incoming call rates. This is due to the MMA program expanding statewide in DY9 and the health plan re-procurement in DY13. There was also an increase in call volume during DY12. This was due to the consolidation of the 1915(c) Project AIDS Care Waiver, Adults with Cystic Fibrosis Waiver, and Traumatic Brain and Spinal Cord Injury Waiver into the SMMC program. During this time, individuals affected by the consolidation were permitted to change their health plans. The level of call volume indicates individuals actively engaging in selecting their health plan.

Choice counseling outreach activities include group counseling sessions, private counseling sessions, and home visits, which also entail one-on-one counseling sessions and are available to all Medicaid recipients. However, as online resources have been expanded, through the development of the online portal, and the availability of the call center increased, the overall demand for home visits and one-on-one choice counseling sessions continues to decrease; as illustrated below. This downward trend is not surprising as the MMA program has matured and recipients have become more comfortable and familiar with the program.



	Q 1 DY11	Q 2 DY11	Q 3 DY11	Q 4 DY11	Q 1 DY12	Q 2 DY12	Q 3 DY12	Q 4 DY12	Q 1 DY13	Q 2 DY13	Q 3 DY13	Q 4 DY13
Group Sessions	41	32	10	11	11	5	0	0	0	0	0	0
Private Sessions	19	5	1	1	2	2	2	0	0	0	0	0
Home Visits & One-On-One Sessions	110	45	26	26	14	18	5	12	9	9	3	1

LOW INCOME POOL

The objective of LIP is to increase access to, stabilize, and strengthen Florida providers who serve Medicaid, uninsured, and underinsured low-income populations. This is achieved by targeting LIP funding to reimburse charity care costs for services provided to these populations. In accordance with updates to Florida law, STC 71 should be amended to include: To be eligible for LIP funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers under s. 409.975(1)(a)2, Florida Statutes, must offer to contract with each managed care plan in their region and essential providers under s. 409.975(1)(b)1. and 3, Florida Statutes, must offer to contract with each managed care plan in the state. Before releasing such supplemental payments, in the event the parties have not executed network contracts, the agency shall evaluate the parties' efforts to complete negotiations. If such efforts continue to fail, the agency shall withhold such supplemental payments beginning in the third quarter of the fiscal year if it determines that, based upon the totality of the circumstances, the essential provider has negotiated with the managed care plan in bad faith. If the agency determines that an essential provider has negotiated in bad faith, it must notify the essential provider at least 90 days in advance of the start of the third quarter of the fiscal year, and afford the essential provider hearing rights in accordance with chapter 120, Florida Statutes.

Eligible providers are hospitals, medical school faculty physician practices, behavioral health providers, federally qualified health care centers, and rural health clinics that furnish care through charity care programs that adhere to the Healthcare Financial Management Association principles. The LIP program operates as a charity care pool used to compensate participating providers for their charity care cost, as long as each of the providers meet the participation requirements in STC 71. Charity care is health care provided at reduced or no cost to low-income patients, and the LIP program reimburses providers for these services up to cost as long as the services are within the definition of “medical assistance” provided in Section 1905(a) of the Social Security Act. The annual allotment for the LIP program, which may not be exceeded and cannot roll over into the next demonstration year, is $1,508,385,773. Permissible expenditures for the program are expressed in STC 66 through 68 of the MMA Waiver as well as in the Reimbursement and Funding Methodology Document. In DY13, the State paid $857.6 million to qualified providers. **Table 3** details the amount paid in DY13 to each of the provider groups.

TABLE 3: DY13 Paid Amounts to Provider Groups

Provider Group	Behavioral Health Providers	FQHCs	Medical School Physicians	Hospitals
DY13 Reported Charity Care Costs	$9,968,026	$278,576,830	$101,302,245	$9,833,833,094
LIP Payments	$7,489,752	$40,546,416	$101,302,245	$708,268,904
Percentage of Charity Care Costs Covered by LIP Payments	75%	15%	100%	7%

The evaluation will include a review of both claims-based reimbursement (through the Diagnosis Related Groups and Enhanced Ambulatory Patient Groups methodologies) and supplemental payments.

RETROACTIVE ELIGIBILITY

The waiver of retroactive eligibility eliminates retroactive Medicaid coverage for non-pregnant adults only, meaning payments for Medicaid-covered services begin the first day of the month in which an application was submitted, rather than up to three-months prior to the month in which an application was submitted. Eligible pregnant women and children under the age of 21 are not affected by this waiver and are still eligible for retroactive Medicaid coverage for up to 90 days prior to the month in which their application was submitted.

The retroactive eligibility policy change, implemented by the State in February 2019, enhances fiscal predictability for the State, promotes continuity of care for recipients, and encourages individuals to engage the health care system by applying for Florida Medicaid as soon as they become eligible. This allows individuals to be placed in a health plan and receive care coordination immediately upon approval of their Medicaid application. By promoting personal responsibility, individuals are encouraged to participate in their own health care by securing and keeping health coverage; individuals should apply for Medicaid without hesitation to encourage continuity of eligibility and enrollment. The waiver of retroactive eligibility will continue to operate under the current STCs for the requested two-year extension period.

The two-year extension would permit the State to continue operating with the waiver of retroactive eligibility while providing the essential time to fully evaluate the policy change's progress towards the goals of fiscal predictability, continuity of care, and personal responsibility as well as the impact to individuals and providers.

BEHAVIORAL HEALTH AND SUPPORTIVE HOUSING

The State initiated a pilot program for Medicaid recipients in Medicaid regions 5 and 7 (Pinellas, Pasco, Seminole, Orange, Osceola, and Brevard counties). There were kickoff events for the Behavioral Health and Supportive Housing Assistance pilot, hosted by the State, on November 20, 2019 and November 21, 2019 in Medicaid regions 5 and 7, respectively. The events were for program providers, the health plans, and interested stakeholders. Secretary Mary C. Mayhew presented and publicly announced the four health plans selected to participate in the pilot program. The event highlighted that the new pilot will be a collaborative effort, between the State and the four health plans; the pilot program officially began on December 1, 2019.

The overall goal of the Behavioral Health and Supportive Housing Assistance pilot is to facilitate housing stability and improve health outcomes for participants. The intent is to serve approximately 4,000 Medicaid recipients annually. This pilot 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, and who are homeless or at risk of homelessness due to their disability. This program will provide enrollees with additional tools necessary to improve health outcomes and achieve stable tenancy and is projected to have the effect of reducing state costs related to unnecessary beneficiary service utilization.

Supportive services offered through the pilot program are designed to promote autonomy and aid in effectively helping recipients engage and remain in their community. These services consist of:

- Transitional housing services - designed to prepare and support the transition into permanent housing
- Tenancy sustaining services - supports the individual in being a successful tenant
- Mobile crisis management - established to provide immediate, on-site de-escalation of issues when crises occur
- Self-help/peer support - designed to allow individuals to work with peer support specialists to help manage SUD or SMI symptoms and promote community living skills
- One-time incidental payment– assists with moving expenses or other housing related needs

Through this program, the State is evaluating the effectiveness of services by assessing the:

- Percentage of participants who achieved housing permanency
- Percentage of participants whose days of homelessness were reduced (when applicable)
- Percentage of participants diagnosed with a SUD receiving medication assisted treatment
- Percentage of participants diagnosed with an SMI who are compliant with medication management requirements
- Percentage of reduced emergency department and inpatient hospital use among participants

The demonstration objective is to improve the 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.

To date, the State has enrolled over 279 participants. While it is too early to provide outcome data, evidence-based studies demonstrate that addressing an individual's social determinants of health is critical to achieving optimal health outcomes. Many of Florida's health plans have programs that focus on addressing such social determinants; however, the need for housing assistance continually comes up as a barrier in need of resolution to address high emergency department use or re-admission rates among recipients diagnosed with an SMI or SUD. The State hopes to capitalize on the successes of this pilot to expand statewide.

Extending the current waiver affords the State the time to achieve optimal enrollment in the program and to bring the program's goals into fruition. Under the extension, the State would have time to collect data on the program's operations and to conduct a deeper evaluation on the effectiveness of the program. The program's effectiveness is evaluated based on the extent to which the provision of these services results in increased care coordination, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care services.

FINANCIAL ACCOUNTABILITY

The MMA program has implemented strict financial oversight requirements for the health plans. These requirements have improved fiscal and program integrity along with improving customer satisfaction and allowing the State to more efficiently manage public resources.

BUDGET NEUTRALITY

Since the start of the demonstration in 2006, expenditures have been well below the authorized budget neutrality limit. As a result, the State continues to be in substantial compliance with the waiver budget neutrality requirements and anticipates that this trend will continue. See **Attachment IX** for the full budget neutrality.

FINANCIAL MANAGEMENT STANDARD QUESTIONS

See **Attachment X** for the State responses to the CMS standard financial management questions.

SUMMARY OF PROGRAM MONITORING

This section provides summaries of the External Quality Review Organization (EQRO) reports, health plan information, State quality assurance monitoring, and other documentation pertaining to quality and access to care provided under the demonstration. The health plans submit performance improvement project results annually and, in DY12, all of the State-mandated performance improvement projects experienced statistically significant improvement. This was the highest percentage increase to date across all of the State-mandated performance improvement topics. The accomplishments achieved, and the upward trend in meeting or exceeding performance improvement project goals, illustrate the continued effectiveness of the program, which will continue to improve through collaborative efforts such as those highlighted in previous sections regarding the health and dental plan quality improvement targets. More detailed information on the mandated performance improvement projects is contained in the following sections.

EXTERNAL QUALITY REVIEW REQUIREMENTS

The Agency contracts with the Health Services Advisory Group (HSAG) as its External Quality Review Organization vendor. The Agency is responsible for contracting with an EQRO and conducting other quality improvement activities, including but not limited to audits of:

- Enrollee records,
- Enrollee plans of care,
- Provider credentialing records,
- Service provider reimbursement records,
- Contractor personnel records, and
- Other documents and files as required under the Contract and its Exhibits.

A summary of activities performed by the Florida EQRO along with their key findings are contained below.

VALIDATING PERFORMANCE IMPROVEMENT PROJECTS

The health plan Performance Improvement Projects (PIP) are showing significant improvements. For the SFY 2017–2018 (DY12) PIP validation cycle, the plans progressed to reporting their performance indicator results after having implemented their interventions for the first re-measurement, after year one, and the second re-measurement after year two. Across the three state-mandated topics (Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits, Preventive Dental Services for Children, and Medication Review), 73% of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. Every one of the 14 Preventive Dental Services for Children PIPs achieved statistically significant improvement over baseline for the PIP's one study indicator.

IMPROVING PERFORMANCE MEASURES

The Agency continues to review the performance measures reported by the health plans and consider changes. As new performance measures are developed that can replace Agency-defined measures, the Agency will adopt those measures in order to collect data that can be compared to other states and national benchmarks. As measures are added and removed from the CMS' Child and Adult Core sets, and as technical specifications for these measures become available, the Agency will work on including these measures in required reporting.

Over the past few years, the Agency has made several changes to the required performance measures. These changes were due to modifications to the HEDIS measures by the National Committee for Quality Assurance and changes to CMS' Child and Adult Core set. The Agency has selected standardized national measures as much as possible but has retained several Agency-defined measures when there were no comparable national measures for key areas of health outcomes. The Agency has also added several of the CMS Medicaid Adult Core set measures to the reporting requirements for the health plans.

VALIDATING PERFORMANCE MEASURES

As discussed in the Program Performance Improvement section, the health plans must report on a specific set of performance measures selected by the Agency. The EQRO determines that the data collected and reported by the health plans for the performance measures selected by the Agency followed the appropriate methodology. The EQRO then reviews and validates the audit findings from each health plan's final audit report produced by the licensed auditing organization. Therefore, any rates and audit designations are determined to be valid, reliable, and accurate. The EQRO conducted performance measure validation activities for calendar year 2017 and 2018 measures. The Agency has reviewed the draft validation report for calendar year 2018 and the EQRO is in the process of finalizing the report. The initial findings show that the performance measures were calculated accurately.

VALIDATING ENCOUNTER DATA

The Agency, in its continuing efforts to improve encounter data, developed the Health Plan Portal. This portal grants health plans access to view encounter data within the Florida Medicaid Management Information System. It contains monitoring tools, such as dashboards and reports on timeliness and accuracy, to assist the health plans in monitoring and tracking encounter accuracy, and it permits plans to submit online attestations, conduct encounter look-ups, view accuracy and timeliness trend data, and submit enhanced benefit data. The Health Plan Portal was implemented in January 2019, and the Agency has hosted meetings with the plans, both online and in-person, to provide a platform for health plans to provide comments and feedback regarding the Health Plan Portal and the encounter validation process.

The improved Encounter Accuracy Report was implemented in April 2019, and provides detailed information regarding every rejected encounter, including the denial reason. The dissemination of these reports has provided the health plans with valuable information, and the easy-to-use platform

has assisted the plans in determining where encounter submission improvements need to be implemented.

These targeted efforts to improve the completeness and accuracy of encounter data have matured to the point that hospital and pharmacy encounter data, which account for approximately 53% of costs, will be used for rate year 2020-2021 capitation rate setting. Previously, the State has used supplemental data sources for rate-setting. By rate year 2021-2022, the State will rely solely on encounter data for capitation rate setting. During State Fiscal Year 2016-2017 (DY11), the EQRO conducted a review of encounter data for dates of services from January 1, 2016 through June 30, 2016, as a follow-up to the study of dental encounters conducted in SFY 2015-2016 (DY10). The review showed that the encounter data had achieved a high level of accuracy, including the following validation findings:

- The overall accuracy rate for procedure codes associated with validated dates of service from the encounter data that were correctly coded on the enrollees' medical records showed a high overall accuracy rate of 94% (7,372 of the 7,849 code pairs found to have equivalent values).
- Dental procedure code validity was high for both plans' and the Agency's submitted encounters with at least 99% valid values.
- The procedure code accuracy rates showed minimal variation across plans, with rates ranging from 87% to 98%.

