Contract MED180

Evaluation of Florida's Managed Medical Assistance (MMA) Program Demonstration:

Final Summative Report, SFY 2014/15–2019/20, DY9–DY14

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Presented to:

AGENCY FOR HEALTH CARE ADMINISTRATION

Prepared by:

Department of Health Outcomes and Biomedical Informatics
College of Medicine, University of Florida

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

and

Department of Health Services Administration
University of Alabama-Birmingham

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List of Acronyms

AHCA	Agency for Health Care Administration
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare and Medicaid Services
DY	Demonstration Year
ED	Emergency Department
FFS	Fee-for-Service
FHURS	Florida Hospital Uniform Reporting System
FQHC	Federally Qualified Health Centers
FS	Florida Statutes
FSU	Florida State University
HEDIS	Healthcare Effectiveness Data and Information Set
HFMA	Healthcare Financial Management Association
LIP	Low Income Pool
MMA	Managed Medical Assistance
MSPP	Medical School Physician Practices
NET	Non-Emergency Transportation
PDHP	Prepaid Dental Health Program
RHC	Rural Health Clinics
SFY	State Fiscal Year
SMI	Serious Mental Illness
STCs	Special Terms and Conditions
SUD	Substance Use Disorder
TU	TransUnion
UAB	University of Alabama Birmingham
UCC	Uncompensated Care
UF	University of Florida

Purpose of the Report

The purpose of this summative report is to present the evaluation of Florida's Managed Medical Assistance (MMA) Program as required by the Code of Federal Regulations and the Special Terms and Conditions of the MMA Section 1115 wavier demonstration. The evaluation 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. The scope of this evaluation is based on the MMA evaluation design developed by the University of Florida, Florida State University, and the University of Alabama Birmingham in accordance with guidance from the federal Centers for Medicare and Medicaid Services (CMS). The MMA evaluation design was also reviewed and approved by CMS prior to the start of this evaluation.

This report presents the key findings of the MMA evaluation to date for the first six years of the ongoing MMA 1115 Demonstration. The first year for the evaluation was Demonstration Year (DY) 9, covering July 1, 2014 to June 30, 2015. Table 1 presents the DY, State Fiscal Year (SFY), and calendar dates for the periods covered in this summative report.

Table 1. Demonstration Years, State Fiscal Years, and Calendar Dates for the MMA Program

Demonstration Year (DY)	State Fiscal Year (SFY)	Dates
Pre-MMA Period		
DY6	SFY 2011-12	July 1, 2011 - June 30, 2012
DY7	SFY 2012-13	July 1, 2012 - June 30, 2013
Transition Year[a]		
DY8	SFY 2013-14	July 1, 2013 - June 30, 2014
MMA Period		
DY9	SFY 2014-15	July 1, 2014 - June 30, 2015
DY10	SFY 2015-16	July 1, 2015 - June 30, 2016
DY11	SFY 2016-17	July 1, 2016 - June 30, 2017
DY12	SFY 2017-18	July 1, 2017- June 30, 2018
DY13	SFY 2018-19	July 1, 2018 - June 30, 2019
DY14	SFY 2019-20	July 1, 2019 - June 30, 2020

[a] DY8 was omitted as a transition year to ensure 1) transition from claims to encounter data pre/post was completed; 2) appropriate data quality procedures were implemented, and; 3) transitory pre/post data anomalies were resolved.

A. Executive Summary

This report presents the results of Florida Medicaid's evaluation of its Managed Medical Assistance (MMA) demonstration as approved by the Centers for Medicare and Medicaid Services (CMS) on June 14, 2013, and implemented statewide during May through July 2014 and subsequently extended three times by CMS. This report presents results covering the period from July 1, 2013 to June 30, 2020.[1] In addition to the original MMA demonstration, this report also presents the first-year results of Florida's three recent initiatives, the Prepaid Dental Health Program (PDHP), the Retroactive Enrollment Policy, and the Supportive Housing Program.

This Executive Summary is organized into the following sections:

- Impact on Quality, Cost, and Access
- Healthy Behaviors Program
- Low Income Pool (LIP) Program
- Prepaid Dental Health Program (PDHP)[2]
- Retroactive Enrollment Policy[3], and
- Supportive Housing Program[4]

Impact on Quality, Cost, and Access

The MMA evaluation found that following the implementation of the MMA demonstration (1) the quality of care for Medicaid enrollees as measured by MMA health plan performance measures improved overall, (2) Medicaid costs per member per month (PMPM) decreased significantly, and (3) access to care as measured by both health plan performance measures and Medicaid enrollee assessments of access improved. Below are key evaluation findings related to quality, cost, and access.

Quality[5]

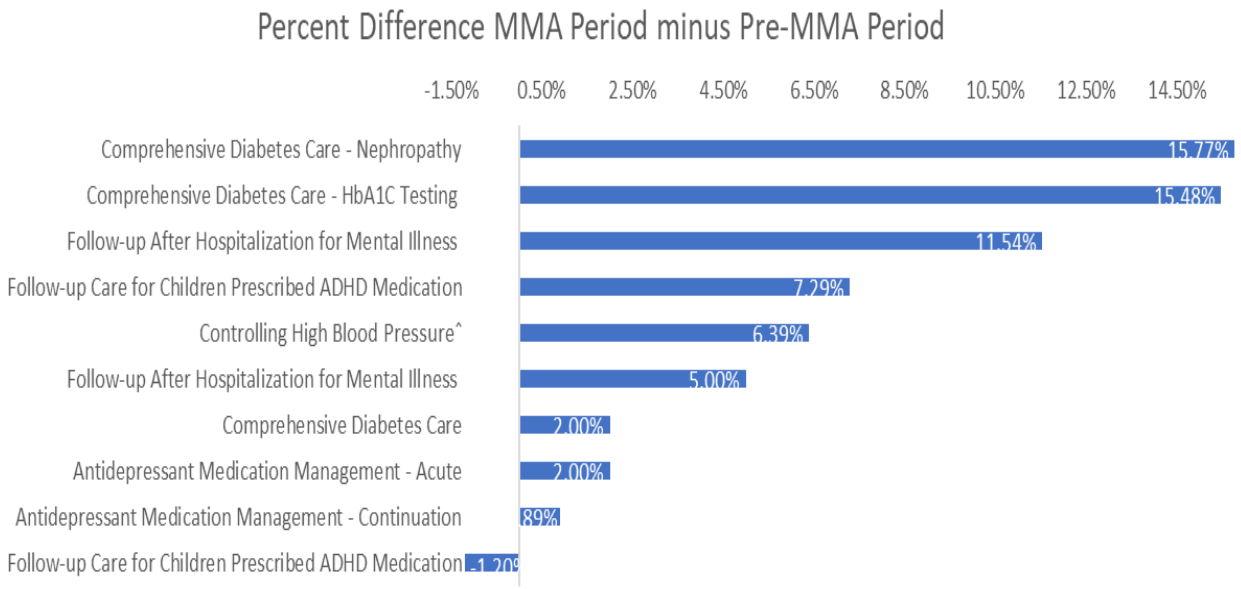
With respect to outcomes, as shown in Figure 1Figure 1. HEDIS Effectiveness Measures: Percent Difference MMA Period Minus Pre-MMA Period

below, a total of 10 health plan performance measures and sub-measures included in the MMA evaluation addressed the effectiveness of care in improving outcomes for cardiovascular health, diabetes, and behavioral health conditions. Comparing these measures over the 2011-2013 pre-MMA period to the 2015-2019 MMA period showed that 9 of the 10 effectiveness measure means were higher in the MMA period than in the pre-MMA period, indicating higher quality of

[1] This period encompasses MMA Demonstration Year 9 (DY9) through DY14, consisting of State Fiscal Year (SFY) 2013-2014 through SFY 2019-20. The first year of MMA operation (DY8 covering SFY 2012-13) was excluded from the MMA time period since it was considered a transition year.
[2] PDHP was implemented in December 2018 through February 2019.
[3] The new retroactive enrollment policy began on February 1, 2019.
[4] The new supportive housing program began in February 2020.
[5] See Table 7 in this report.

care during the MMA period.[6] The average percentage difference across all 10 measures between the MMA and pre-MMA periods was +7.10 percent.

Figure 1. HEDIS Effectiveness Measures: Percent Difference MMA Period Minus Pre-MMA Period



- In comparing the pre-MMA period to the MMA period, approximately 20 of the 27 health plan performance measures (approximately74%) improved, five measures (19%) were unchanged, and two measures (7%) declined by one percent or less.[7] Six measures increased by more than 10 percent from the pre-MMA to the MMA periods:
  - Chlamydia Screening in Women 21-24 years (42%)
  - Adult BMI Assessments (19%)
  - Chlamydia Screening in Women 16-20 years (16%)

[6] For the majority of health plan performance measures, higher scores indicate higher quality. For a handful of performance measures, however, lower scores indicate higher quality (e.g., Mental Health Readmission Rate). Such measures are labelled INVERSE throughout this report.