During SFY 2019-2020 (DY14), the Agency contracted with the EQRO to conduct a review of encounter data for dates of services from January 1, 2018 through November 30, 2018, for MMA physician (professional) encounters. The Agency anticipates the study being completed by June 2020.

AGENCY MONITORING AND COMPLIANCE OUTCOMES

The Agency oversees the program utilizing a multi-prong monitoring approach that incorporates subject matter experts across the Agency to ensure health and dental plans are in compliance with their contracts. The Agency monitors plans' performance through a variety of mechanisms including, but not limited to, plan reports and submissions, desk and on-site compliance reviews, and reviews of complaints and grievances. Monitoring efforts occur weekly, monthly, quarterly, yearly, and on an ad-hoc basis.

This compliance framework ensures plans are held accountable when an action, or lack thereof, does not meet contractual requirements. The most prevalent areas of non-compliance over the past four demonstration years, which resulted in a compliance action being taken, have been plan administration and management as well as covered services; demonstrated in the chart on the following the page and in **Table 4**.

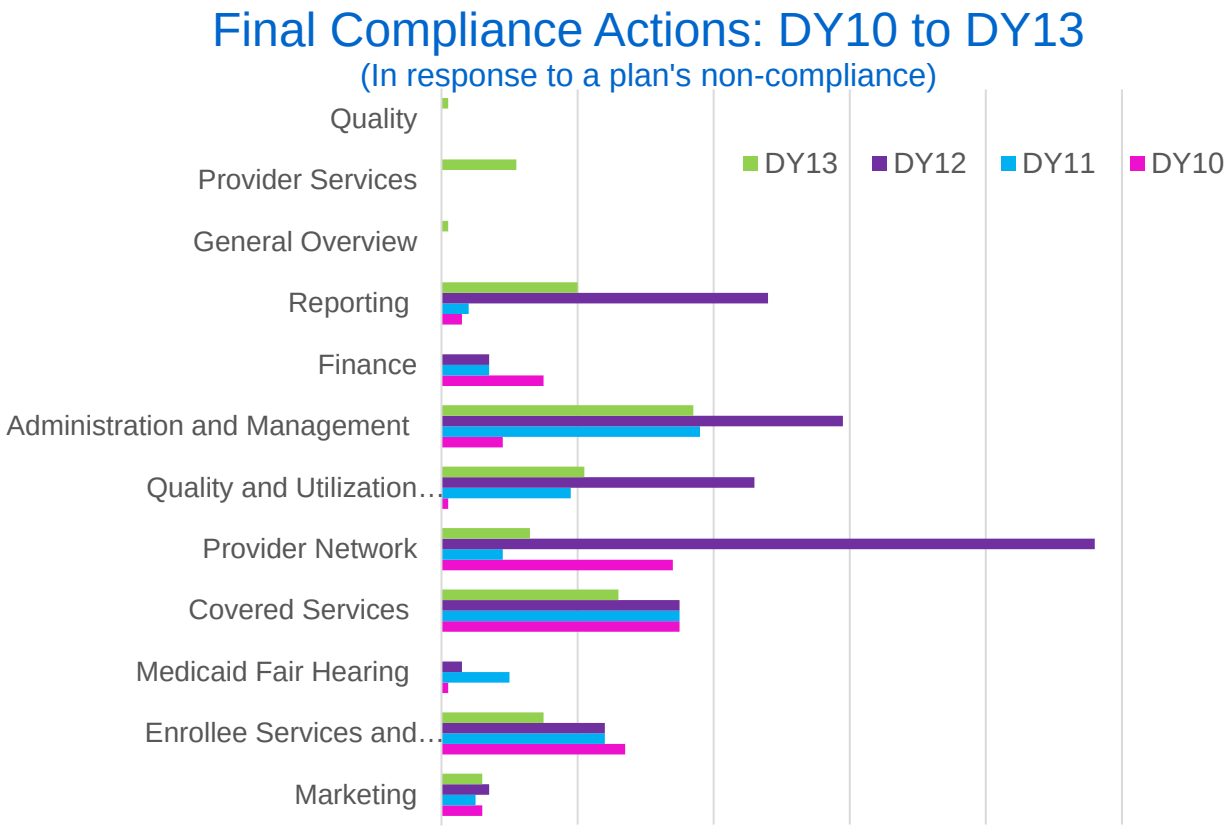


TABLE 4: Itemized Compliance Actions				
Area of Non-Compliance (contract violation)	**DY10**	**DY11**	**DY12**	**DY13**
Marketing	6	5	7	6
Enrollee Services and Grievances	27	24	24	15
Medicaid Fair Hearing	1	10	3	0
Covered Services	35	35	35	26
Provider Network	34	9	96	13
Quality and Utilization Management	1	19	46	21
Administration and Management	9	38	59	37
Finance	15	7	7	0
Reporting	3	4	48	20
General Overview	0	0	0	1
Provider Services	0	0	0	11
Quality	0	0	0	1
Totals	**131**	**151**	**325**	**151**

COMPLAINT DATA

To enhance transparency, promote efficiency, and improve tracking, trending, and response times, the Agency established a centralized recipient and provider assistance operations center to receive and manage all complaints. Recipients, providers, or any other stakeholder may report complaints to the Agency:

Online: http://ahca.myflorida.com/Medicaid

By phone: 1-877-254-1055

Recipients and providers may also report complaints directly to the plan. The following graph and corresponding table contain health and dental complaint data, reported both to the plans and the Agency, for DY11 through DY13. Please note that the total complaint data may contain duplicative information as recipients and/or providers may have filed the same complaint with both the plan and the Agency.

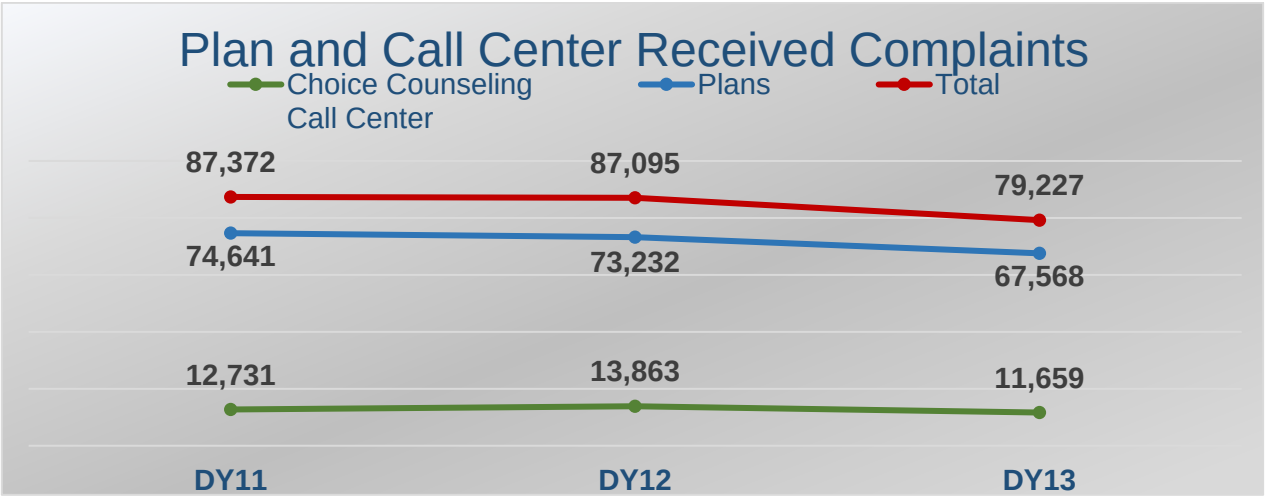


TABLE 5: Health and Dental Complaint Data							
Complaint Source	DY11	DY12	DY13		DY11	DY12	DY13
Choice Counseling Call Center	12,731	13,863	11,659	Enrollment	3,973,300	3,939,013	3,736,035
MMA Plan	74,641	73,232	67,568	Plan and Call Center Complaints*	87,372	87,095	79,227
Total	**87,372**	**87,095**	**79,227**	**Complaints per 1,000 Enrollees**	**22**	**22**	**21**

EVALUATION STATUS AND FINDINGS

This section provides a summary of the interim evaluation report of the demonstration, including evaluation activities and findings to date and plans for evaluation activities during the extension period.

EVALUATION OF THE DEMONSTRATION

The evaluation of the demonstration is an ongoing process conducted during the life of the demonstration. The purpose of evaluating demonstration components is to ensure that all of the programs authorized under the demonstration are operating successfully and to identify areas for improvement. Evaluation reports are required under the Code of Federal Regulations as well as the Special Terms and Conditions of the waiver. The State will continue the current evaluation design as approved by CMS on April 27, 2020. A copy of the approved evaluation design is included as **Attachment XI** to this report.

To date, the Agency has evaluated DY9 (SFY 2014-15), DY10 (SFY 2015-16), DY11 (SFY 2016-17), and DY12 (SFY 2017-18). These evaluations were conducted in accordance with the approved evaluation design for Components 1 through 7. The evaluations addressed each component's research questions and compared the results to what was hypothesized. The structure of the MMA program evaluation design has evolved slightly over the first four years. However, the overall MMA evaluation design continues to be organized around a series of components addressing the various dimensions of the MMA program. Below are the seven evaluation components that were addressed during the first four years:

1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
2. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
3. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
4. The impact of LIP funding on hospital charity care programs;
5. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care;
6. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals; and
7. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner.

Moving forward, there are three new components of the MMA evaluation that will be addressed beginning with the evaluation of DY13 and will extend through DY15. These components include: (8) the prepaid dental program, (9) the retroactive enrollment policy change, and (10) the behavioral health and supportive housing assistance program. Detailed information on the research questions, hypotheses, data sources, outcome measures, and analytic methods

associated with all existing and upcoming components are contained in the attached evaluation design.

For a demonstration extension request, 42 CFR 431.412(c)(vi) requires an evaluation report to be submitted alongside the demonstration extension application. While the State can provide annual evaluation reports that analyze different components for DY 9 -12, a comprehensive evaluation report covering all demonstration years will not be available until January 2022. The currently approved evaluation design timeline states that the Draft Interim Evaluation Report, for the completed years of the demonstration, DY9 through DY14, is due to CMS on January 1, 2022, and the Agency anticipates meeting that deadline.

While components (1) through (7) have been evaluated over a four-year period, the evaluation of components (8) through (10) is yet to be finalized. The first year of encounter/claims data that will be used in the evaluation of the prepaid dental health program (Component 8) will be available on a quarterly basis beginning with SFY 2020-21; the waiver of retroactive eligibility (Component 9) will be available September 2020; and the behavioral health and supportive housing assistance program (Component 10) will be available January 2021. By extending the evaluation period, the State will be able to evaluate these three components over multiple years, as well as have additional time to evaluate all ten components over one DY to look for trends among components.

CMS has worked with states to standardize evaluation methodologies for waivers of retroactive eligibility so that it can better assess the impacts of this policy. To this end, CMS provided detailed evaluation design guidance to be used as a basis for discussions with the evaluators. Florida used this guidance in its proposed evaluation design. As the first-year results for the change in retroactive eligibility will be available in the next two months, we present here a summary of some of the key components of the evaluation design:

1. How will eliminating retroactive eligibility affect new enrollee financial burden?
2. How will eliminating retroactive eligibility affect provider uncompensated care amounts?
3. Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?
4. What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?

As noted earlier in this document, the State first implemented the waiver of retroactive eligibility in February 2019 to enhance fiscal predictability. In comparison to several of the other components of the evaluation design, if the waiver expires on June 30, 2022 (the current expiration date), the current evaluation design will only provide for two years of evaluation for retroactive eligibility. The State believes a waiver extension will provide the opportunity to fully examine the effects of the waiver of retroactive eligibility on Medicaid recipients via a longitudinal study as demonstrated in the approved evaluation design.

EVALUATION DESIGN

The evaluation design includes a discussion of the goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration,

and more generally on recipients, providers, plans, market areas, and public expenditures. Agency staff work with the independent evaluators at the University of Florida, who have subcontracted with Florida State University and the University of Alabama at Birmingham, on an ongoing basis to update and revise the evaluation design to align with the amended STCs as needed. The Agency submitted the following amendment requests to CMS, which included subsequent updates to the evaluation design:

- An amendment to operate a statewide Medicaid Prepaid Dental Health Program was approved November 2018.
- An amendment to waive retroactive eligibility for certain populations was approved November 2018, and evaluation guidance regarding this component was received in March 2019.
- An amendment to operate a Behavioral Health and Supportive Housing Assistance pilot was approved March 2019. Under this amendment, the State is authorized to implement a pilot program providing behavioral health services and supportive housing assistance services to beneficiaries who have a serious mental illness (SMI), substance abuse disorder (SUD), or co-occurring SMI/SUD diagnoses.
- The Agency submitted the finalized evaluation design incorporating the retroactive eligibility and Behavioral Health and Supportive Housing Assistance programs on March 2, 2020, and CMS approved these revisions on April 27, 2020.

This final evaluation design was negotiated with CMS over a period of approximately nine months to ensure all evaluation questions are rigorous and capable of truly evaluating the effectiveness of these amendments to the MMA program. The evaluation design approved by CMS on April 27, 2020 is the design that will be utilized by the evaluation team to evaluate the waiver during the extension of the demonstration.

As stated, the evaluation team has completed the evaluations for DY9 through DY12, and these reports evaluated the research questions and hypotheses for components one (1) through seven (7). The evaluation team is currently in the progress of requesting and analyzing data that will be used in the evaluation of DY13 (SFY 2018-19). In DY13, all 10 components of the evaluation design (research questions and hypotheses) will be evaluated, with the first preliminary report due to the Agency in October 2020.

Since the results presented in this waiver extension application are preliminary, the State intends to conduct further evaluation during the extension period. The Agency will produce a Draft Interim Comprehensive Evaluation Report that fully assesses how the intended demonstration goals and objectives are being or were met by January 2022.