[7] See Table 7 in this report. Note that (1) the two measures that declined (Child Access to Primary Care Practitioners age 12-24 mos. and Follow-up After Hospitalization for Mental Illness - 30 days) declined by one percent or less and (2) the classification of measures as increased, unchanged, or declined is only approximate and depends on the assumed numerical precision of the raw data and the significant digits used in calculating period averages. For this reason, we recommend concentrating on those measures that have absolute percentage changes over time greater than one percent.

- Total Annual Dental Visits (13%)
- Comprehensive Diabetes Care-Nephrology (12%)
- Well-Child Visits in the First 15 Months of Life - 6+ visits (11%)

Cost

- Medicaid cost per-member per-month (PMPM)[8] was substantially lower during the MMA period compared to the pre-MMA period, as shown in the following table:

Table 2. Adjusted* Per-Member Per-Month Expenditures Before and After MMA Implementation

	Pre-MMA (SFY 2011-12 through SFY 2012-13)		MMA (SFY 2014-15 through SFY 2019-20)	
	Mean	Median	Mean	Median
TANF	$428	$314	$241	$180
SSI	$1,448	$1,536	$1,230	$1,330
DUAL	$542	$512	$222	$203

* Costs were adjusted statistically for demographics (age, sex, race/ethnicity) and health status using a two-part model (see the Methodology chapter and the results of RQ 1G in the body of this report).

These very sizable reductions in mean and median Medicaid expenditures PMPM in the MMA period compared to the pre-MMA period are all the more remarkable given the improved performance in HEDIS and CAHPS measures (see below) observed over the same period. Trends in expenditures PMPM, HEDIS scores, and CAHPS assessments should be monitored in future years to ensure that these results are sustainable.

Access

- In comparing the Healthcare Effectiveness Data and Information Set (HEDIS) accessibility measures between the pre-MMA period and the post-MMA period (CY2015-2019)[9], 21 of the 23 measures (91.3%) improved and two measures (8.7%) remained the same. None of the measures declined. The measures with the largest improvements (defined as greater than or equal to 10 percent) were:
  - Adults' Access to Preventive/Ambulatory Health Services 65+ Years (15%)
  - Immunizations for Adolescents – Combination 1 (14%)
  - Timeliness of Pre-Natal Care (13%)
  - Timeliness of Post-Partum Care (13%)
  - Well-Child Visits in the First 15 Months of Life (11%)
- Overall, there was an upward trend among the HEDIS performance measures

[8] Medicaid cost per PMPM was measured by (1) Agency capitation payment rates under MMA compared to (2) Agency payments to providers under the previous fee-for-service system.

[9] See Table 3 in this report.

relating to accessibility, quality of care, and timeliness of services post-MMA implementation.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures concerning getting needed care and getting care quickly[10] increased in the MMA period relative to the pre-MMA period for both adults and children. Satisfaction with the number of doctors to choose from was also much higher in the MMA period.
- Health plans adopted a variety of quality improvement (QI) strategies generally focused on improving communication and engagement with patients and their providers, often with a focus on addressing member social determinants of health. Fundamental to the performance improvement activities was the reliance on data to identify gaps in care. The evaluation plan's use of single-group interrupted time-series analysis limits the ability to conclude that there is a causal relationship between plan quality improvement activities and improved HEDIS scores. However, it is plausible that plan QI programs may be one of a variety of factors associated with improvements in access to and utilization of health services.

Enrollee Satisfaction[11]

- Enrollee satisfaction as reflected in the enrollees' overall rating of their health plans in CAHPS increased for both adults and children between the pre-MMA period (2013 and 2014[12][13]) and the MMA period (2015-2019). More specifically,
  - The percentage of adult enrollees rating their health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased on average from 48.5 percent in the pre-MMA period (2013-2014) to 61.7 percent in the MMA period (2015-2019).
  - Similarly, the percentage of parents rating their child's health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased from 58.0 percent in the pre-MMA period (2013-2014) to 67.3 percent in the MMA period (2015-2019).

[10] See Tables 4 and 5 in this report.
[11] See Tables 4-6 in this report.
[12] CY 2014 was treated as a transition year in this evaluation, but is included in the pre-MMA period for this particular comparison. In general, the pre-MMA comparison periods will vary somewhat depending on the CAHPS measures under scrutiny for two reasons: (1) CAHPS changed the way it aggregated its answers during the evaluation period and (2) the detailed tabulations on answers for CAHPS measures necessary to retabulate the aggregations to make them consistent and comparable are not available for both adults and children for all years both pre- and post-MMA, Consequently, comparison periods have to conform to which detailed tabulations are available for which measures in which years. This is an unavoidable limitation that limits comparisons across measures, but still allows pre-post comparisons for each measure independently
[13] Some of the pre-MMA to MMA period comparisons of CAHPS may be influence by changes in survey modes (e.g., telephone-only mode in pre-MMA period to mixed mode (telephone and mail) in the MMA period.

Healthy Behaviors Program

Programs Offered

- MMA plans were required to offer three core Healthy Behaviors programs: a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse treatment program. Plans may also offer additional optional programs. (It is important to note, however, that participation in all Healthy Behaviors programs is voluntary and some programs are exclusively targeted to a particular age or health condition, so not every enrollee is eligible to participate in certain programs.) The types of Healthy Behavior programs increased from DY9-DY14, as did the number of plans offering optional programs. In DY9 only four optional programs were offered, whereas from DY11-DY14, 10 or more optional programs were offered.

Enrollee Participation

- For DY9, the medically directed weight loss program reported the highest number of current enrollees (22,295), as well as the highest number of enrollees who completed the program (1,709). Of all programs offered (core or optional), the program with the highest number of enrollees was the children's nutrition incentive program (142,758), followed by well-child visit programs (136,636).
- In DY10, the medically directed weight loss program reported the highest number of current enrollees (25,105), as well as the highest number of enrollees who completed the program (2,170). Of all programs offered (core or optional), the program with the highest number of enrollees was the well-child visits program (134,735). The program with the second highest number of enrollees was the children's nutrition incentive program (134,162). The well-child visits program had the highest number of enrollees who completed the program (6,434) followed by the children's nutrition incentive program (4,250) and the medically directed weight loss program (2,170).

Comparing Health Behaviors enrollment across years is problematic. Prior to the availability of individual-level Healthy Behaviors data in DY13 and DY14, MMA plans reported Healthy Behaviors summary data in different ways, and some plans changed the method used to capture enrollments over time.

Enrollee Demographics[14]

- **Participation by gender:** Among the core programs, females were more likely than males to be enrolled in DY13 and DY14. Among optional programs, the pregnancy/maternity, Baby Blocks, breast cancer screening, cervical cancer

[14] Participant demographics from individual enrollee-level Healthy Behaviors records were available only starting in Q3 of DY13.

screening, and chlamydia screening consisted of almost 100 percent females.

- **Participation by age:** Enrollee age distributions differed depending on the program type. Among the core programs, for example, the smoking cessation program consisted largely of DY13 and DY14 enrollees ages 21-40 and ages 41-60, followed by those over age 60, and ages 0-20. Among optional programs, the following programs consisted mostly of those ages 0-20 in DY13 and DY14: well-child visits and lead screening. The pregnancy/ maternity and Baby Blocks programs primarily consisted of those ages 21-40. In addition, the following programs were majority ages 21-40 enrollees: cervical cancer screening, chlamydia screening, and adult preventive care. The following programs consisted mostly of enrollees ages 41-60: diabetes care and breast cancer screening.
- **Participation by race/ethnicity:** Enrollee race/ethnicity[15] distributions differed depending on the program type. For example, among the core programs in DY13 and DY14, White enrollees were most likely to be enrolled in the smoking cessation and alcohol or substance abuse recovery program. Race/ethnicity was more evenly distributed in DY13 and DY14 for White, Black, and Hispanic enrollees for the weight loss program. Among optional programs, race/ethnicity varied by program but was relatively equally distributed, with a few exceptions such as preventive adult care, which reported about 10-15 percent more White enrollees than Black enrollees, Hispanic enrollees, and enrollees of another race.
- **Differences in service utilization among enrollees participating in Healthy Behaviors programs versus enrollees not participating:** Mean PMPM service utilization was higher among enrollees participating in Healthy Behavior programs versus enrollees not participating. This result is likely due to:
    - *Selection bias:* Enrollees who chose to participate in Healthy Behaviors programs may have worse health status, on average, compared to enrollees who did not participate in the Healthy Behaviors programs. People with lower health status tend to use more health services compared to people with higher health status.
    - *Lack of follow-up time:* Given the chronic nature of the medical conditions addressed by several of the Healthy Behaviors programs, long-term expected changes in PMPM service utilization will not be observable until future time periods.

Low-Income Pool (LIP) Program

- The LIP program provided between $576M and up to $2B in funds to safety-net providers in DY9 through DY14 to provide stability and offset uncompensated medical care costs as charity care for uninsured low-income individuals.
- Over the course of the demonstration, the majority of providers that received LIP funds to offset charity care costs were hospitals; however, Federally Qualified Health Centers (FQHCs) and Medical School Physician Practices (MSPPs) also received funding in

[15] The other race/ethnicity category includes: Asian, Native American, and Other races as listed in the Medicaid eligibility files.

DY12 through DY14.

- Because the types of providers, funding amounts, and number of reporting providers that received LIP funding varied from year to year, it is not possible to make comparisons, identify meaningful trends, or infer any type of causal relationship between LIP funding and access to care based on the data provided.

Prepaid Dental Health Program (PDHP)[16]

Since CY 2019 was the first year of the PDHP, there are no comparator years. Changes in quality, access, use, and costs will be assessed in the future by comparing adjusted rates across years for each dental health plan and for the PDHP overall.

Quality

Dental plans were assessed across a total of 11 measures for child and adult enrollees as shown in

[16] Both dental and medical encounter data were used in the PDHP evaluation. The dental encounter data were the source of dental use rates and the medical encounter data were used to measure dental-related ED visits.

- Table 12. Two measures – Annual Dental Visits and Oral Evaluations – pertained to all program enrollees. Six measures were specific to child enrollees and three were specific to adult enrollees.
- For child-specific services in CY 2019, the enrollee use rate for annual dental visits was 50.92 percent and the adjusted[17] use rate for oral evaluation services was 39.72 percent. For adult-specific services, the adjusted event rate for ambulatory care for dental caries not requiring inpatient services for the PDHP program overall was 6.72 per 100,000 member months. Liberty Dental Plan had the lowest rate among the plans on this measure at 2.28 per 100,000 member months[18].
- The first-year of PDHP operation saw an 11.3 percent reduction in dental-related ED visits paid for by the MMA plans. While not statistically significant at conventional levels, these results should be monitored in the future since additional data may increase the statistical power to detect such a difference as statistically significant (i.e., not due to random chance). Dental-related ED visits are potentially avoidable with regular preventive dental utilization and good oral hygiene.

Access and Use

- The accessibility of PDHP services was assessed using selected items related to accessibility from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Each of the three PDHP plans (DentaQuest, Liberty Dental Plan, and Managed Care of North America [MCNA] Dental) administered the CAHPS survey to the parents/guardians of child patients enrolled in the plan, and the reported satisfaction measure is based on the percentage of respondents who responded positively to the survey item in question.
- In terms of satisfaction with access to dental services, results varied across both CAHPS survey items and PDHP dental plans. For example, when parents were asked about their child seeing a dentist, over 90 percent of respondents for DentaQuest and Liberty Dental were satisfied while only 54 percent of MCNA respondents were satisfied. Measures such as clinic waiting times of 15 minutes or more, which can impede accessing care, were experienced by a minority of respondents (i.e., less than 37% across all three plans). However, when these delays were experienced, an explanation for the delay was rarely provided (22-37%). There was broad variation across the plans for some access measures. For example, 86 percent of respondents with DentaQuest reported seeing a provider if their child had a dental emergency, compared to 50 percent of respondents from Liberty Dental, and 39 percent from MCNA. Similarly, 71 percent of DentaQuest respondents reported seeing a specialist when needed compared to 49 percent and 41 percent for Liberty Dental and MCNA, respectively. Other areas of concern included the ease of finding a dentist. The calculated satisfactions across the plans was 57-59 percent, suggesting that roughly 40 percent of respondents were not satisfied with the ease of finding a dental provider for their child.

Use

[17] For a description of the adjustment process, see the discussion of two-part statistical models in the "Quantitative Data and Methods" subsection of the "Analytic Methods" section of "D. Methodology" in this report.
[18] See the details in Table 12.

- In terms of overall dental utilization, there was no detectable change in total dental encounters PMPM (i.e., dental visits) following the PDHP implementation. However, there is evidence that more dental services were provided during each visit following the implementation of PDHP. In particular, there was a statistically significant 3.7 percent increase in total dental services following PDHP implementation.
- With respect to specific types of dental visits, preventive and other dental visit rates PMPM increased by 4.4 percent following PDHP implementation, with the largest increases occurring for younger children and adults.

Costs

- Average PMPM expenditures were calculated by fiscal year (SFY 2017-18 and SFY 2019-20) as well as by pre-Statewide Medicaid Prepaid Dental Health Program (pre-PDHP) (SFY 2017-18) and PHDP (SFY 2019-20) periods. A multivariate interrupted time-series analysis was conducted to better understand the pattern of changes in expenditures, as well as to control for any differences in the distribution of age, race, gender, or risk scores between the pre-PHDP and PHDP enrollees.
- In the multivariate model, mean adjusted PMPM expenditures decreased from $157 to $143 after the statewide Medicaid PDHP implementation, while median adjusted PMPM expenditures decreased from $168 to $154.
- Caution should be used in interpreting these promising first-year PDHP results since COVID impacted the final three months of SFY 2019-20 and additional years of data are needed to determine the long term association between the PDHP and dental health costs as well as to identify trends in expenditures through time.

Retroactive Enrollment

- New enrollee medical debt upon Medicaid enrollment increased by $12 PMPM for new enrollees overall[19] following the retroactive enrollment policy change compared to prior to the policy change.
- When limiting the analysis to only new enrollees with non-zero new medical debt, the mean increase in medical debt upon enrollment was substantially larger at $85 PMPM.[20]
- No change was detected in total non-medical debt accrued in the 12 months prior to new Medicaid enrollment for those who enrolled following the policy change compared to those who enrolled prior to the policy change.
- No changes in provider uncompensated care costs or financial margins were found between the year prior to the policy change compared to the first year following the policy change.

Supportive Housing Services

This summative report examines only the first year of operation (SFY 2019-20) of the supportive housing project, which only operated in limited regions and with eligible enrollees in six participating plans, so these findings should be considered the initial impacts of the project. These impacts are likely to evolve as the project matures over time.

- From January 2020 through December 2020 the Housing Assistance Pilot program recorded enrollment of 4,807 member months, which represents an average of 400 enrollees in any given month.
- A total of 208 Housing Assistance Pilot enrollees used at least one service in the program.
- The mean age was approximately 47 years (range: 21 years to 79 years). Approximately 25 percent of enrollees were assessed to be homeless, with 35 percent assessed to be at risk for homelessness.
- Case manager assessments indicated that 1.45 percent of enrollees shifted from being at risk of homelessness to being homeless. Conversely, some homeless enrollees experienced a positive change in their status: 5.50 percent changed from being at risk to having stable housing, 1.60 percent moved from being homeless to having stable housing, and 6.62 percent moved from being homeless to being at risk. At risk is identified by either lacking resources for safe/permanent housing, annual income below 30 percent of median family income, receipt of eviction notice, multiple moves in a year for economic reasons, living in a hotel/motel, or living in another's home.

[19] Importantly, this includes new enrollees who had zero medical debt.
[20] Two caveats concerning these findings should be kept in mind. First, these increases are *mean* increases. The actual changes in medical debt vary widely around these overall means. Consequently, a small percentage of Medicaid enrollees are likely to incur increases in medical debt substantially in excess of these means of $12 PMPM and $85 PMPM.

- Five (less than 1%) of the 696 enrollees in the housing pilot were successfully discharged. None of them subsequently became homeless again and resumed using services during the first year of the pilot.
- Per-member per-month (PMPM) avoidable hospitalizations and emergency department visits decreased after enrollment in the pilot program. Given the limited time period under which the pilot program has operated and generated data for evaluation, it is premature to draw any definitive conclusions about changes in avoidable or medically necessary hospitalizations and emergency department visits that occurred after enrollee participation in the pilot program.
- PMPM primary care provider (PCP) visits, outpatient visits, and pharmacy service utilization decreased after enrollment in the pilot program.
- PMPM behavioral service utilization increased after enrollment in the pilot program.
- PMPM costs for services provided through the pilot program averaged $244, with a median of $135.
- A total of $178,256 was spent for all housing assistance services provided through the pilot program across all plans combined.
- Tenancy sustaining services (e.g., education and training on the roles, rights, and responsibilities of the tenant and landlord) were the most prevalent services used among all participants, with 76.44 percent of the 208 participant-users receiving this service. When examining specific service types by plan, this pattern continued, with at least half of all participants in each of the six plans receiving tenancy sustaining services.
- Participants in all six plans utilized both transitional housing services (which includes incidental services/support services) and tenancy sustaining services. Clear Health and Coventry participants did not use additional services based on the DY14 encounter data. Simply Healthcare, Magellan, Staywell and Staywell-SMI participants used self-help/peer support services in addition to both transitional housing services and tenancy sustaining services. Magellan was the only plan with participants who used mobile crisis management services (in addition to tenancy sustaining services, transitional housing services, self-help/peer support services), though utilization remained low (11.63%).