DY11 MMA WAIVER EVALUATION FINDINGS

Notable findings for the evaluation of DY11 (SFY 2016-17) for Projects 1 through 4 are included below.

PROJECT 1: ACCESS TO CARE, QUALITY OF CARE, AND COST OF CARE

- Performance on HEDIS measures related to access to care remained relatively stable between CY 2016 and 2017, although two measures noticeably improved: Adult's Access to Preventive/Ambulatory Services for enrollees over the age of 65 (80% in CY 2016 to 90% in CY2017) and Well Child Visits in the First 15 Months of Life (63% in CY 2016 to 70% in CY2017).
- Performance on CAHPS measures related to access to care were stable between DY10 (SFY2015-16) and DY11 (SFY2016-17) for both adults and children.
- Improvements in performance indicators associated with certain Performance Improvement Projects have occurred between 2017 and 2018. Key factors associated with the success of specific initiatives include aggressive outreach and engagement with enrollees.
- Improvements in the quality of care shown in DY9 (SFY2014-15) and DY10 (SFY2015-16) have been sustained with relatively little year-to-year change.
- Medicaid costs per member per month are lower in the MMA period (SFY 2014-15 through SFY 2016-17) compared to the pre-MMA period (SFY 2011-12 through SFY 2013-14) while quality of care remained stable.

PROJECT 2: HEALTHY BEHAVIORS PROGRAMS

- Of the mandatory programs required of all plans in DY11, the medically-directed weight loss program reported the highest number of current enrollees (31,273), as well as the highest number of enrollees who completed the program (658).
- Out of all healthy behavior programs in DY11, the well-child visits program had the highest number of enrollees who completed the program (124,608), followed by the dental program (58,273).

PROJECT 3: LOW INCOME POOL (LIP)

- In DY11, 157 hospitals received a total of approximately $577 million in LIP supplemental payments for providing charity care services to individuals.
- Hospitals that received LIP funding and reported milestone data in DY11 reported providing approximately 7.5 million total service encounters for charity care to patients across six service categories.

PROJECT 4: DUAL-ELIGIBLE ENROLLEES

- For behavioral health services in DY11, dual-eligible enrollees have lower dollars per user compared to non-dual-eligible enrollees ($389.65 vs. $1,563.86, respectively).
- For behavioral health services in DY11, both dollars per encounter and encounters per user are lower for dual-eligibles compared to non-dual-eligibles ($81.80 vs. $144.51 and 4.76 vs. 10.82, respectively).
- In DY11, dual-eligible enrollees are using more transportation services, but those services have lower costs per use compared to non-dual-eligible enrollees.

DY12 MMA WAIVER EVALUATION FINDINGS

Notable findings for Projects 1 through 4 are included below.

PROJECT 1: ACCESS TO CARE, QUALITY OF CARE, AND COST OF CARE

- Significant improvements were noted for Controlling High Blood Pressure (55 % to 64%) and Mental Health Re-Admission Rate (41% to 26%) from DY11 to DY12.
- 92% (22 measures) of the 24 service accessibility measures showed improvement and two measures remained stable between the pre-MMA and MMA periods.
- Average per member per month expenditures continue to be lower for all eligibility groups during the MMA period compared to the pre-MMA period, while performance on quality metrics has improved.

PROJECT 2: HEALTHY BEHAVIORS PROGRAMS

- Of the healthy behavior programs required of all plans in DY12, the medically-directed weight loss program reported the highest number of current enrollees (1,026), as well as the highest number of enrollees who completed the program (124).
- Out of all healthy behavior programs in DY12, the well-child visits program had the highest number of enrollees who completed the program (36,126), followed by pregnancy/ maternity programs (3,209).

PROJECT 3: LOW INCOME POOL (LIP)

- In DY12, 172 hospitals received a total of approximately $745 million in LIP payments.
- There were 7.9 million encounters across six service categories (discharges, inpatient days, emergency department visits, outpatient visits, affiliated encounters, and filled prescriptions) for charity care patients in DY12.

PROJECT 4: DUAL-ELIGIBLE ENROLLEES

- For behavioral health services in DY12, dual-eligibles had lower dollars per user compared to non-dual-eligibles ($253.68 vs. $1030.82, respectively).
- For behavioral health services in DY12, both dollars per encounter and encounters per user were lower for dual-eligibles compared to non-dual-eligibles ($53.67 vs. $110.94 and 4.73 vs. 9.28, respectively).
- For behavioral health services in DY12, both dollars per encounter and encounters per user contributed to the lower dollars per user for dual-eligibles.

PUBLIC NOTICES

Requirement: Documentation of the State's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

PUBLIC NOTICE PROCESS

The Agency conducted a public comment period from June 1, 2020 to June 30, 2020.

To solicit input on the waiver extension request, the Agency notified stakeholders of the public comment period using the following methods:

- A public notice published in the Florida Administrative Registrar on June 1, 2020 in compliance with Chapter 120, Florida Statutes;
- Emails to individuals and organizations on the Agency's interested stakeholders list; and
- A prominent link posted on the Agency's website where individuals could obtain the public notice materials:

  https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The following table summarizes public participation during the State's public comment period.

Date	Type of Interaction	Participants
June 8, 2020	Public Meeting via Webinar and Conference Call	178
June 17, 2020	Public Meeting via Webinar and Conference Call	96
June 1 – June 30, 2020	Email Submissions	60 Total 28 Comments/Questions

CONSULTATION WITH INDIAN HEALTH PROGRAMS

The Agency consulted with the Florida Indian Health Programs[1] through written correspondence sent via email, which solicited input on the waiver extension request. See **Attachment VI** for a copy of the emailed letters.

PUBLIC MEETINGS

Individuals who were unable to attend the web-based meetings could participate via conference call by using the toll-free number provided by the Agency. During the webinars, the Agency provided an overview of the MMA program, a brief history of the MMA Waiver, a description of the extension request, and allotted time for public comments.

Pursuant to the provisions of the Americans with Disabilities Act, any person who required special accommodations to participate in the webinars were advised to notify Karen Williams-Rockwell at the Agency via email, Karen.Williams-Rockwell@ahca.myflorida.com, at least seven days prior to the webinar.

Individuals who are hearing or speech impaired, were able to contact the Agency using the Florida Relay Service, 1 (800) 955-8771 (TDD) or 1 (800) 955-8770 (Voice).

Schedule of Public Meetings		
Location	**Date**	**Time**
Webinar **GoToMeeting:** https://attendee.gotowebinar.com/register/5097900362915034381	June 8, 2020	3:00 p.m. – 4:00 p.m.
Webinar **GoToMeeting:** https://attendee.gotowebinar.com/register/2727264232989173008	June 17, 2020	3:00 p.m. – 4:00 p.m.

[1] The State of Florida has two federally recognized tribes, the Seminole Tribe and Miccosukee Tribe, and does not have any Urban Indian Organizations.

SUBMITTING WRITTEN COMMENTS

Written comments on the waiver extension request were submitted to the Agency during the public comment period via the following methods:

Mail: 1115 MMA Waiver Extension Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Email: FLMedicaidWaivers@ahca.myflorida.com

Public comments received by the Agency during the public comment period are summarized in **Attachment V**. The summary in **Attachment V** is comprised of the public comments received during the public meetings, by mail, and through emails sent to the above email address.

WAIVER AND EXPENDITURE AUTHORITIES

Requirement: A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

The State is not proposing any alterations or amendments to the STCs in this MMA Waiver extension request, except STC 71 to align with updates in Florida law adopted after the public comment period closed. The State is requesting that the current waiver and expenditure authorities, granted by the CMS on March 26, 2019 (and as specified in the STCs) be continued during the waiver extension.

The current approved Waiver and Expenditure Authorities are included as **Attachment IV**.

ATTACHMENT I: BENEFIT PACKAGES

MMA Standard Benefit Package	
Advanced practice registered nurse services	Mental health services
Ambulatory surgical treatment center services	Medical supplies, equipment, prostheses, and orthoses
Birthing center services	Nursing
Chiropractic services	Laboratory and imaging services
Birth Center and Licensed Midwife Services	Optometrist services
Early and periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy services
Emergency services	Physician services, including physician assistant services
Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate	Podiatric services
Healthy Start services, except as provided in s. 409.975(4).	Prescription drugs
Optical services and supplies	Renal dialysis service
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services

Expanded Benefits Offered by Health Plans	
General Expanded Benefits *Available for children and/or adults*	**Adult Expanded Benefits (cont.)**
Cellular Services (minutes and/or data)	Computerized Cognitive Behavioral Therapy
Circumcision (newborns only)	Durable Medical Equipment/Supplies
CVS Discount Program (20% discount off certain items)	Equine Therapy
Doula Services (birth coach who helps pregnant women)	Group Therapy (Behavioral Health)
Home Delivered Meals	Hearing Services
Housing Assistance (rent, utilities, and/or grocery assistance)	Home Health Nursing/Aide Services
Meal Stipend (available for long distance medical appointment day-trips)	Homemaker Services (e.g., hypoallergenic carpet cleanings)
Over-the-Counter Benefit	Home Visit by a Social Worker
Swimming Lessons (children only)	Individual/Family Therapy
Transportation Services to Non-Medical Appointments/Activities	Massage Therapy
Adult Expanded Benefits *These services are only available for adults because they are already covered for children on Medicaid when medically necessary*	Medication Assisted Treatment Services
Acupuncture Services	Mental Health Targeted Case Management
Art Therapy	Nutritional Counseling
Behavioral Health Assessment/Evaluation Services	Occupational Therapy
Behavioral Health Day Services/Day Treatment	Outpatient Hospital Services
Behavioral Health Intensive Outpatient Treatment	Pet Therapy
Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)	Physical Therapy
Behavioral Health Psychosocial Rehabilitation	Prenatal Services
Behavioral Health Screening Services	Primary Care Services
Chiropractic Services	Respiratory Therapy

Expanded Benefits Offered by Health Plans (cont.)	
Adult Expanded Benefits (cont.)	**Child Welfare Specialty Plan Services** *These services are only available for enrollees in a specialty plan*
Speech Therapy	Care Grant
Substance Abuse Treatment or Detoxification Services (Outpatient)	Life Skills Development
Therapeutic Behavioral On-Site Services	Transition Assistance – Youth Aging Out of Foster Care
Vaccine – Influenza	**HIV/AIDS Specialty Plan Services** *These services are only available for enrollees in a specialty plan* Transition Assistance
Vaccine – Pneumonia	Home and Community-Based Services
Vaccine – Shingles	Vaccine - Hepatitis B
Vaccine – TdaP	Vaccine - Human Papilloma Virus
Vision Services	Vaccine – Meningococcal
Waived Copayments	
Long-Term Care Services *These services are only available for LTC enrollees*	
Assisted Living Facility/Adult Family Care Home - Bed Hold Days	
Individual Therapy Sessions for Caregivers	
Nursing Facility to Community Setting Transition Assistance	

The dental plans also offer a wide array of expanded benefits to their enrollees. The following expanded benefits options are provided by the dental plans if recipients are 21 or older with prior approval from the plan:

Dental Plan Expanded Benefits
Additional dental exams
Additional dental X-rays
Additional extractions
Dental Screenings
Fillings (silver and white)
Fluoride
Oral Health Instructions
Sealants
Teeth Cleanings (basic and deep)

ATTACHMENT II: ADDITIONAL PROGRAMS

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:

1. MomCare

MomCare includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is mandatory 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 dis-enroll 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.

2. Healthy Start Coordinated System of Care

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

PROGRAM FOR ALL INCLUSIVE CARE FOR CHILDREN (PACC)

Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the Children's Medical Services plan who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider:

- 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.
- 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.

- Respite Support
  Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by registered nurse, licensed practical nurse, or home health aide with pediatric experience. This service is limited to 168 hours per year.
- Hospice Nursing Services
  Assessment, pain, and symptom management along with in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.
- 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.
- Pain and Symptom Management
  Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.
- Bereavement and volunteer services
  Bereavement and volunteer services are provided but are not reimbursable services.

COMPREHENSIVE HEMOPHILIA DISEASE MANAGEMENT PROGRAM

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service. The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs, via one of the specialized contracted vendors, from the therapeutic MOF Factor IX, and MOE- Anti-Hemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand.

The program provides the following services, at no additional cost to the State, in addition to product distribution:

- Pharmacy benefit management
- Direct beneficiary contact
- Personalized education
- Enhanced monitoring
- Direct support of beneficiaries in the event of hospitalization
- 24-hour, 7-day a week access to registered nurses and licensed pharmacists

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. Medicaid-Medicare eligible individuals may voluntarily enroll in this program.