Findings from Care Coordination Surveys and Implementation Interviews

- All of the care coordinators agreed that care coordination is more effective for the study population following the pilot program implementation compared to prior to the pilot program implementation.
- Facilitators for the effectiveness of care coordination included linkage of services/community partnerships, meetings with a housing specialist, and member communication.
- Barriers limiting the effectiveness of care coordination included poor communication (i.e. difficulty in contacting enrollees), lack of community/financial resources, COVID-19, and cumbersome processes.

- Facilitators to pilot implementation included the following: collaborations with stakeholders, cooperation with other plans, and availability of staff specializing in housing matters.
- Barriers to pilot implementation include the coordination of data transfer between DCF and AHCA (including member eligibility and contact information) that some have reported as "cumbersome". This data when eventually delivered to plans may be inaccurate, limiting the ability of plans to effectively provide care coordination services. Other problems include member reluctance to participate in care coordination, social determinants of health, availability of housing, provider or continuity of care issues, and non-serious mental illness status.
- For identification of program enrollees, the plans used a combination of internal and external strategies which included the following: Agency enrollment files, collaboration with community partners, referrals from provider networks, member outreach, and internal organizational strategies involving data analytics and case management.

Findings from Enrollee Surveys[21]

- Enrollee satisfaction was high across all housing services, with 100 percent reporting satisfaction with self-help/peer support, 93 percent reporting satisfaction with mobile crisis management, 87 percent reporting satisfaction with tenancy sustaining services, and 78 percent reporting satisfaction with transitional housing services.
- Enrollees reported high levels of ease in using all housing support services, with 100 percent for self-help/peer support, 86 percent for tenancy sustaining services, 80 percent for mobile crisis management services, and 75 percent for transitional housing services.

Given the limited time period under which the pilot program has operated and generated data for evaluation, it is premature to draw any definitive conclusions about rates of discharge from the program, as well as changes in utilization of various MMA services that occurred after enrollee participation in the pilot program.

[21] There were a total of 101 respondents to the overall survey.

B. General Background Information

History of Managed Care Demonstrations in Florida

The Centers for Medicare and Medicaid Services (CMS) initially approved Florida's 1115 Research and Demonstration Waiver, "Medicaid Reform", on October 19, 2005. Florida 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 Florida 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.

Federal CMS approved a second extension of the MMA 1115 waiver demonstration for a period of five years beginning August 3, 2017 through June 30, 2022. On November 30, 2018, CMS approved an amendment to the demonstration that allowed the state to operate a statewide prepaid dental health program (PDHP), modified the LIP to add regional perinatal intensive care centers as an eligible hospital ownership subgroup and community behavioral health providers as a participating provider group, and waived retroactive eligibility for all beneficiaries under the demonstration, except for pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21.

On March 26, 2019, CMS approved an amendment to the demonstration to implement a pilot program that provides additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The pilot program operated in two regions of the state: Regions 5 (Pasco and Pinellas counties) and Region 7 (Brevard, Orange, Osceola and Seminole counties). The pilot program provided enrollees with additional tools necessary to improve health outcomes and achieve stable tenancy, and should have the effect of reducing state costs related to unnecessary beneficiary service utilization. The state agreed to evaluate the extent to which provision of these services results in improved integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care[22].

On February 18, 2020, an amendment to the demonstration was approved that enables Florida to increase the behavioral health and supportive housing assistance pilot's annual enrollment

[22] Florida Supportive Housing and Behavioral Health STCs, April 2019.

limit, modified the LIP's permissible expenditures related to federally qualified health centers (FQHC) and rural health clinics (RHC), and memorialized some budget neutrality-related edits to the behavioral health and supportive housing assistance pilot table in the STCs. Federal CMS approved a third extension of the MMA 1115 waiver demonstration (Project No. 11-W-00331/3) effective January 15, 2021 through June 30, 2030.

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

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

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 specified components of the evaluation (Florida State University and University of Alabama at Birmingham).

Evolution of the MMA Demonstration

While the organization of the MMA Demonstration has evolved over the past six years, its core components have remained stable and have consisted of five major projects.

Project 1 examines the cost, utilization, quality, accessibility, and timeliness of care of the MMA Demonstration (1) compared to the Fee-for-Service (FFS) program that preceded the MMA

Demonstration and (2) compared year-to-year within the MMA period. The comparisons to FFS care shed light on the effectiveness of the MMA Demonstration's managed care principles relative to the more traditional principles embodied in FFS care.

Project 2 focuses on the Healthy Behaviors program.

Project 3 examines the Low-Income Pool (LIP) program.

Project 4 compares Florida Medicaid enrollees eligible for both acute Medicaid services and long-term care Medicaid services. In this report, these enrollees are referred to as joint eligibles to distinguish them from the Medicare-Medicaid dual eligibles.

Project 5 addresses Medicare-Medicaid dual eligibles and compares dual eligible enrollees who receive care in Medicare and Medicaid in health plans jointly owned by the same entity to those dual eligibles who receive care in Medicare and Medicaid health plans that are not jointly owned by the same entity.

Projects 1-4 were conducted in each demonstration year over the DY9 through DY14 period. **Project 5,** however, was sunset in DY12.

In addition to Projects 1-5, three new demonstration programs were added to the MMA evaluation program over time as separate new projects: (1) the Florida Prepaid Dental Health Program (PDHP) began operating in DY13-14 (Project 5, as a replacement for the original Project 5 dealing with joint eligibles which ended in DY12); (2) the limits on retroactive enrollment for new Medicaid enrollees began in DY13 (Project 6); and (3) the Supportive Housing Assistance demonstration began operating in DY14 (Project 7).

C. Evaluation Questions and Hypotheses

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

- Goal 1: 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.
- Goal 2: Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Goal 3: 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.
- Goal 4: Increasing access to, stabilizing, and strengthening providers that serve uninsured, low- income populations in the state by targeting LIP funding to reimburse

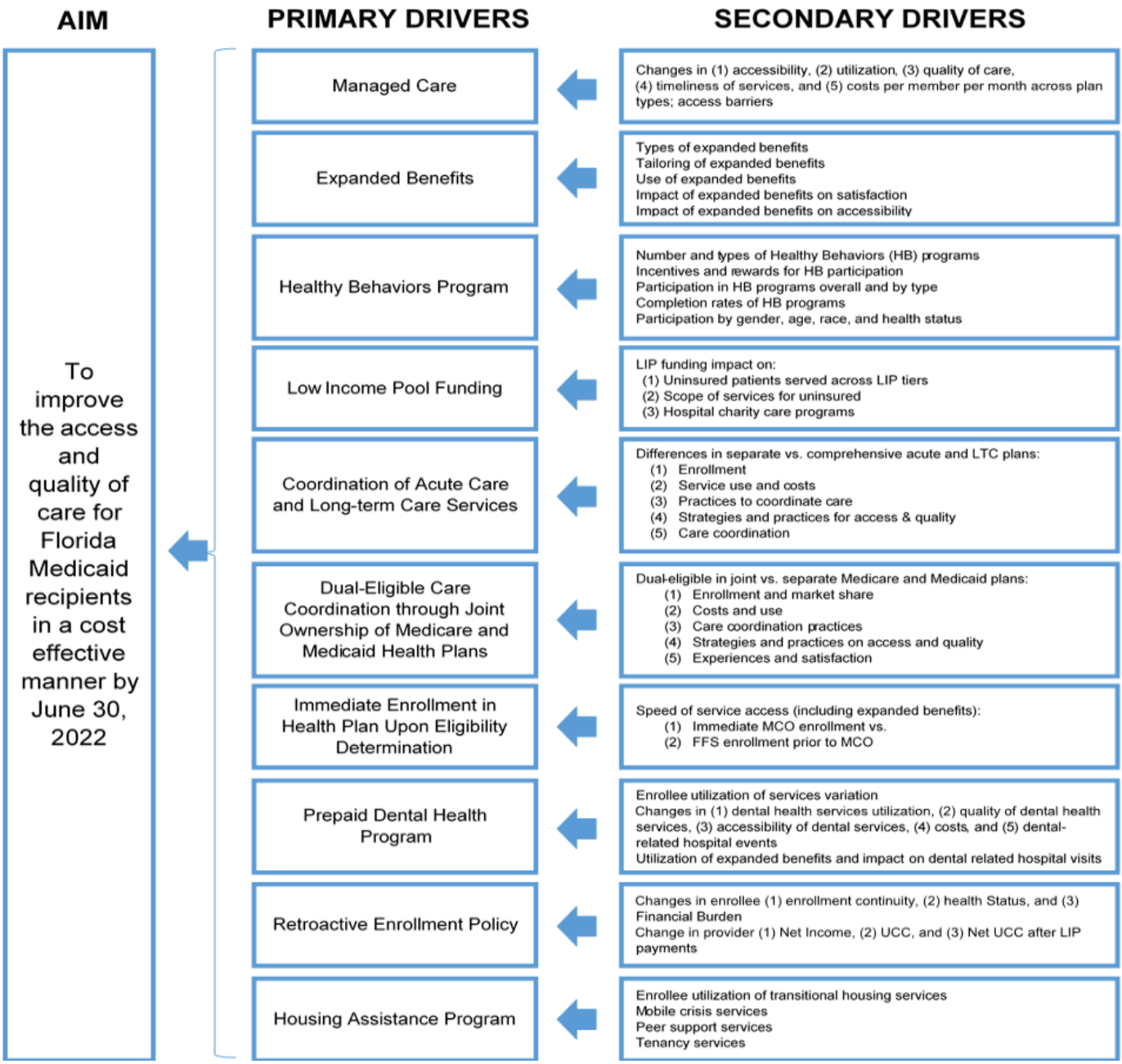
UC costs for services provided to low-income uninsured patients at hospitals, FQHCs RHCs that are furnished through charity care programs that adhere to the HFMA principles.[23]

- Goal 5: 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.
- Goal 6: 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.

Figure 2 presents the driver diagram for the MMA Program Goals. Figure 2 shows how the overall aim of the MMA Program ("To improve the overall access and quality of care for Florida Medicaid recipients in a cost effective manner.") is related to a series of Primary Drivers and how those Primary Drivers are related to a more detailed series of Secondary Drivers.

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

Figure 2. Florida Managed Medical Assistance Program Goals: Driver Diagram



The overall aim of the MMA Demonstration and its objectives are reflected not only in the Primary and Secondary Drivers above, but were translated and operationalized as the evaluations, questions, and hypotheses organized by project and component as listed below. The statewide MMA Demonstration and this evaluation report are direct outgrowths of the reform program that began in 2006, as presented in the background section above. Ultimately, Florida's statewide MMA Demonstration seeks to promote the goal of the federal Medicaid

authorization legislation (Title XIX of the Social Security Act) by providing high quality health services to low-income individuals who would otherwise fail to receive such services.

Project 1, Component 1 - Cost, Quality and Access

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

Hypothesis 1A: 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?*

Hypothesis 1E. 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).

Project 1, Component 2 - Expanded Benefits. The effect of expanded benefits on enrollees' utilization of services, access to care, and 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?*

2B. *To what extent do enrollees use these expanded benefits?*

Hypotheses. 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.

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).

Project 1, Component 5 - Joint Eligibles, The effect of having separate managed care programs for acute care and LTC services on enrollment and utilization.

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?*

Hypotheses: 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.

Project 1, Component 7- Express Enrollment

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?*

There are no hypotheses associated with these questions.

Project 2. Component 3 – Healthy Behaviors

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 (the 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?*

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.

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

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.

Project 3. Component 4 - Low Income Pool

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.

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

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

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

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

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

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

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, 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.

Project 4. Component 6 – Dual Eligible for Behavioral Health and Non-Emergency Transportation

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

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 the 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.

Project 5. Component 8. Pre-paid Dental Services Utilization

8A. *How does enrollee utilization of dental 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 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 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 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. (*a*) *How does enrollee utilization of dental services impact dental-related hospital events (e.g., emergency department, inpatient hospitalization)?* ***(b)*** *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 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 services, including timeliness of dental 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.

Project 6. Component 9- Retroactive Enrollment Eligibility

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.

Project 7. Component 10 - Supportive Housing Assistance

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

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

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

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

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

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

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

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

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

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

related to relevant study outcomes using quantitative methods.

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

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

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

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

D. Methodology

This evaluation used a combination of primary data collection and secondary administrative data for its analyses. In addition, the evaluation applied both qualitative and quantitative research methods to these data to answer its research questions. This section provides a basic description of these data and methods and how they were used. The details of the methodology by research question are listed in Table 6 (page 48) of the Evaluation Design in Volume II of this report.

Evaluation Design

This evaluation relied on a pre-post design and interrupted time-series regression methods to answer questions about the MMA program impact. Questions concerning the operations of the MMA program relied on single-period descriptive analyses based on both quantitative and qualitative methods.

Evaluation Period

The MMA period covered by this report consisted of DY9-D14. DY8 was considered a transition year and was omitted from this evaluation. The pre-MMA period used for comparison purposes covered DY6 through DY7.

The PDHP, retroactive enrollment, and supportive housing components of this evaluation were implemented at various junctures during the MMA period. In particular, the PDHP program was implemented in December 2018 through February 2019, the retroactive enrollment policy change took effect in February 1, 2019, and the supportive housing pilot began December 1, 2019. Consequently, the MMA period for these more recent interventions is correspondingly shorter than the MMA period for the original components of the MMA program.

Target and Comparison Populations

The target population for this evaluation consisted of Medicaid enrollees who were enrolled in an MMA plan starting in May 1, 2014 and thereafter. Because Florida shifted the Medicaid population that was mandatory for managed care enrollment to MMA over a period of three months in May through July, 2014, no contemporaneous comparison population within Florida

was available. For HEDIS and CAHPS measures, national Medicaid results for HEDIS and CAHPS provided a reference population for questions involving those measures.

Evaluation Measures

A wide variety of measures were used in this evaluation, including:

Financial Measures

- Medicaid MCO capitation payment rates
- Amount paid to Medicaid providers for an encounter or service
- Uncompensated care (UCC) amounts
- Provider financial margin
- Low-Income Pool (LIP) payments

Utilization Measures

- Inpatient admissions
- Hospital patient-days
- Outpatient visits
- Physician visits by specialty
- Healthy Behaviors program participation
- Behavioral health encounters
- Non-emergency transportation encounters
- Unique patient counts

Performance and Quality Measures

- HEDIS measures
- CAHPS ratings

Data Sources

The evaluation collected primary survey and interview data from health plan personnel, Agency employees, and MMA enrollees. Secondary quantitative data were furnished by the Agency and included eligibility, claims, and encounter data as well as health and dental plan-level HEDIS and CAHPS data. The Agency also furnished considerable supplemental data on particular aspects of the MMA program, including Low Income Pool (LIP) data and reports, Healthy Behaviors program participation data, Florida Hospital Uniform Reporting System (FHURS) data, and Supportive Housing Assistance pilot program roster data, among others. The MMA evaluation team also purchased credit reporting data from TransUnion (TU) on Medicaid new enrollee total and medical debt loads to evaluate the impact of the change in retroactive enrollment policy on new enrollee financial burden.

Analytic Methods

Qualitative Data and Methods

In-depth interviews were transcribed into Word documents to facilitate coding and thematic analysis. The qualitative evaluation team used Nvivo to code the transcripts. An initial codebook of *a priori* codes was developed from the interview guide. Following grounded theory methods, reviewers identified new codes for new themes that emerged in the analysis; and as new codes were produced, the codebook was updated and previously coded transcripts were back-coded to capture the new themes.

Quantitative Data and Methods

Descriptive bivariate analyses commonly used t-tests to compare the expected values for continuous variables and chi-square tests to compare the relative frequencies for cross-tabulated discrete variables.

The statistical analyses of cost and use commonly relied on two-part statistical mixture models. The first part involved a logistic regression of whether cost (or use) was greater than zero (>0) as a function of demographics (age, sex, gender), CDPS total risk score, months enrolled, a zero-one dummy variable for individuals who switched comprehensive/separate regimes during the year, and a zero-one dummy that equaled one if the enrollee was in a comprehensive plan (COMP=1) and equaled zero if the enrollee was in separate plans (COMP=0).

The second part of the two-part model was estimated for those enrollees with cost greater than zero and consisted of a generalized linear model with log-link function and an appropriate error distribution (e.g., Poisson, Gamma, Inverse Gaussian). The error distribution was chosen based on the way in which the error variance varied with the predicted cost. The regressors in this second part model were identical to the regressors used in the first-part.

Separate two-part cost and use models were estimated for the various specific types of costs and use examined (e.g., total, hospital inpatient, hospital outpatient, pharmacy, primary physician, and specialist physician).

The two parts were combined by generating predicted probabilities of non-zero values and predicted values conditional on nonzero values under (1) the entire sample enrolled in the treatment or intervention group (TREAT=1) and (2) the entire sample enrolled in the comparison or non-intervention group (TREAT=0). The expected value was calculated by multiplying the predicted probability of nonzero values by the expected value conditional on nonzero values for both TREAT=1 and TREAT=0 cases. The difference between the expected value for TREAT=1 and TREAT=0 was tested to determine if the difference was statistically significantly different from zero.

E. Methodological Limitations

The key methodological limitation in making causal inferences about the impacts of the MMA program was Florida's decision to implement the MMA program by shifting the Medicaid population that was mandatory for managed care enrollment from their pre-MMA Medicaid

programs to the MMA program over a single three-month period. This shift of the Medicaid population that was mandatory for managed care enrollment to the MMA program statewide at a single point in time precluded the use of causal inference techniques such as difference-in-differences that rely on phased implementation across time and/or geographic regions of the state.

The COVID-19 pandemic and its widespread disruption of economic and social life posed another major methodological limitation for this evaluation. Combined with COVID-19's major impact on the health care sector, attempting to separate the ongoing evolution of the MMA program impacts from the widespread disruptions stemming from the COVID-19 pandemic has proven to be a daunting challenge.