ATTACHMENT III: PERFORMANCE MEASURES AND RESULTS

The Agency has specific performance measures for which the health plans are required to submit data. These performance measures are in place to monitor health care service delivery and to provide a mechanism for assessing the effectiveness of the program. The Agency reviewed the following quality performance measure sets to ensure the Agency required measures in the MMA contract were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable:

- Health Plan Effectiveness Data and Information Set (HEDIS) measures
- CMS core set of children's health care quality measures for Medicaid and Children's Health Insurance Program (child core set)
- CMS core set of adult health care quality measures for Medicaid (adult core set)

Calendar Years (CY) 2017 and 2018 Florida Medicaid Managed Care Performance Measures				
	CY 2017		CY 2018	
Measure	CY 2017 Weighted Mean	CY 2017 Comparison to National Mean[1,4]	CY 2018 Weighted Mean	CY 2018 Comparison to National Mean[2,4]
Adolescent Well-Care Visits	57%	Higher	60%	Higher
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years	68%	Lower	70%	Lower
Adults' Access to Preventive/Ambulatory Health Services - 45-64 years	86%	Higher	86%	Higher
Adults' Access to Preventive/Ambulatory Health Services - 65+ years	90%	Higher	90%	Higher
Adults' Access to Preventive/Ambulatory Health Services - Total	75%	Lower	77%	Lower
Adult BMI Assessment	90%	Higher	89%	Higher
Annual Dental Visit - Total[3]	51%	Lower	50%	Lower
Annual Monitoring for Patients on Persistent Medications - ACEs/ARBs	93%	Higher	93%	Higher
Annual Monitoring for Patients on Persistent Medications - Diuretics	93%	Higher	93%	Higher
Annual Monitoring for Patients on Persistent Medications - Total	93%	Higher	93%	Higher
Antidepressant Medication Management - Acute Phase	53%	At the mean	53%	Lower
Antidepressant Medication Management - Continuation Phase	37%	Lower	37%	Lower
Asthma Medication Ratio- Total	N/A	N/A	72%	Higher
Breast Cancer Screening	58%	Lower	60%	Higher
Cervical Cancer Screening	60%	Higher	60%	Higher
Controlling High Blood Pressure	55%	Lower	64%	Higher
Childhood Immunization Status - Combination 2	78%	Higher	78%	Higher
Childhood Immunization Status - Combination 3	74%	Higher	73%	Higher

	CY 2017		CY 2018	
Measure	**CY 2017 Weighted Mean**	**CY 2017 Comparison to National Mean[1,4]**	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[2,4]**
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95%	At the mean	95%	At the mean
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	88%	Higher	89%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	88%	Lower	89%	Lower
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	84%	Lower	86%	Lower
Chlamydia Screening in Women - 16-20 years	62%	Higher	64%	Higher
Chlamydia Screening in Women - 21-24 years	70%	Higher	71%	Higher
Chlamydia Screening in Women - Total	64%	Higher	65%	Higher
Comprehensive Diabetes Care - HbA1c Testing	86%	Lower	86%	Lower
Comprehensive Diabetes Care - HbA1c Poor Control (INVERSE)	41%	Lower (Better)	42%	Lower (Better)
Comprehensive Diabetes Care - HbA1c Good Control	49%	Higher	48%	Lower
Comprehensive Diabetes Care - Eye Exam	55%	At the mean	56%	Lower
Comprehensive Diabetes Care - Nephropathy	93%	Higher	92%	Higher
Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years	11%	Lower	12%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years	6%	Lower	5%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - Total	7%	Lower	7%	Lower
Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase	48%	Higher	41%	Lower
Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	64%	Higher	55%	Lower

	CY 2017		CY 2018	
Measure	**CY 2017 Weighted Mean**	**CY 2017 Comparison to National Mean[1,4]**	**CY 2018 Weighted Mean**	**CY 2018 Comparison to National Mean[2,4]**
Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years	43%	At the mean	42%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 18+ years	42%	Higher	42%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - Total	42%	Higher	41%	Lower
Immunizations for Adolescents - Combination 1	72%	Lower	74%	Lower
Lead Screening in Children	67%	Lower	71%	Higher
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	39%	Higher	40%	Higher
Timeliness of Prenatal Care	82%	Higher	83%	Higher
Postpartum Care	65%	Higher	63%	Lower
Use of Multiple Concurrent Antipsychotics in Children and Adolescents- Total	2%	At the mean	2%	At the mean
Use of First- Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	62%	Higher	62%	Higher
Well-Child Visits in the First 15 Months of Life - 0 Visits (INVERSE)	2%	Lower (Better)	2%	At the mean
Well-Child Visits in the First 15 Months of Life - 6+ Visits	69%	Higher	70%	Higher
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78%	Higher	78%	Higher

[1] National Mean as published by NCQA, Medicaid product line. The National Mean that is compared to is the National Mean for 2016 reporting, which is calculated using CY 2015 service data.

[2] National Mean as published by NCQA, Medicaid product line. The National Mean that is compared to is the National Mean for 2017 reporting, which is calculated using CY 2016 service data.

[3] Calendar Year 2018 Annual Dental Visit calculation by University of Florida for all MMA enrollees meeting the eligible population criteria during the year.

[4] Green shading indicates the statewide weighted mean is better than the National Mean. Blue shading indicates the statewide weighted mean is at the National Mean. Yellow shading indicates that CY 2018 statewide weighted means are lower than the National Mean but better than the CY 2017 statewide weighted means.

ATTACHMENT IV: CURRENTLY APPROVED WAIVER AND EXPENDITURE AUTHORITIES

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITIES

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

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

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

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

Title XIX Waivers

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

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

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

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

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

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

4. Retroactive Eligibility **Section 1902(a)(34)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITIES

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

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

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

1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.
2. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured and/or underinsured.
3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.
4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 18, effective January 1, 2018.
5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 19, effective January 1, 2018.
6. Expenditures for behavioral health and supportive housing assistance services to individuals in MMA, as described in STC 55, effective as of the approval date of the amendment (March 26, 2019). The state will implement this pilot less than statewide and institute annual enrollment limits to 42,500 member months each demonstration year.

a. REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 6.

All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the behavioral health and supportive housing assistance services. In addition, the following Medicaid requirement is not applicable:

i. Statewide Operation Section 1902(a)(1)

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

ii. Amount, Duration and Scope Section 1902(a)(10)(B)

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

iii. Reasonable Promptness Section 1902(a)(8)

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

ATTACHMENT V: SUMMARY OF PUBLIC COMMENTS

The following table summarizes the public comments received during the 30-day public comment period conducted by the Agency, which began June 1, 2020 and ended on June 30, 2020. The Agency carefully considered all comments received on the waiver extension. While the Agency is not recommending changes to the STCs for all of these comments, the Agency takes all comments seriously and may be undertaking efforts related to these comments in the future, within or outside of the STCs.

Regardless of the method of communication, all of the comments received have been categorized into subject areas. The contents in the subject areas are summarized, and express the concern or interest as well as the commenter's sentiment on the subject.

Subject	Public Comment/Question
Evaluation	Concerns were expressed to the Agency regarding the lack of an evaluation, which would normally accompany an extension request. Specifically, this issue was raised in connection with the retroactive eligibility waiver and access to care for children, families, and seniors.
Expanded Benefits	The Agency received a few comments requesting that vaccinations, such as the flu shot and the pneumonia vaccine, be included as mandatory benefits instead of an optional expanded benefit for the MMA plans. Request for an information campaign, to be conducted by the Agency as well as the MMA plans, that disseminates information regarding each MMA plans' expanded benefit offerings specifically which expanded benefits are provided and to what extent. (e.g. Up to $xyz for Housing Assistance.) Additionally, it was proposed that the Agency collect and disseminate utilization data for expanded benefits.
Extension Length	The Agency received questions on why the State was only requesting a 2-year extension.
Low-Income Pool (LIP)	Several comments expressed the importance of this program and inquired about the LIP allotment and whether it will be increased.

Subject	Public Comment/Question (cont.)
Medicaid Delivery System	The Agency received an inquiry about the State exploring the option of eliminating MMA plans and instituting a fee-for-service system in order to save money.
MMA Plan Monitoring	Questions about the Agency's general MMA plan monitoring process were posed during the public meeting.The Agency received questions regarding the annual MMA plan survey, disseminated to providers, regarding the MMA plan's performance, customer service, and reimbursements. Specifically, when the survey will be sent to providers.Additional questions about the survey the MMA plans conduct and report to the Agency where presented. The question related to the process by which the survey is conducted; by the MMA plan or an independent surveyor.
MMA Plan Reprocurement	The Agency received inquiries regarding how the MMA Waiver extension will affect the MMA plan procurement cycle.
Network Adequacy	In light of COVID-19 and the expansion of telehealth, questions were raised about MMA plans use of telehealth and how that impacts local providers providing in-person services.
Pharmacy Benefit Managers (PBM)	Several emails and letters were submitted regarding the monitoring, operations, and practices of PBMs, along with complaints about PBM practices.

Subject	Public Comment/Question (cont.)
Provider Reimbursement	Several emails were submitted pertaining to insufficient MMA plan reimbursement rates, their claims processing practices, and reimbursement denials. Specifically, requesting that the Agency take action to increase rates, such as instituting a recurring inflation provision that aligns with the CPI.
Reporting	Several comments were received requesting additional demographic data be provided, such as race/ethnicity. One comment contained a recommendation that the waiver extension request include provisions on how the state intends to implement CMS' 2024 requirement of Child Core Set performance measure reporting.
Retroactive Eligibility Waiver	The Agency received several comments expressing concerns about the extension of the waiver of retroactive eligibility. These comments raised questions regarding the evaluation of the retroactive eligibility waiver and concerns about the impacts it has on Medicaid beneficiaries' access to care and medical debt.
General Questions	The Agency received multiple general questions regarding the MMA program, including topics such as future amendments, the Behavioral Health and Supportive Housing Assistance pilot, Cultural Competency Plans, the timing of the extension, Quality Initiative workgroups, and the complaint process.
Questions/Comments Unelated to the Waiver Extension	The Agency received comments unrelated to the extension request. These comments were regarding subjects such as electronic visit verification, skilled nursing, targeted case management, and institutions for mental diseases expansion.

ATTACHMENT VI: LETTERS TO THE MICCOSUKEE AND SEMINOLE TRIBES

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

May 29, 2020

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from June 1, 2020 to June 30, 2020. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held:

- Webinar: June 8, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/5097900362915034381
- Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

If you have any questions about this amendment or would like to hold a call, please contact Karen Williams-Rockwell of my staff via email at Karen.Williams-Rockwell@ahca.myflorida.com.

Sincerely,

Beth Kidder

Beth Kidder
Deputy Secretary for Medicaid

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

May 29, 2020

Dr. Paul Isaacs
Executive Director, Health and Human Services
Seminole Tribe of Florida
6365 Taft Street, Suite 2004
Hollywood, FL 33024

Dear Dr. Isaacs:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from June 1, 2020 to June 30, 2020. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held:

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- Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

If you have any questions about this amendment or would like to hold a call, please contact Karen Williams-Rockwell of my staff via email at Karen.Williams-Rockwell@ahca.myflorida.com.

Sincerely,

Beth Kidder

Beth Kidder
Deputy Secretary for Medicaid

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ATTACHMENT VII: FLORIDA ADMINISTRATIVE REGISTER NOTICE

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration (Agency) announces public meetings to which all persons are invited.

DATES AND TIMES: June 8, 2020, 3:00 p.m. – 4:00 p.m.; June 17, 2020, 3:00 p.m. – 4:00 p.m.

PLACES: Webinar; June 8, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link: GoToMeeting https://attendee.gotowebinar.com/register/5097900362915034381

Webinar; June 17, 2020, 3:00 p.m. – 4:00 p.m. To participate, register via the following link: GoToMeeting https://attendee.gotowebinar.com/register/2727264232989173008

GENERAL SUBJECT MATTER TO BE CONSIDERED: Two-year extension request for Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver.

SUMMARY DESCRIPTION OF EXTENSION REQUEST: The State is seeking federal authority to extend Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 through June 30, 2024. The MMA program operates statewide and provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including higher quality of care and stronger protections for Florida Medicaid recipients.

A full description of the extension request and the public notice document will be published on the Agency's website at the following link:

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

PUBLIC NOTICE AND PUBLIC COMMENT PERIOD: The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The Agency will consider all public comments received regarding the proposed extension request. The 30-day public notice and public comment period is from June 1, 2020 through June 30, 2020. This public notice and public comment period is being held to solicit public input from recipients, providers, all stakeholders, and interested parties on the proposed extension request for Florida's 1115 MMA Waiver.

To submit comments by postal service or email please adhere to the following instructions. When providing comments regarding the extension request for the 1115 MMA Waiver, please put '1115 MMA Waiver Extension' in the subject line.

Mail comments and suggestions to: 1115 MMA Waiver Extension, Office of the Deputy Secretary for Medicaid, Agency for Health Care Administration, 2727 Mahan Drive, MS 8, Tallahassee, Florida 32308. Email your comments and suggestions to FLMedicaidWaivers@ahca.myflorida.com.

A copy of the agenda may be obtained by contacting Karen Williams-Rockwell by email at Karen.Williams-Rockwell@ahca.myflorida.com.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the Agency at least

seven days before the workshop/meeting by contacting: Karen Williams-Rockwell by email at Karen.Williams-Rockwell@ahca.myflorida.com. If you are hearing or speech impaired, please contact the Agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

ATTACHMENT VIII: PROVIDER ALERT

The Agency for Health Care Administration (Agency) is announcing the start of a 30-day public notice and comment period. The State is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2020 to June 30, 2024. The MMA program operates statewide and provides primary and acute medical care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver with no amendments, in order to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

For more information on the public meetings, information on submitting comments, and to view a comprehensive description of the waiver extension request. Please visit:

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

During the meetings, the Agency for Health Care Administration will provide a description of the MMA program and allow time for public comments. The public meetings for the MMA Waiver extension request will take place:

Webinar
Monday, June 8, 2020 from 3:00 p.m. - 4:00 p.m.
GoToMeeting: https://attendee.gotowebinar.com/register/5097900362915034381

Webinar
Wednesday, June 17, 2020 from 3:00 p.m. - 4:00 p.m.
GoToMeeting: https://attendee.gotowebinar.com/register/2727264232989173008

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the Agency at least seven days before the workshop/meeting by contacting Karen Williams-Rockwell via email at Karen.Williams-Rockwell@ahca.myflorida.com

If you are hearing or speech impaired, please contact the Agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

In addition to providing comment at the afore mentioned public meetings, comments can be submitted via mail or email per the instructions below. The Agency will conduct the 30-day public notice and comment period from June 1, 2020 to June 30, 2020, prior to the submission of the Demonstration Extension Application to Centers for Medicare and Medicaid Services (CMS). The public notice and public comment period is being held to solicit public input from recipients, providers, and all stakeholders and interested parties. The Agency will consider all public comments received during the public notice and comment period regarding the proposed MMA Waiver Extension Application.

Comments will be accepted from June 1, 2020 through June 30, 2020.

Mail comments and suggestions to:

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver Extension Request" referenced in the subject line.
Additional information about the SMMC program can be accessed by visiting www.ahca.myflorida.com/SMMC

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

ATTACHMENT IX: BUDGET NEUTRALITY

Requirement: Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

BUDGET NEUTRALITY COMPLIANCE

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested waiver extension period (July 1, 2020 to June 30, 2024) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the CMS financial management standard questions, see **Attachment X**. The following tables address the budget neutrality items specified above and documents the waiver's budget neutrality.