F. Results

For ease of readability, this section presents the results from the key research questions addressed by the MMA evaluation over the DY9 through DY14 period. These results are organized around the following topics:

- Quality, Cost, and Access
- Healthy Behaviors Program
- Low Income Pool Program
- Prepaid Dental Health Program
- Retroactive Enrollment Policy
- Supportive Housing Pilot, and
- Other Evaluation Topics

MMA Program Quality, Cost, and Access (RQs 1A-1G)

Research Question 1A

What barriers do enrollees encounter when accessing primary care and preventive services?

Data and Methods

Timely access PCP wait-time requirements ensure that appointments for medical and behavioral health services are available on a timely basis. Agency contracts with MMA plans require the plans to provide access to appointments within a specified time frame based on the type of visit.

In DY9-DY12, plans were required to provide access to urgent care within one day of the request, access to routine sick care within seven days of the request, and access to well-care visits within 30 days of the request. In DY13-DY14, changes were made to the wait-time requirements and categorization of visit type. In these two years, plans were required to provide access to urgent care appointments within 48 hours of a request for medical or behavioral health care services that did not require prior authorization, and within 96 hours of a request for medical or behavioral health care services that did require prior authorization. Access to non-urgent behavioral health appointments needed to be provided within 7 days after discharge from

an inpatient behavioral health admission for follow-up behavioral health treatment; within 14 days for initial outpatient behavioral health treatment; within 14 days of a request for ancillary services for the diagnosis or treatment of an injury, illness or other health condition; within 30 days of a request for a primary care appointment; and within 60 days of a request for a specialist appointment after the appropriate referral was received by the specialist. Additionally, the method in which wait times were reported varied by year. In DY9, DY13, and DY14, a numeric value was reported by plan either in hours or days. For DY10-12, wait times were reported by plan as to whether the contractual standard was met.

Results

From DY9-DY14, wait times were mostly met for all types of visits except for urgent behavioral health care services in DY14. In DY9, the average wait time was 1.07 days for urgent care visits, 4.1 days for routine visits, and 17 days for well-care visits. In DY10-DY12, the average percentage of PCPs who did not meet contractual wait-time requirements was 8.3 percent for urgent care visits, 4.3 percent for routine care visits and 1.5 percent for well-care visits. Wait times not met increased each year from DY10-DY12 for both urgent care and well-care visits. In DY13-DY14, wait times for medical services on average did not exceed 43.3 hours for visits that do not require authorization and 77.7 hours for visits that required authorization, while wait times for behavioral services did not exceed 48.6 hours for visits that did not require authorization and 107.1 hours for visits that required authorization.

On average, non-urgent appointment wait times were met for all services and did not exceed 5.9 days for post-discharge from an inpatient behavioral health admission for follow-up treatment; 8.5 days for initial outpatient behavioral health treatment; 5 days for a request for ancillary services for the diagnosis or treatment of injury or illness, 7.8 days of a request for a primary care appointment, and 14.3 days of a request for a specialist appointment.

From DY13 to DY14, appointment wait times increased on average for urgent medical and behavioral services visits not requiring authorization, and for behavioral services requiring authorization. Appointment wait times decreased on average for medical services requiring authorization. Non-urgent appointment wait times decreased on average for all services from DY13 to DY14.

Research Question 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?

Data and Methods

To determine changes in the accessibility of services among health plans in the pre-MMA period and the MMA period using data provided by the Agency, weighted means adjusting for differences in enrollment size and measure eligibility across plans for each of the 23 HEDIS accessibility measures were calculated for each year.

Results

Comparing the HEDIS accessibility measures between the pre-MMA period and the post-MMA period (CY 2015-2019) in Table 3, 21 of the 23 (91%) measures improved after MMA implementation and two measures (9%) remained the same. None of the measures declined. The measures with the largest improvements (defined as greater than or equal to 10%) were:

- Adults' Access to Preventive/Ambulatory Health Services 65+ Years (15%)
- Immunizations for Adolescents – Combination 1 (14%)
- Timeliness of Pre-Natal Care (13%)
- Timeliness of Post-Partum Care (13%)
- Well-Child Visits in the First 15 Months of Life (11%)

Table 3. Comparison of Changes in Statewide Means of Performance Measures, Pre-MMA Plans (CYs 2011-2013) and All MMA Plans (CY 2015, CY 2016, CY 2017, CY 2018, and CY 2019)

Measure	Component	Average of CY 2011-2013 Weighted Means Pre-MMA Plans	CY 2015 Statewide Weighted Means MMA Plans	CY 2016 Statewide Weighted Means MMA Plans	CY 2017 Statewide Weighted Means MMA Plans	CY 2018 Statewide Weighted Means MMA Plans	CY 2019 Statewide Weighted Means MMA Plans
Adolescent Well-Care Visits	--	49%	53%	53%	57%	60	63%
Adults' Access to Preventive/Ambulatory Health Services	20-44 years	67%	69%	68%	68%	70%	70%
Adults' Access to Preventive/Ambulatory Health Services	45-64 years	82%	85%	84%	86%	86%	86%
Adults' Access to Preventive/Ambulatory Health Services	65+ years	70%	77%	80%	90%	90%	87%
Adults' Access to Preventive/Ambulatory Health Services	Total	72%	75%	74%	76%	77%	77%
Breast Cancer Screening	--	52%	61%	55%	58%	60%	61%
Cervical Cancer Screening	--	56%	51%	56%	60%	60%	58%
Childhood Immunization Status	Combo 2	77%	77%	78%	78%	78%	79%
Childhood Immunization Status	Combo 3	72%	72%	74%	74%	73%	74%
Children and Adolescents' Access to Primary Care Practitioners	12-24 months	95%	95%	94%	95%	95%	95%
Children and Adolescents' Access to Primary Care Practitioners	25 months – 6 years	88%	89%	88%	88%	89%	89%

Measure	Component	Average of CY 2011-2013 Weighted Means Pre-MMA Plans	CY 2015 Statewide Weighted Means MMA Plans	CY 2016 Statewide Weighted Means MMA Plans	CY 2017 Statewide Weighted Means MMA Plans	CY 2018 Statewide Weighted Means MMA Plans	CY 2019 Statewide Weighted Means MMA Plans
Children and Adolescents' Access to Primary Care Practitioners	7-11 years	86%	89%	89%	88%	89%	90%
Children and Adolescents' Access to Primary Care Practitioners	12-19 years	83%	86%	85%	84%	86%	87%
Chlamydia Screening in Women	16-20 years	57%	59%	60%	62%	64%	63%
Chlamydia Screening in Women	21-24 years	69%	69%	69%	70%	71%	69%
Chlamydia Screening in Women	Total	62%	62%	63%	64%	65%	64%
Immunizations for Adolescents	Combination 1	58%	67%	71%	72%	74%	76%
Lead Screening in Children	--	59%	61%	66%	67%	71%	75%
Timeliness of Prenatal Care	--	72%	83%	84%	82%	83%	92%
Postpartum Care	--	52%	59%	64%	65%	63%	75%
Well-Child Visits in the First 15 Months of Life	0 visits (**INVERSE**)[a]	2%	2%	2%	2%	2%	2%
Well-Child Visits in the First 15 Months of Life	6+ visits	56%	58%	64%	69	70%	73%
Well-Child Visits in the Third through Sixth Years of Life	--	75%	75%	76%	78%	78%	80%

[a]For the majority of health plan performance measures, higher scores indicate higher quality. For a handful of performance measures, however, lower scores indicate higher quality (e.g., Mental Health Readmission Rate). Such measures are labelled INVERSE throughout this report.

In addition to the HEDIS results above, the CAHPS results from 2013-2020 for adults and children (Table 4 and Table 5) show higher consumer satisfaction rates during the MMA period for Ease in Getting Needed Care and Ease in Getting Care Quickly, two important measures of accessibility.

Table 4. Comparison of Consumer Satisfaction with Access to Care based on Adult CAHPS Surveys, Pre-MMA (CY 2013-2014) and MMA (CY 2015-2020) Periods

CAHPS Survey Year	Ease in Getting Needed Care (Q9): 4	Ease in Getting Care Quickly (Q6): 4
2013 Adult	-	53%
2014 Adult	53%	55%
2015 Adult	58%	65%
2016 Adult	56%	63%
2017 Adult	59%	66%
2018 Adult	56%	62%
2019 Adult	58%	65%
2020 Adult	56%	62%
Pre-MMA (2013-2014) Consumer Satisfaction	**53%**	**54%**
MMA (2015-20) Consumer Satisfaction	**57%**	**64%**
Percentage Difference (Pre- vs. Post-MMA)	**8%[a]**	**18%[b]**

[a] This is a percentage difference in two percentages, not their arithmetic difference.
[b] This is a percentage difference in two percentages, not their arithmetic difference. Also, any apparent rounding error results from carrying greater precision in the calculation than is shown in the table.