GENERAL BUDGET NEUTRALITY REQUIREMENTS

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs of the waiver, as agreed upon by the state and Federal CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality "test", as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida's Research and Demonstration Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

BUDGET NEUTRALITY RESULTS TO DATE

The table located on the following page provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Member per Month (PMPM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PMPM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through Demonstration Year 13, expenditures have been $20.5 billion less than the authorized budget neutrality limit. However, during last approved extension Florida saving were rebased, and the new cumulative variance through Year 13 is $10.5 billion. As a result, the State remains in compliance with budget neutrality and anticipates that, by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

MEG 1 and 2 Cumulative Statistics DY1 – DY8					
DY 01	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					**91.02%**
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					**89.15%**
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					**83.07%**
DY 04	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					**76.94%**
DY 05	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					**71.73%**
DY 6	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					**70.14%**
DY 7	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	28,179,336	$7,224,274,901	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% Of WOW					**67.49%**
DY 08	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PMPM**
MEG 1 & 2	28,867,69	$7,198,209,036	$1,579,606,142	$8,777,815,179	$304.07
WOW	28,867,69			$13,874,528,641	$480.62
Difference				$(5,096,713,462)	
% Of WOW					**63.27%**

MEG 1 and 2 Cumulative Statistics			
DY 09	**Actual CM**	**Total**	**PMPM**
Meg 1 & 2	29,099,424	$10,347,831,844	$355.60
WOW	29,099,424	$11,249,933,407	$386.60
Difference		$(902,120,063)	
% Of WOW			91.98%
DY 10	**Actual CM**	**Total**	**PMPM**
Meg 1 & 2	34,305,923	$12,559,757,972	$366.11
WOW	34,305,923	$13,717,298,419	$399.85
Difference		$(1,157,540,447)	
% Of WOW			91.56%
DY 11	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	38,019,658	$12,624,224,928	$332.04
WOW	38,019,658	$15,635,114,920	$409.88
Difference		$(3,010,889,992)	
% Of WOW			81.01%
DY 12	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	35,058,163	$13,842,405,018	$394.84
WOW	35,058,163	$13,398,987,974	$382.19
Difference		$443,417,044	
% Of WOW			103.31%
DY 13	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	33,473,543	$14,107,683,047	$421.46
WOW	33,473,543	$13,476,710,645	$402.61
Difference		$630,972,402	
% Of WOW			104.68%

FLORIDA'S 1115 RESEARCH AND DEMONSTRATION WAIVER

The 1115 waiver templates supporting the waiver's compliance with the budget neutrality STCs will be included as required by CFR upon submission to CMS. Additionally, the projection of budget neutrality benchmarks for the requested two-year waiver extension (July 1, 2022 - June 30, 2024) is included. The following are the basic concepts and assumptions used to project the two years (DY17-DY18).

The Without Waiver (WOW) trend applied to the member month projections are based on the waiver's historic population and voluntary Fee-For-Service population trends experienced during DY09 to DY13 for Aged and Disabled population (MEG1), and DY09 to DY13 for TANF and related group (MEG2). During this amendment the trend methodology was updated to combine historical and churning population since 85% of Florida Medicaid population is now in MMA. The actual PMPM for DY13 is being utilized as a jump to trend forward through DY18. The same "president's trend' rates as defined in the latest amendment are being used for the WOW PMPM projections.

The With Waiver (WW) projections follow the same concept as the WOW calculations. There are no president's trends utilized in the WW projections. All the WW trend rates were derived from the historical and churning population trends.

WOW and WW Months of Aging are defined as the 24 months for MEG1 and 36 months for MEG2 from the mid-point of DY12 through the mid-point DY15. Regarding historic trend data for DY13, expenditures are included through December 31, 2019. Since the demonstration years are defined as dates-of-service, there will be additional claim submissions still forthcoming for this year.

During last amendment two new hypothetical populations were introduced, MEDS-AD and Housing Assistance. WOW and WW include them as new hypothetical groups. Total spending allowed for MEDS-AD and Behavioral Health and Supportive Housing Assistance Pilot are found in STC 95, and STC 96 respectively.

With the above calculated PMPMs and member months, the total WOW expenditures including the two renewal years are projected to be $72,109,060,502 compared to the WW expenditures of $69,303,905,919 for period. This would result in a savings of $2,805,154,583. Separate calculations are identified for the two programs covered under this waiver renewal as Costs Not Otherwise Matchable (CNOM). These are HIV/AIDS beneficiaries, Healthy Start program, and the Program of All Inclusive Care for Children.

MEG 3 was established in the initial waiver application as approved by Federal CMS. The MEG is also referred to as the LIP and is not directly linked to Medicaid eligibility. Expenditures for the LIP program are authorized to provide services to the uninsured and underinsured.

Distributions to qualifying providers under the LIP program are determined by the type of provider and services as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the claims processing system but are lump sum payments made directly to the provider to offset the allowable charity care services.

The limit for the LIP program is established in the budget neutrality and is reported in accordance with the requirements of the STCs of the waiver specific to budget neutrality. However, the program requirements and monitoring are subject to STCs of the waiver established for the LIP program.

The Agency is seeking to continue funding for the LIP at $1,508,385,773 annually, for the waiver extension period of July 1, 2022 through June 30, 2024. The following table provides the anticipated annual enrollment (unduplicated person count) and the annual expenditures for each year of the two-year extension period.

DY	Annual Unduplicated Enrollment	Annual Expenditures	Low Income Pool
DY17 (SFY 22-23)	4,381,593	$19,231,382,400	$1,505,385,773
DY18 (SFY 23-24)	4,499,896	$20,527,056,570	$1,505,385,773

The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

ATTACHMENT X: STANDARD FINANCIAL QUESTIONS

The following questions were asked and the Agency's responses provided in relation to all payments made to all providers under the section 1115 demonstration under review.

a. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

   A. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?

      State response: Providers retain 100 percent of all payments made relating to this program.

   B. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

      State response: If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS on the CMS 64 report.

b. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

   A. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

      State Response: The state share of payments for these programs are appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, Tobacco Settlement Trust Fund, Grants and Donations Trust Fund, and the Public Medical Assistance Trust Fund.

   B. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide the NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please also indicate if any managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.

State Response: The non-federal share for the Low Income Pool is provided through Intergovernmental Transfers.

C. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

State Response: The state share of payments for these programs are appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, Tobacco Settlement Trust Fund, Grants and Donations Trust Fund, and the Public Medical Assistance Trust Fund.

D. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

State Response: The state and the intergovernmental transfer provider enter into a Letter of Agreement annually, signed by the provider by October 1. The Agency invoices the provider based on the pledged amounts in the letter of agreement on an annual basis or based on an alternative plan if specifically approved by the Agency. The Agency begins invoicing after the Low Income Pool model is approved by the Legislature through the Budget Amendment process.

E. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds is in accordance with 42 CFR 433.51(b).

State Response: There are no certified public expenditures directly related to the payments for this program.

F. For any payment funded by CPEs or IGTs, please provide the following:

i. A complete list of the names of entities transferring or certifying funds;
ii. The operational nature of the entity (state, county, city, other);
iii. The total amounts transferred or certified by each entity;
iv. Clarify whether the certifying or transferring entity has general taxing authority; and
v. Whether the certifying or transferring entity received appropriations (identify level of appropriations).

State Response: Please see the SFY 2018-19 Summary of LIP IGTs that immediately follows the conclusion of these questions. No entities received appropriations for this purpose.

c. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state Plan. If

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

State Response: Please see the SFY 2018-19 LIP Payment and Charity Care listing, available at http://ahca.myflorida.com/Medicaid/Finance/finance/LIP-DSH/LIP/docs/SFY2018-19_LIP_Payments_Charity_Care.pdf.

d. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated).

State Response: The methodology for the Low Income Pool is outlined in the Special Terms and Conditions and the Reimbursement and Funding Methodology documents.

e. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

A. If payments exceed the cost of services (as defined above), does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

State Response: Payments to providers would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, this is documented, and the federal share is calculated and returned to CMS. The excess is returned to the state and the federal share is reported on the CMS 64 report.

f. In the case of risk-based MCOs, PIHPs, and PAHPs:

A. Are there any payments to MCOs, PIHPs, PAHPs, or providers that are outside of the actuarial sound capitation rates in 42 CFR 438.4?

State Response: Yes, besides the capitation payments made to MCOs, Florida Medicaid also pays MCOs supplemental (kick) amounts for maternity costs and a separate annual amount for the ACA Health Insurance Providers Fee (HIPF), if applicable. The kick payments are developed by our actuaries and the HIPF methodology and amounts are reviewed by our actuaries.

B. Are there any actual or potential payments which would be subject to 42 CFR 438.6(b), 438.6(c), 438.6(d), 438.60, or 438.74? (These payments could be for such things as managed care plan incentive arrangements, risk sharing mechanisms such as stop-loss limits, risk corridors, medical loss ratios with a remittance, or contractual requirements that direct the managed care plans on how to pay providers, or direct payments from the State to providers such as DSH hospitals, academic medical centers, or FQHCs.)

State Response: Yes, Florida Medicaid pays DSH hospitals, certain hospitals for Graduate Medicaid Education (GME), Medical School Faculty payments, and wrap payments to FQHCs. There are payment arrangements subject to 42 CR 438.6(c) for Medical School Faculty Physicians, Florida Cancer Hospitals, and Public Emergency Medical Transportation.

C. If so, how do the arrangements in Item (b) comply with the requirements on payments in §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74 of the managed care regulations?

State Response: All payments are in compliance with the requirements on payments of the managed care regulations.

D. In situations, where MCOs, PIHPs, or PAHPs are not permitted to retain some or all of the recoveries of overpayments under the policies required in 42 CFR 438.608(d), does the state return the federal share of the recovery to CMS on the quarterly expenditure report?

State Response: No, Florida Medicaid does not require MCOs to refund to the State any recoveries of overpayments to their network providers.

g. In the case of non-risk-based PIHPs, and PAHPs:

A. How do the arrangements comply with the upper payment limits specified in §447.362 limits on payments?

State Response: Payments are limited to the Medicaid fee-for-service rate on the applicable Medicaid fee-for-service schedule.

B. If payments exceed the cost of services, does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

State Response: Payments to providers relating to this program would not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the State and the Federal share is reported on the 64 report to CMS.

Summary of Low Income Pool Funded by Local and State Government	
SFY 2018-19	
Local Government	**Intergovernmental Transfers**
City of Jacksonville	$21,911,460
City of Orlando	$55,600,336
City of Pensacola	$14,462,331
Florida Board of Governors/DOE	$2,025,000
Halifax Hospital Medical Center Taxing District	$10,979,107
Health Care District of Palm Beach County	$2,424,718
Hillsborough County	$32,901,917
Lee Health	$21,331,313
Manatee County	$629,825
North Brevard County Hospital District	$1,308,672
North Broward Hospital District	$16,350,660
North Lake County Hospital District	$834,401
Public Health Trust of Miami Dade County	$50,183,181
Sarasota County Public Hospital Board	$6,322,197
South Broward Hospital District	$22,188,519
Southeast Volusia Hospital Taxing District	$104,195
UF Board of Trustees	$17,587,791
Total Group 1 - Hospitals	**$277,145,623**

Florida International University	$839,866
Public Health Trust of Miami Dade County	$14,502,573
UF Board of Trustees	$22,656,632
USF Board of Trustees	$1,640,498
Total Group 2 - Medical School Physician Practices	**$39,639,569**

Local Government	Intergovernmental Transfers
Brevard County Board of County Commissioners	$868,598
City of Jacksonville	$398,279
Collier County Board of County Commissioners	$605,978
Escambia County Board of County Commissioners	$351,284
Florida Department of Health	$462,750
Health Care District of Palm Beach County	$1,900,485
Hernando County Board of County Commissioners	$150,000
Hillsborough County	$2,258,157
Indian River Taxing District	$214,614
Lee Health	$102,139
Leon County	$339,580
Manatee County Board of County Commissioners	$1,419,268
Marion County	$251,096
Marion County Hospital District	$186,896
Orange County	$1,928,785
Osceola County Board of County Commissioners	$261,019
Pinellas County	$818,851
Polk County	$539,113
Seminole County	$221,608
The Children's Trust	$2,587,312
Total Group 3 - Federally Qualified Health Centers	**$15,865,812**

Hillsborough County	$191,677
Leon County	$258,362
Manatee County	$258,038
North Lake Hospital Taxing District	$554,117
Orange County Board of County Commissioners	$1,343,497
Osceola County Board of County Commissioners	$193,183
West Volusia Hospital Authority	$135,388
Total Group 4 - Behavioral Health Providers	**$2,934,262**

Grand Total	**$335,585,266**

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

Presented to:

Centers for Medicare and Medicaid Services

Prepared by:

Florida Agency for Health Care Administration

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College of Medicine
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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.[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.

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-

[2] 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, August 3, 2017 through June 30, 2022.

3. Description of the Demonstration and History of the Implementation

The Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Research and Demonstration Waiver, "Medicaid Reform", on October 19, 2005. Florida initially implemented the program in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay, and Nassau counties on July 1, 2007.

On June 30, 2010, the Agency for Health Care Administration (Agency) submitted a three-year waiver extension request to maintain and continue operations of the Medicaid Reform program. Federal CMS approved the three-year waiver extension request on December 15, 2011 for the period December 16, 2011 through July 31, 2014.

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

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

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

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

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

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

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

4. MMA Program Description and Objectives

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

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

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

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

4.1 Populations Covered in the MMA Program

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

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

Table 1. Mandatory and Optional State Plan Eligibility Group

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

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
IV-E Foster Care and Adoption Subsidy	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & Related Group
Pregnant women	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Group
Section 1931 parents or other caretaker relatives	No more than Aid to Families with Dependent Children (AFDC) Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.)	Title XIX	TANF & Related Group
Aged/Disabled Adults	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & Related Group

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

Optional State Plan Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 20(c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217	This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 20(c).	Title XIX	Aged/Disabled

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

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

Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 25.

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

a) Individuals who have other creditable health care coverage, excluding Medicare;

b) Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

c) Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);

d) Individuals with developmental disabilities enrolled in the home and community- based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;

e) Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility; and

f) Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

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

a) Individuals eligible for emergency services only due to immigration status;

b) Family planning waiver eligible;

c) Individuals eligible as women with breast or cervical cancer; and,

d) Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan, except as inpatients in a medical institution).

B. Evaluation Questions and Hypotheses

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

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

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

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

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

Research Questions:

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

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

1B. *What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to MMA plans?*

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

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

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

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

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

1E. *What strategies are standard MMA and specialty MMA plans using to improve quality of*

care? Which of these strategies are most effective in improving quality and why?

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

1F. *What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans?*

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

1G. *What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per-enrollee costs in the MMA period (MMA plans as a whole, standard MMA plans and specialty MMA plans)?*

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

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

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

Research Questions:

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

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

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

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

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

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

2D. *How do enrollees rate their experiences and satisfaction with the expanded benefits that*

are offered by their health plan?

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

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

Research Questions:

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

3A. *What Healthy Behaviors programs do MMA plans offer? What types of programs and how many are offered in addition to the three required programs (medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)?*

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

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

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

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

> ***Hypothesis 3Ei.*** *There will be no difference in utilization of 1) preventive services and 2) outpatient services between enrollees participating in Healthy Behaviors programs and enrollees not participating in Healthy Behaviors programs.*
>
> ***Hypothesis 3Eii.*** *There will be no change in the utilization of ER, inpatient and outpatient hospital and physician specialty services for treatment of conditions that these programs are designed to prevent or manage for enrollees after enrolling in the Healthy Behaviors program.*

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

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

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

Research Questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Component 5. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care[4]

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

Research Questions:

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

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

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

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

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

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

The State has elected to evaluate this component by focusing on the experiences of dual

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

eligibles in receiving behavioral health services and non-emergency transportation services because these services are covered by Medicaid.

Research Questions:

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

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

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

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

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

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

Research Questions:

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

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

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

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

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

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

Research Questions:

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

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

8B. *What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

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

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

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

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

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

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

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

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

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

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

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

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

8I. *How do enrollees rate their experiences and satisfaction with dental health services,*

including timeliness of dental health services, provided by their dental health plans?

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

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

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

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

Research Questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Research Questions 9G and 9H will be answered descriptively based on a random telephone survey of men and non-pregnant women subject to the new retroactive enrollment policy. These questions are exploratory and descriptive in nature so there are no hypotheses to be tested.

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

Research Questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Driver Diagram and Component 9 and Component 10 Logic Models

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

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

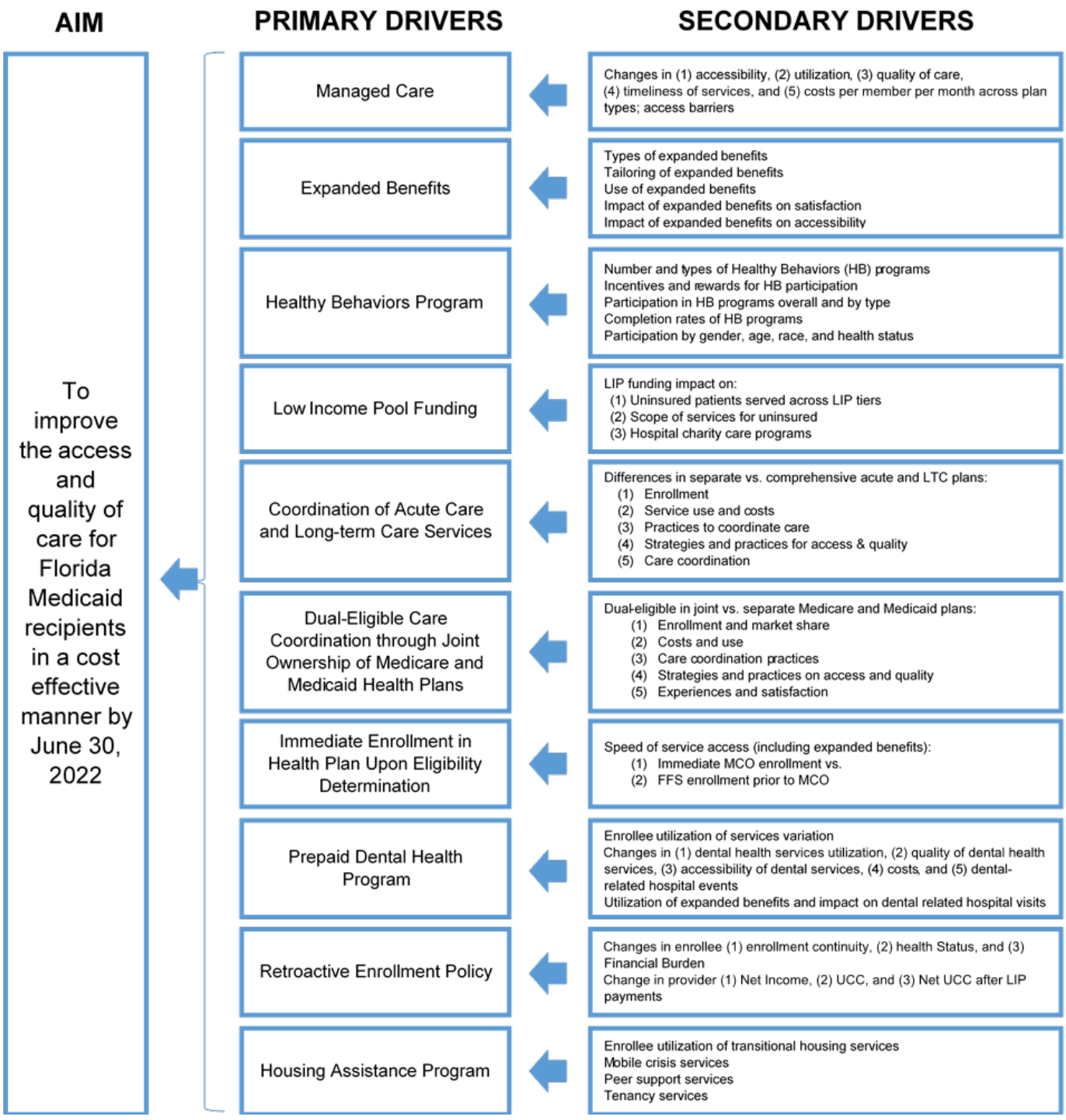
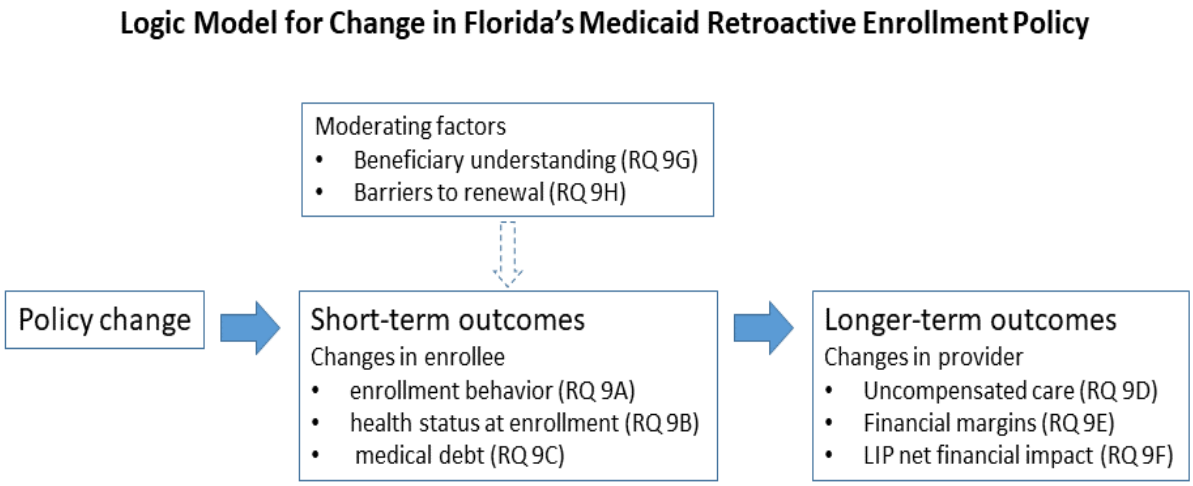


Figure 2 presents the logic model for Component 9 that depicts the hypothesized causes/effects associated with the change in Medicaid retroactive enrollment policy in Florida. The figure starts with the policy change as the intervention that drives the observed changes and lists both short-term outcomes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

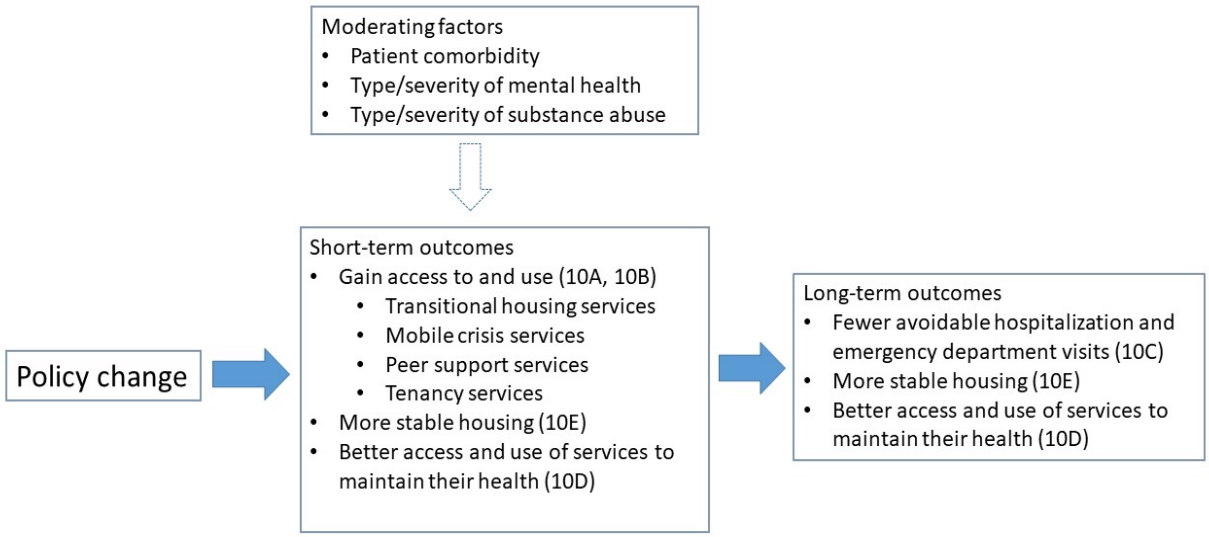
Figure 2. Logic Model for Change in Florida's Medicaid Retroactive Enrollment



Logic Model for Component 10: Housing Assistance Pilot Program

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

Figure 3. Logic Model for Housing Assistance Pilot Program



C. Methodology

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

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

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

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

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

1. Evaluation Design

This evaluation employs both pre-post and post-only analyses as appropriate for the research question under examination. For example, for Research Question 1G, "What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (Fee For Service (FFS), Reform plans and pre-MMA 1915(b) waiver plans) compared to per enrollee costs post-MMA implementation (MMA plans as a whole, standard MMA plans and specialty MMA plans)?", a pre-post perspective is required.

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

2. Target and Comparison Populations

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

3. Evaluation Period

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

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

4. Evaluation Measures

This evaluation uses a wide variety of measures of quality, access, and costs. ***Table 2*** and

Table *3*, below, list the CAHPS and HEDIS measures, and Table 4 lists additional measures used in this evaluation.

Table 2. CAHPS Measures Used in the Evaluation

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

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey* Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.
Care from Dentists and Staff	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)
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")

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey* Note – The dental plans are only collecting CAHPS data for children; therefore, the evaluation will focus solely on child dental CAHPS results until such time adult dental CAHPS data become available.
Dental Plan 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	≥ 2 visits (182 days apart)	Agency-defined	--	--
(Note – This measure will not be reported after CY 2016 data)				
Immunizations for Adolescents	Combination 1	NCQA HEDIS	Child	1407
Lead Screening in Children	--	NCQA HEDIS	--	--
Prenatal and Postpartum Care	Prenatal Postpartum	NCQA HEDIS	Child (Prenatal) and Adult (Postpartum)	1517
Frequency of Ongoing Prenatal Care/Prenatal Care Frequency	≥ 81% of expected visits	NCQA HEDIS/Agency-defined	Child	1391

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

Measure	Components	Steward/ Source	CMS Adult/Child Core Measure?	NQF #
Highly Active Anti-Retroviral Treatment		Agency-defined	--	
Mental Health Readmission Rate		Agency-defined	--	
Medication Management for People with Asthma		NCQA HEDIS	--	1799
Transportation Timeliness		Agency-defined	--	
Dental Performance Measures				
Annual Dental Visit	Total	NCQA HEDIS		1388
Preventive Dental Services		CMS Medicaid & CHIP Child Core Set	Child	__
Dental Treatment Services		Agency-defined/CMS-416 Data	Child	__
Sealants for 6-9 Year-old Children at Elevated Caries Risk		CMS Medicaid & CHIP Child Core Set/Dental Quality Alliance (DQA)	Child	2508
Oral Evaluation		DQA/NQF	Child	2517
Topical Fluoride for Children at Elevated Caries Risk		DQA/NQF	Child	2528
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.

Transportation Timeliness (TRT)

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

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

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

Dental Treatment Services

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

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

Numerator: The unduplicated number of individuals receiving at least one dental treatment

service by or under the supervision of a dentist, as defined by HCPCS codes D2000-D9999 (CDT codes D2000-D9999) or equivalent CPT codes, that is, only those CPT codes that involved periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services.