Table 5. Comparison of Consumer Satisfaction with Access to Care based on Child CAHPS Surveys, Pre-MMA (CY 2013-2014) and MMA Periods (CY 2015-2020)

CAHPS Survey Year	Ease in Getting Needed Care (Q9): 4	Ease in Getting Care Quickly (Q6): 4
2013 Child	53%	62%
2014 Child Medicaid (Non-Reform)	66%	70%
2015 Child Medicaid Health Plan	60%	77%
2016 Child	60%	76%
2017 Child	62%	75%
2018 Child	61%	78%
2019 Child	63%	76%
2020 Child	63%	78%
Pre-MMA (2013-2014) Consumer Satisfaction Rates	**60%**	**66%**

CAHPS Survey Year	Ease in Getting Needed Care (Q9): 4	Ease in Getting Care Quickly (Q6): 4
MMA (2015-20) Consumer Satisfaction Rates	**62%**	**77%**
Percentage Difference (pre-MMA vs MMA)	**3%**	**16%**

As shown in Table 6, overall ratings of enrollees' satisfaction with their health plans increased in the MMA period compared to the pre-MMA period as well.

Table 6. Adult and Child CAHPS Overall Rating of Their Health Plan, MMA vs. Pre-MMA Periods

Adults	Overall Rating of Health Plan		Children	Overall Rating of Health Plan	
2013	47%	Pre-MMA	2013	57%	Pre-MMA
2014	50%	48.50%	2014	59%	58.00%
2015	59.39%		2015	65.01%	
2016	57.42%		2016	68.44%	
2017	69.88%		2017	61.76%	
2018	60.62%	MMA	2018	70.22%	MMA
2019	61.12%	61.69%	2019	71.18%	67.32%

Research Question 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?

Data and Methods

Claims and encounter data were used to capture service utilization and place it into the following categories for the study period: inpatient visits, outpatient visits, ED visits, and professional (physician) visits. For the MMA period, service utilization for professional visits was broken out by physician and specialist visits using encounter data. All utilization is reported on a per-member per-month (PMPM) basis, meaning that it represents the average number of visits that a Medicaid enrollee had in a month. These results also can be easily converted into annual rates per person by multiplying the PMPM rate by 12 months (e.g., 0.14 ED visits PMPM is equivalent to 1.68 ED visits per member per year). Further detailed information related to the analyses conducted, univariate results, and results by HIV, SMI, CW, and CSMN sub-groups are available in annual MMA evaluation reports for Project 1.

Results

Multivariate Analyses

Compared to the pre-MMA period, adjusted[24] utilization in the DY9 MMA period showed reductions (shown as mean values) for multiple types of services:

- Inpatient stays (0.05 PMPM versus 0.03 PMPM)
- Outpatient visits (0.36 PMPM versus 0.12 PMPM)
- ED visits (0.24 PMPM versus 0.17 PMPM)
- Professional visits (physician visits) (2.15 PMPM versus 1.62 PMPM).

When comparing utilization across standard vs. specialty MMA plans in DY9, adjusted mean service utilization was higher in standard plans for:

- Outpatient visits (0.13 PMPM in standard plans versus 0.09 PMPM in specialty plans)
- ED visits (0.15 PMPM in standard plans versus 0.14 PMPM in specialty plans)
- Physician visits (0.38 PMPM in standard plans versus 0.18 PMPM in specialty plans).

Mean service utilization was higher in specialty plans for:

- Inpatient stays (0.05 PMPM in specialty plans versus 0.02 PMPM in standard plans)
- Professional visits (1.59 PMPM in specialty plans versus 1.54 PMPM in standard plans)
- Specialist visits (0.34 PMPM in specialty plans versus 0.32 PMPM in standard plans).

With the addition of DY10-DY14 in the MMA period, reductions were seen in the mean number of all services – inpatient stays, outpatient visits, ED visits, and professional visits – between the pre-MMA and MMA periods:

- For inpatient admissions, mean adjusted PMPM services decreased from between 0.04-0.05 visits PMPM (pre-MMA) to 0.02-0.03 visits PMPM (MMA).
- Outpatient visits decreased from between 0.36-0.37 PMPM (pre-MMA) to 0.12-0.15 PMPM (MMA)
- ED visits decreased from between 0.22-0.24 PMPM (pre-MMA) to 0.15-0.22 PMPM (MMA)
- Professional visits decreased from between 2.14-2.48 PMPM (pre-MMA) to 1.55-1.73 PMPM (MMA)
- The adjusted mean number of physician visits PMPM was 0.69 visits, while the number of specialist visits was 0.87 visits PMPM.

Research Question 1D

What changes in quality of care for enrollees are evident post MMA implementation, comparing:

[24] Utilization was adjusted statistically for demographics (age, sex, race/ethnicity) and health status using a two-part statistical model (see the Methodology chapter and the results of RQ 1G in the body of this report).

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)?

Data and Methods

To determine changes in the quality of care among health plans in the pre-MMA period and the MMA period using data provided by the Agency, weighted means for each HEDIS measure were calculated for each year based on the eligible population. The means were then averaged across all plans for each time period.

Results

As shown in Table 7, from DY9 to DY14, 20 of the 27 performance measures (approximately 74%) improved, five measures (19%) remained the same, and two measures (7%) declined compared to the pre-MMA period. Both of the measures that declined (Follow-up After Hospitalization for Mental Illness (30-days) and Child Access to Primary Care Practitioners (age 12-24 mos.) declined by one percent or less. By contrast, six measures had improvements greater than 10 percent from the pre-MMA period to the MMA period:

- Chlamydia Screening in Women 21-24 years (42%)
- Adult BMI Assessments (19%)
- Chlamydia Screening in Women 16-20 years (16%)
- Total Annual Dental Visits (13%)
- Comprehensive Diabetes Care-Nephrology (12%)
- Well-Child Visits in the First 15 Months of Life - 6+ visits (11%)

Table 7. Comparing MMA Program Weighted Means to Pre-MMA Program Weighted Means[†]

Measure	Component	Pre-MMA			MMA				
		2011	2012	2013	2015[a]	2016	2017	2018	2019
Adult BMI Assessment	--	57%	72%	82%	86%	87%	90%	89%	93%
Antidepressant Medication Management	Acute	52%	52%	53%	52%	51%	53%	53%	55%
Antidepressant Medication Management	Continuation	35%	37%	38%	37%	36%	37%	37%	40%
Adolescent Well-Care Visits	--	48%	50%	50%	53%	53%	57%	59%	63%

Measure	Component	Pre-MMA			MMA				
		2011	2012	2013	2015[a]	2016	2017	2018	2019
Childhood Immunization Status	Combo 2	78%	78%	76%	77%	78%	78%	78%	79%
Childhood Immunization Status	Combo 3	72%	72%	71%	72%	74%	74%	73%	74%
Children and Adolescents' Access to Primary Care Practitioners	12-24 mos.	95%	97%	95%	95%	94%	95%	95%	95%
Children and Adolescents' Access to Primary Care Practitioners	25 mos.–6 yrs.	89%	89%	89%	89%	88%	88%	89%	89%
Children and Adolescents' Access to Primary Care Practitioners	7-11 years	89%	89%	89%	89%	89%	88%	89%	90%
Children and Adolescents' Access to Primary Care Practitioners	12-19 years	86%	86%	86%	86%	85%	84%	86%	87%
Chlamydia Screening in Women	16-20 years	41%	48%	49%	59%	60%	62%	64%	63%
Chlamydia Screening in Women	21-24 years	28%	28%	28%	69%	69%	70%	71%	69%
Chlamydia Screening in Women	Total	61%[b]	62% [b]	62%[b]	62%	63%	64%	65%	64%
Immunizations for Adolescents	Combination 1	68%	68%	68%	67%	71%	72%	74%	76%
Lead Screening in Children	--	60%	58%	60%	61%	66%	67%	71%	75%
Well-Child Visits in the First 15 Months of Life	0 visits (INVERSE)	3%	2%	2%	2%	2%	2%	2%	2%
Well-Child Visits in the First 15 Months of Life	6+ visits	57%	56%	54%	58%	63%	69%	70%	73%
Comprehensive Diabetes Care -	HbA1c Good Control (<8.0%)	46%	47%	43%	43%	44%	49%	48%	49%
Comprehensive Diabetes Care -	HbA1c Poor Control (>9.0%) (INVERSE)	46%	45%	48%	48%	45%	41%	42%	42%
Comprehensive Diabetes Care	Eye Exam	46%	47%	49%	51%	56%	55%	56%	56%

Measure	Component	Pre-MMA			MMA				
		2011	2012	2013	2015[a]	2016	2017	2018	2019
Comprehensive Diabetes Care -	Nephropathy	79%	80%	80%	92%	91%	93%	92%	92%
Comprehensive Diabetes Care	HbA1C Testing	78%	80%	80%	81%	82%	86%	86%	87%
Controlling High Blood Pressure^	--	52%	51%	53%	50%	55%	55%	64%	66%[d]
Follow-up After Hospitalization for Mental Illness[e]	7 day	35%	34%	27%	36%	43%	31%	30%	28%
Follow-up After Hospitalization for Mental Illness[e]	30 day	54%	51%	45%	42%	56%	51%	50%	48%
Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Continuation & Maintenance Phase	56%	52%	62%	63%	65%	64%	55%	57%
Mental Health Readmission Rate	-- (INVERSE)	26%[b]	31%[b]	32%[b]	27%	34%	41%	26%	NR
Medication Management for People with Asthma-50% Medication Compliance	Total	[c]	[c]	[c]	54%	54%	55%	57%	59%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	--	76%	74%	75%	75%	76%	78%	78%	80%

† In accordance with HEDIS reporting requirements, measures for plans with denominators less than 30 were not included in the calculations of the weighted means. Also, for the majority of health plan performance measures, higher scores indicate higher quality. For a handful of performance measures, however, lower scores indicate higher quality (e.g., Mental Health Readmission Rate). Such measures are labelled INVERSE throughout this report.