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

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

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

Table 4. Additional Measures used in the Evaluation

Measure	Description	Research Question(s)
Plan Reported Enrollee Issues/Grievances	Number of grievances and appeals by type	1A
Access to care issues/complaints (by plan type)	Extract from Agency's Client Information & Registration Tracking database. Type of complaint (e.g. access, quality of care)	1A
Service Utilization. Use Claims and encounter data		
Inpatient	Per Member Per Month (PMPM) average number of visits that a Medicaid enrollee had in a month	1C
Outpatient	PMPM average number of visits that a Medicaid enrollee had in a month	1C
ED	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Professional Physician	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Specialist	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Service Use per Enrollee per Year. Service utilization is per actual enrollee year. Statistical analysis of use to rely on binomial regression models of service use by the type of service		

Measure	Description	Research Question(s)
Hospital Inpatient Admissions	Mean Service Use	5C
Hospital Inpatient Days	Mean Service Use	5C
Hospital Outpatient Visits	Mean Service Use	5C, 10D
Physician Primary Care Visits	Mean Service Use	5C, 10D
Physician Specialist Visits	Mean Service Use	5C
Pharmacy Claims	Mean Service Use	5C, 10D
Emergency Dept. Visits	Mean Service Use	5C
LTC Services	Mean Service Use	5C
Assisted Living	Mean Service Use	
HCBS	Mean Service Use	5C
Home Health	Mean Service Use	5C
Hospice	Mean Service Use	5C
Nursing Home	Mean Service Use	5C
Transitional Housing Services	Mean Service Use	10B
Mobile Crisis Services	Mean Service Use	10B
Peer Support Services	Mean Service Use	10B
Tenancy Services	Mean Service Use	10B
Potentially Preventable Hospitalizations	Mean Service Use	10C
Potentially Preventable Emergency Department Visits	Mean Service Use	10C
Behavioral Health Services	Mean Service Use	10D
Average PCP Appointment Wait Times. Average appointment wait times. Data Source: Timely Access PCP Wait Times Report		
Urgent Care	Days	1F
Routine Sick	Days	1F
Wellcare Visit	Days	1F
Mean Costs. Cost of specific MMA services will be obtained from the amount paid by the MMA plan to the provider in the encounter record. For MMA period comparisons to the pre-MMA periods, MMA capitation payments will be used as a measure of the cost to Medicaid under MMA.		
Total MMA and LTC Costs Combined	Per Member Per Month Mean Cost	1G
Total MMA	Per Member Per Month Mean Cost	1G
Hospital Inpatient	Per Member Per Month Mean Cost	1G
Hospital Outpatient	Per Member Per Month Mean Cost	1G
Physician Primary Visit	Per Member Per Month Mean Cost	1G
Physician Specialist Visit	Per Member Per Month Mean Cost	1G
Pharmacy Cost	Per Member Per Month Mean Cost	1G
Emergency Dept. Cost	Per Member Per Month Mean Cost	1G
Total LTC Costs	Per Member Per Month Mean Cost	1G
Assisted Living Costs	Per Member Per Month Mean Cost	1G
HCBS Costs	Per Member Per Month Mean Cost	1G
Home Health Costs	Per Member Per Month Mean Cost	1G
Hospice Costs	Per Member Per Month Mean Cost	1G
Nursing Home Costs	Per Member Per Month Mean Cost	1G

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

Plan Interviews – Most Common Themes (Subsequent year themes to be determined)		
Quality of Care	% of content	1E
Behavioral Health	% of content	6B
Non-emergency Transportation	% of content	6B
Housing Assistance Pilot implementation	% of content	10A

Housing Services Care Coordination	% of content	10E
Types of Healthy Behaviors Programs and Incentives **Data Source: Quarterly Healthy Behaviors Summary Reports**		
Medically Approved Smoking Cessation Program	#, incentives and value	3A, 3B, 3C
Medically Directed Weight Loss Program	#, incentives and value	3A, 3B, 3C
Medically Approved Alcohol or Substance Abuse Recovery Program	#, incentives and value	3A, 3B, 3C
Preventive Well Child Care	#, incentives and value	3A, 3B, 3C
Prenatal, Maternity, & Postpartum Visits	#, incentives and value	3A, 3B, 3C
Preventive Adult Care (PCP visits)	#, incentives and value	3A, 3B, 3C
Mammograms	#, incentives and value	3A, 3B, 3C
Cervical Cancer Screening	#, incentives and value	3A, 3B, 3C
Enrollee Participation and Completion Rates in Healthy Behaviors Programs (Mandatory and Optional)		
Number currently enrolled	#	3C
Enrollees who completed program	#	3C
Plans Offering Program	#	3C
Plan with Most Participants	#	3C
By Gender	# (Male, Female)	3D
By Age Group	# (Age Grp 0-20, 21-40, 41-60, over 60)	3D

5. Data Sources

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

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

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

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

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

Data Source	Time Period*	Variables
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
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,

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

6. Analytic Methods

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

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

Overall Analytic Design Issues

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

Unfortunately, evaluation designs such as difference-in-differences and propensity-score matching that address the limitations of pre-post and post-only designs are not ideally suited for evaluating Florida's MMA program, with the exception of selected questions in (1) the Housing Assistance Pilot (Component 10) and (2) the impact of Florida's retroactive enrollment policy change on new enrollee financial burden (Component 9). Florida's statewide transition to the MMA program took place over a three-month period[4] and included over 90 percent of Florida's Medicaid enrollees. This poses special challenges for employing evaluation designs such as difference-in- differences and propensity-score matching since no suitable comparison groups were available within Florida Medicaid following MMA implementation. Employing comparison groups outside of Florida Medicaid is problematic because such comparison groups will differ in systematic ways from Florida Medicaid enrollees. Such systematic differences will likely generate large pre-period treatment-comparison differences that will likely violate the parallel time trends assumption of difference-in-differences.

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

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

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

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

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

Statistical Testing and Modeling

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

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

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

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

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

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

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

Qualitative Analyses

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

- ***RQ1E**: What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?*

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

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

Methods

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

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

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

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

Qualitative interview analysis. Qualitative research teams will use Atlas.ti (V8) or Nvivo to analyze interview transcripts produced for research questions RQ1E and RQ6C, following

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

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

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

Qualitative issues and approaches for specific questions.

Research Question 1E

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

Research Question 2D

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

Research Question 6B and 10E

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

Research Question 6C

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

The survey tool to be administered for research question 6C may include: (1) items from the CAHPS Health Plan Survey for Medicaid, Version 4.0 supplemental set addressing health plan transportation, (2) the Experience of Care and Health Outcomes (ECHO) Survey – a validated survey tool from the Agency for Healthcare Research and Quality that assesses experiences with behavioral health care, (3) other questions on non-emergency transportation provided in correspondence with AHCA, and (4) questions from the Medicare Health Beneficiary Survey to collect information on self-reported health and functional status for dual-eligible members.
The survey will have the option to be completed by sampled members or (in cases where the member is physically or mentally unable to participate) by proxy respondents (such as family members) who are familiar with the member's health and health care.

Research Question 8J

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

Research Question 9A

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

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

ability to conduct analyses of these data.

Research Question 9G

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

Research Question 9H

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

Research Question 10A

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

Research Question 10E

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

Table 6. Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 1: The effect of managed care on access to care, quality and efficiency of care, and the cost of care				
1A. What barriers do enrollees encounter when accessing primary care and 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
1B. What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to MMA plans?	-**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 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)	-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 the MMA program	-CAHPS, HEDIS, encounter data as necessary	-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
	-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			
1C. What changes in the utilization of services for enrollees are evident post MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans, and pre-MMA 1915(b) waiver plans) to	Utilization: - Inpatient -Outpatient -ED -Professional (Physician, Specialist)	-Pre-MMA vs. MMA periods -Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans	-Medicaid claims, eligibility, enrollment, encounter data	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
utilization of services in post MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?				
1D. What changes in quality of care for enrollees are evident post MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in MMA plans in the MMA period; and 2) quality of care in specialty MMA plans vs. standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard plans vs. enrollees in specialty plans (to the extent possible)?	-**Standard measures and composites of the CAHPS survey**: -Overall Rating of Health Plan -Overall Rating of Health Care -Shared Decision-Making -Overall Rating of Personal Doctor -Overall Rating of Specialist -**MMA program weighted HEDIS means**: -Adolescent Well-Care Visits -Childhood Immunization Status (Combo 2 , Combo 3) -Children and Adolescents' Access to Primary Care Practitioners (12-24 mos, 25 mos-6 yrs, 7-11 yrs, 12-19 yrs) -Chlamydia Screening	-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data -Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans	-Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data -HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures	-Descriptive statistics and t-test. Analyze overall ratings variables related to satisfaction with health care, health plan, shared decision-making, personal doctor, and specialists

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	in Women (16-20 yrs, 21-24 yrs, Total) -HIV-Related Outpatient Medical Visits (2 visits ≥182 days apart) -Immunizations for Adolescents (Combo 1) -Lead Screening in Children -Well-Child Visits in the First 15 Months of Life (0 visits, 6+ visits) -Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life -Adult BMI Assessment -Antidepressant Medication Management (Acute, Continuation) -Comprehensive Diabetes Care (HbA1c Testing, HbA1c Good Control, HbA1c Poor Control, Eye Exam, Nephropathy, LDL-C Screening, LDL-C Control) -Controlling High Blood Pressure -Follow-up After Hospitalization for a Mental Illness (7 day, 30 day) -Follow-up Care for Children Prescribed ADHD Medication (Continuation, Maintenance) -Highly Active Anti-Retroviral Treatment -Mental Health Readmission Rate -Medication Management for People with Asthma (50% and 75% medication			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	compliance)			
1E. What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?	-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)
1F. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans?	-Standard measures and composites of the CAHPS survey: -Getting Care Quickly -Average PCP appointment wait times for urgent care, routine sick visits, and well care visits -MMA program weighted HEDIS and other performance measure means: -Prenatal and Postpartum care (Prenatal, Postpartum) -Transportation Timeliness	-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 -Agency defined measure related to transportation timeliness	-Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of services (e.g., getting care quickly, timeliness of prenatal care, postpartum care and transportation timeliness)
1G. What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per-enrollee costs in the MMA period (MMA plans as a whole, standard	-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

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

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

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

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 4 : The impact of LIP funding on hospital charity care programs				
For the evaluation of DY10 (SFY 2015-16) only **4A.** What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?	-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
For the evaluation of DY10 (SFY 2015-16) only **4B.** What types of services are being provided to Medicaid, uninsured, and underinsured 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) **4C.** What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many	-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	-Descriptive statistics and univariate analyses as applicable

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP funding? **4D.** What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals? **4E.** What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?			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 -DSH reporting data as available -Information on hospital charity care programs (policies, procedures, descriptions etc.)	
Beginning with the evaluation of DY12 (SFY 2017-18) **4F.** What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical	-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	-Descriptive and univariate analyses, to the extent possible

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

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
plans that provide both acute (medical) care and LTC services? **5C.** Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?		-Service utilization and costs	-Capitation payment data	
Component 6: The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals				
6A. How many MMA enrollees are also Medicare recipients (dual-eligibles) and to what extent do dual-eligible enrollees utilize behavioral health and non-emergency transportation services? **6B.** What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-	-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	-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	-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
eligible enrollees? **6C.** How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health and non-emergency transportation services?	behavioral health 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 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				
7A. How quickly do new enrollees access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible and enrolling in a health plan? **7B.** Among new enrollees, what is the time to access services for enrollees who are enrolled under express enrollment compared to enrollees who were enrolled prior to the implementation of express enrollment?	-Time to access services from enrollment date to date of first service use	New MMA enrollees (7A, 7B) New Medicaid enrollees in pre-MMA HMO and PSN plans in DY7 (7B) -New MMA enrollees who selected their MMA plan (7A) -New MMA enrollees who were auto-enrolled in an MMA plan (7A) -New MMA enrollees who switched plans within 120 days of initial enrollment (7A) -New MMA enrollees who did not switch plans within 120 days of initial enrollment (7A)	-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
Component 8: The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services				
8A. How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area? **8B.** What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program (PDHP)?	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	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.
8C. What changes in quality of dental health services 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 - Preventive 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			
8D. What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	**-Measures from CAHPS Dental Survey related to Access to Services (see Table 3):** -Percentage of respondents reporting their dental appointments are usually or always as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always get an appointment with their dental specialist as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always spend 15 minutes or less in the waiting room before seeing someone for their appointment (vs. sometimes or never) -Percentage of respondents reporting someone usually or always tells them why there is a delay or how long the delay will be if they have to wait more than 15 minutes in the waiting room before being seen for an	-PDHP program CAHPS access to care results examined over time	-CAHPS data described in Table 3	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of services

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	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")			
8E. What barriers do enrollees encounter when accessing dental health services?	-Frequencies of complaints, grievances, and appeals related to access to care for dental services	- Statewide Medicaid Prepaid Dental Health Program enrollees reporting complaints, and issues to (1) the Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) or (2) individual plan reports of complaints, grievances, and appeals	-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data -Dental plan data on frequencies of complaints, grievances, and appeals related to access to care -Medicaid Fair Hearing data	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to access to primary care and preventive services
8F. How many enrollees utilize expanded benefits provided by the dental health plans and which ones are most commonly used?	- Number of dental plan enrollees that use expanded dental benefits -Expanded dental benefits that are used most frequently by dental enrollees	-Users of expanded dental benefits	-Dental encounter data -Data on the types of expanded benefits offered by each dental plan.	-Descriptive analyses
8G. How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)?	-Medicaid dental encounter records for dental plan enrollees merged by Medicaid enrollee ID with MMA encounter records for hospital ED and inpatient use -Rates of dental service	-Statewide Medicaid Prepaid Dental Health Program enrollees who also use MMA services	-Medicaid dental and medical encounter data, eligibility, enrollment, encounter data	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the

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

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

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	unavailable, RQ 9C will rely on the self-pay charge data prior to enrollment as outlined above. 2) Hospital utilization and charges with self-pay payor status from the three-months prior to Medicaid application date both before and after the policy change.		enrollee encounter data both before and after the policy change for the three months prior to Medicaid application date.	using linked encounter data both before and after the policy change. In particular, self-pay charges will measure the amount of health care charges previously covered by Medicaid under retroactive eligibility that will now fall to the self-pay patient and/or provider uncompensated care. The evaluation team will also examine any pre-post changes in Medicaid FFS and Medicaid MMA payer classes proportions to determine if any such changes are consistent with earlier enrollment by those no longer eligible for retroactive enrollment.
9D. How will eliminating retroactive eligibility affect provider uncompensated care amounts? **9E.** How will eliminating retroactive eligibility affect provider financial performance (income after expenses)? **9F.** How will eliminating retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?	-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 -Hospital and SNF net income and rates of return -Hospital net change impact of UCC: UCC – LIP payments	-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 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.**	-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
9G. *Do beneficiaries subject to the retroactive eligibility waiver understand that they will not be covered during enrollment gaps?* ***9H.*** *What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?*	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.
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.				
10A. How many MMA plans participate in the Housing Assistance Services pilot program? How many enrollees are participating in the housing assistance services program, by plan? How does participation in the housing assistance services program vary by gender, age, race/ethnicity and health status of enrollees? How did MMA plans implement the pilot program?	-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
10B. What is the frequency and duration of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program	-Total number of enrollees using transitional housing services -Total number of enrollees using mobile crisis services -Total number of enrollees using peer	-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
by plan? What is the proportion of enrollees who are successfully discharged from the pilot but subsequently become homeless again and resume using services?	support -Total number of enrollees using tenancy services			
10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving housing assistance services?	-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
10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program?	-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
10E. Based on interviews with MMA plan staff, including Care Coordinators, is care coordination more effective for the study population as a result of the Pilot program?	-Qualitative assessment of care coordination effectiveness before and after implementation of the Pilot program -Percentage of participants achieving	-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	-Descriptive statistics

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

D. Methodological Limitations

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

- Current and subsequent years will continue to show that the MMA demonstration remains non-complex and mostly unchanged; therefore, evaluation results may be limited in providing additional or divergent findings from prior evaluations. In addition, the MMA program continues to operate smoothly without administration changes, with minimal appeals and grievances, and with no known issues with CMS 64 reporting or budget neutrality. Consequently, the new STCs were modified to simplify and streamline the state's reporting requirements to CMS, moving from quarterly to annual reporting. In addition, monthly calls with CMS are now on a periodic basis as the need is determined.

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

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

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

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

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

Another potential challenge for the retroactive enrollment evaluation is the need to merge Medicaid enrollment records with Florida Health Data Center statewide inpatient discharge and ambulatory and ED visit data to capture the utilization of new Medicaid enrollees in the

three months prior to Medicaid application. While such a merge should be possible given common identifiers in the datasets, such a merge has not been attempted previously to the best of our knowledge and the match rate is therefore unknown. This will become a material limitation should credit reporting medical and total debt data be unavailable for this evaluation.

E. Attachments

1) Independent Evaluator.

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

The Principal Investigator for the project is Dr. Bruce Vogel, whose contact information is as follows:

Associate Professor
Department of Health Outcomes and Biomedical Informatics, University of Florida
2004 Mowry Road, P.O. Box 100177
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(352) 294-5970
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See Dr. Vogel's Curriculum Vitae (CV) attached.

2) No Conflict of Interest.

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

3) Evaluation Budget.

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

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

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

4) Timeline and Major Milestones.

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

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

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

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

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

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

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

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

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

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

*Deliverables due to CMS.

5). State Expectations

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

Research Question*	State Prediction
Component 1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care	
1B. What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to MMA plans?	Accessibility of services will show statistically significant improvement for MMA plans as a whole compared to pre-implementation plans (Reform plans and 1915(b) waiver plans).
1C. What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans and pre-MMA 1915(b) waiver plans) to utilization of services in post-MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?	I. Appropriate utilization of services will be statistically significantly greater in MMA plans as a whole than in pre-implementation plans (Reform plans and 1915(b) waiver plans). II. Specialty MMA plans will provide enrollees with improved access to services related to the specialty condition compared to standard MMA plans.
1D. What changes in quality of care for enrollees are evident post-MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in MMA plans in the MMA period; 2) quality of care in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard plans versus enrollees in the specialty plans (to the extent possible)?	I. Quality of care will show statistically significant improvement in MMA plans as a whole compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans). II. Quality of care will be statistically significantly higher for enrollees in specialty MMA plans compared to enrollees with the specialty condition (e.g. HIV) in standard MMA plans.
1F. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA	Timeliness of services will show statistically significant improvement in post-MMA implementation plans compared to pre-MMA

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

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

the Statewide Medicaid Prepaid Dental Health Program?	implementation of the Statewide Medicaid Prepaid Dental Health Program.
8C. What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Quality of dental care for enrollees will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program.
8D. What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Accessibility of dental services will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program.
8G. How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)? How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?	I. Appropriate use of dental services will show statistically significant improvement following the implementation of the Statewide Medicaid Prepaid Dental Health Program. II. Appropriate utilization of Emergency Department (ED) and inpatient hospitalization services will show statistically significant improvement for enrollees who use dental expanded benefits compared to those who do not use such benefits.
8H. What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	Per-enrollee cost of dental health services will show less month-to-month variability and/or slower rates of increase following implementation of the Statewide Medicaid Prepaid Dental Health Program.
Component 9. The impact of the waiver of retroactive eligibility on beneficiaries and providers.	
9A. How will eliminating retroactive eligibility change enrollment continuity?	Eliminating retroactive eligibility will increase the likelihood of enrollment and enrollment continuity.
9B. How will eliminating retroactive eligibility change the enrollment of eligible people when they are health relative to those eligible people who have the option of retroactive eligibility?	Eliminating retroactive eligibility will increase enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility.
9C. How will eliminating retroactive eligibility affect new enrollee financial burden?	Elimination of retroactive coverage eligibility will not have adverse financial impacts on consumers.

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

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

6). Modified Difference-in-Differences Approach

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

Standard Difference in Differences

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

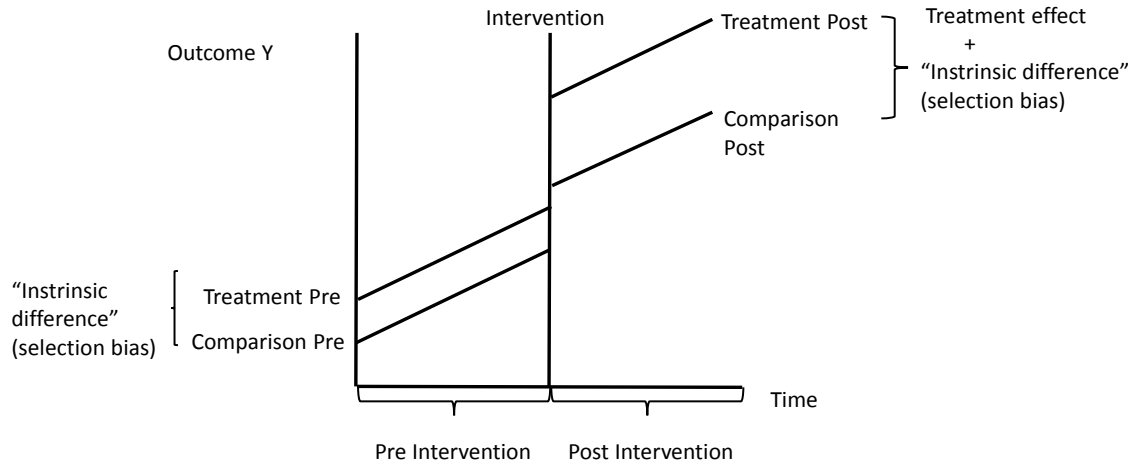
Another common approach employs treatment and comparison groups where the comparison group is chosen to resemble the treatment group as closely except that the comparison group only receives usual care. The difference in outcomes between the treatment and comparison groups is then taken as an estimate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

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

How D-i-D Works

Figure 2[5] 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)

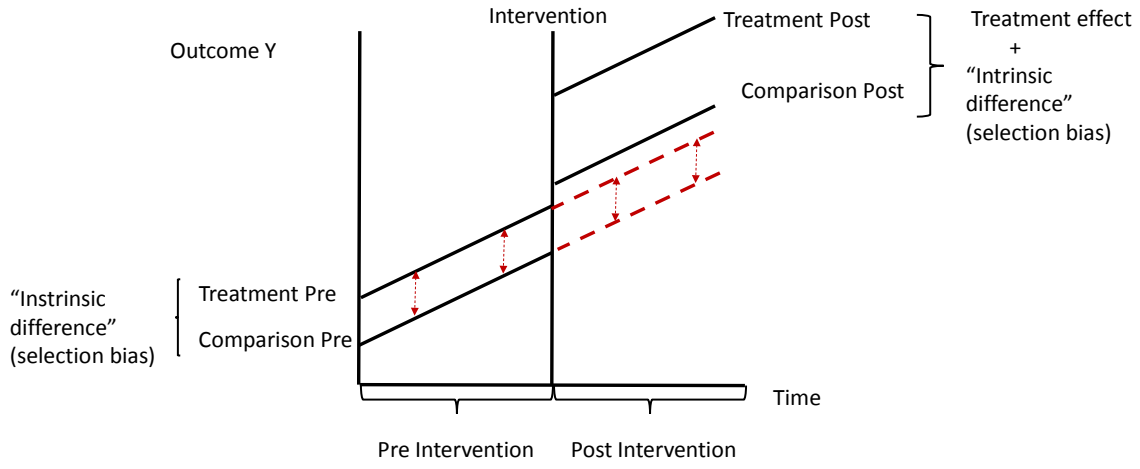
[5] Figure 1 has been omitted from this attachment for purposes of brevity.

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 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.

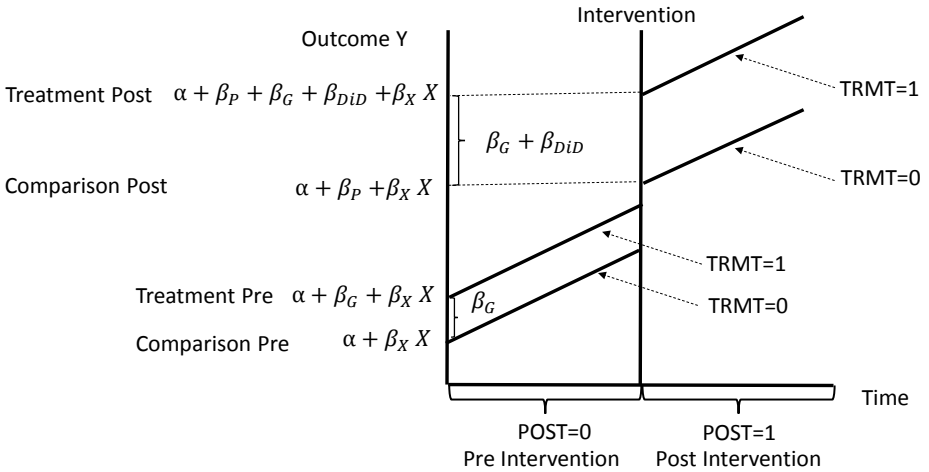
Figure 4 shows graphically the way D-i-D works based on the D-i-D statistical model. In Figure 4, the outcome Y is on the vertical axis and time is on the horizontal axis. The horizontal axis is divided into pre- and post-intervention segments. The four straight lines in Figure 4 correspond to the treatment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

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



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

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

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

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

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.

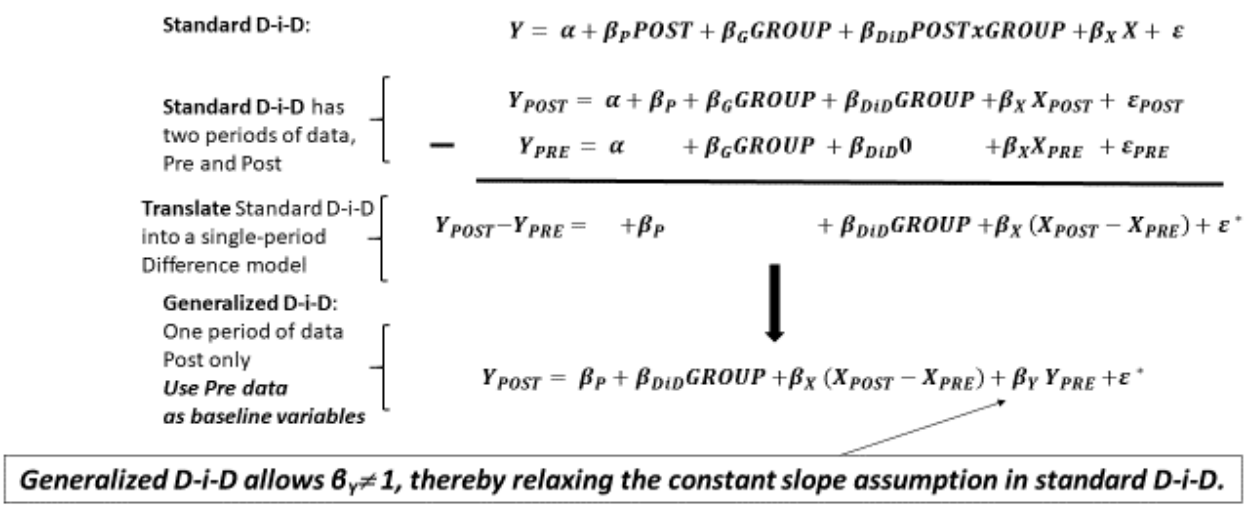
Figure 5 shows how the standard D-i-D model is translated into this more flexible formulation. First, the standard D-i-D model is separated into two parts, one for the post period and one for the pre period. Then, these two equations are differenced to produce a single equation difference model. Lastly, 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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