[a]Because 2014 is a hybrid/transition year, data for 2014 is not included in this table.

[b] Statewide weighted mean data for the pre-MMA period was not available for two of the quality *measures; Chlamydia Screening in Women-Total and Mental Health Readmission Rate.* Thus, weighted averages of the reform and non-reform weighted means were used for the pre-MMA period.

[c] The Medication Management for People with Asthma – 50 percent Medication Compliance measure was newly added in 2015, so there are no data for the pre-MMA period.

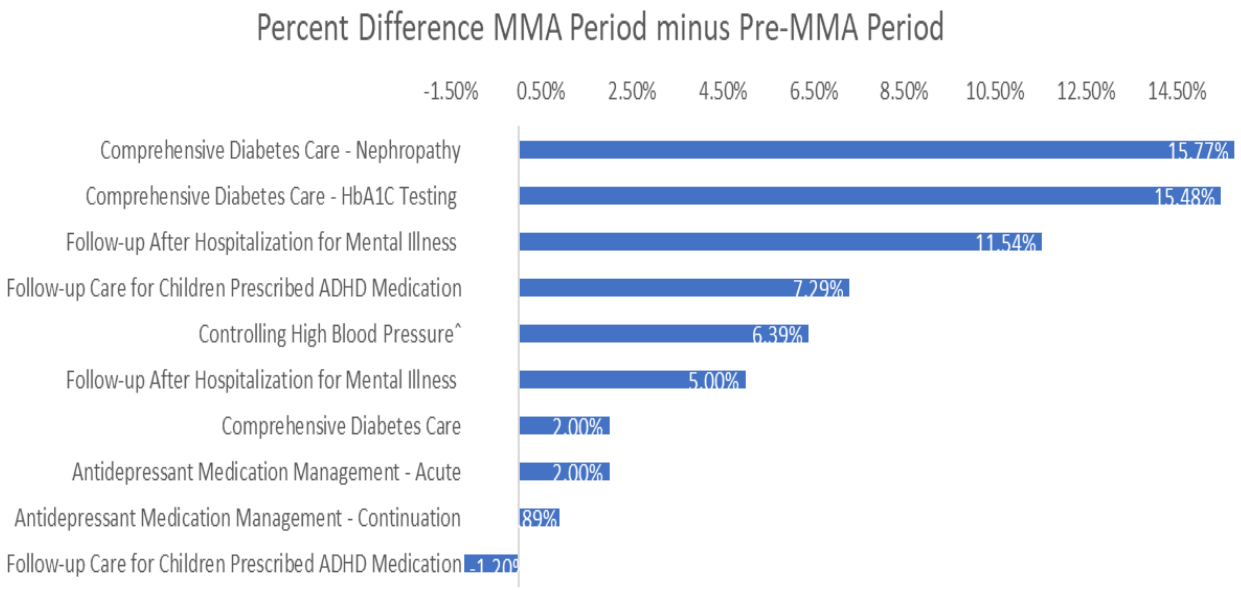
[d]The specs for the HEDIS measure Controlling High Blood Pressure changed for CY2018 to exclude members with advanced illness and frailty (HEDIS, 2019). NR =Not Reported.

[e]Both follow-up after mental health hospitalization measures were redefined between CY2016 and CY2017 to exclude follow-up visits on the day of discharge. This redefinition distorts comparisons across this period.

With respect to outcomes, a total of 10 health plan performance measures and sub-measures included in the MMA evaluation addressed the effectiveness of care in improving outcomes for cardiovascular health, diabetes, and behavioral health conditions. Comparing these measures over the 2011-2013 pre-MMA period to the 2015-2019 MMA period showed that 9 of the 10 effectiveness measure means were higher in the MMA period than in the pre-MMA period, indicating higher quality of care during the MMA period. The average percentage difference

across all 10 measures between the MMA and pre-MMA periods was +7.10 percent.

Figure 3. HEDIS Effectiveness Measures, Percent Difference MMA Period Minus Pre-MMA Period



Research Question 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?

Data and Methods

Several data sources were used to determine the types and effectiveness of quality improvement activities implemented by the MMA plans. Data sources included:

- Presentations from Agency meetings or 'check-ins' with plans that occurred quarterly throughout 2016.
- Validation summary reports produced by the Health Services Advisory Group (HSAG) [2016- 2017 Florida Annual PIP Validation Summary Report, 2017-2018 Florida Annual Performance Improvement Project Validation Summary Report, and External Quality Review Report. SFY 2018-2019].
- In-depth interviews and written survey responses from health plan representatives in 2018, 2019, and 2021.

Strategies to Improve Quality of Care

Background. Contractual arrangements between the Agency and MMA plans required that plans implement four performance improvement projects (PIPs). Between 2014 and 2018 the Agency mandated that two of the PIPs be in the following areas: *Improving Timeliness of*

Prenatal Care and Well-Child Visits in the First 15 Months of Life and *Six or More Visits* and *Preventive Dental Services for Children*. In addition, plans were instructed to implement a nonclinical/administrative PIP that was approved by the Agency, and a fourth PIP that fell into one of three state-defined categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, or asthma); integration of primary care and behavioral health care; or reduction of preventable readmissions.

Since 2018 and through 2023, the Agency changed the mandated PIP programs to each of the following PIPs: 1) Improving Birth Outcomes, 2) Reducing Potentially Preventable Events, and 3) Administration of the Transportation Benefit. In addition, plans are to select an additional PIP based on the following topics: Behavioral Health or Integration of Mental Health Care with Primary Care.

Regardless of the type of PIP, MMA plans implemented strategies designed to enhance communication and engagement with patients, provider education and engagement programs, care coordination, and an explicit focus on member social determinants of health. Fundamental to the performance improvement activities is the reliance on data to target specific population groups and identify gaps in care. In general, health plans approached quality of care from a population health perspective. This means that the focus is predominately on developing and implementing strategies aimed at helping members get or remain healthy, as opposed to developing strategies to improve the process, efficiency, and safety of care delivery.

Communication and Engagement with Patients. Plans used direct mailings, smart phone applications, texts, and phone calls to communicate and educate patients about scheduling appointments, the appropriate use of emergency services, risks of C-section deliveries and the benefits of prenatal care, and information on good health behaviors such as smoking cessation. For example, to improve the timeliness of prenatal care, plans delivered maternal health education to pregnant and postpartum women via texts and phone calls.

MMA plans utilized incentives and reward programs to encourage patients to engage in healthy behaviors. For example, member awards programs were implemented to encourage parents to complete prenatal care on time and to receive the appropriate number of well-child visits within the first 15 months of life.

Provider Education and Engagement. MMA plans are using a variety of approaches to engage and educate providers. Examples include using plan staff to help primary care practices make calls to patients and schedule appointments, identifying members with gaps in care and notifying the assigned provider, and engaging with medical practices to improve member satisfaction with care and billing practices. Reported examples of provider education included training OB/GYNs on billing and coding in order to improve access to timely prenatal care, introducing providers to the Health Information Exchange and encounter notification systems, screening for substance abuse issues, and identifying community resources.

Plans are increasingly using value-based incentive programs such as pay for performance to work with providers to improve care coordination and close gaps in care. For example, in 2018 there were targeted interventions to increase the percentage of the plan's Medicaid providers who report using certified electronic health records in a meaningful manner.

Care Coordination and Transitions of Care. Plan quality improvement efforts remain focused on managing transitions in care and improving care coordination. Data analytics is a critical tool in helping plans identify patients who need case management or who have recently experienced

an emergency department or inpatient event. Plans have implemented programs to follow up with patients after discharge including assuring connections with case managers and appropriate community resources. A specific focus is on integrating primary care and behavioral health following an emergency department visit or inpatient event. This is thought to be critical in the management of individuals with behavioral challenges or with severe mental illness.

Data Analytics. Plans' use of data analytics emerged as a core mechanism to support quality improvement activities. Plans rely on their encounter and claims data to design quality improvement strategies. (Data are used to segment the population (e.g. by race, ethnicity, geographical region, or language) in order to design targeted outreach and educational programs for their members. Data analytics are deployed to ensure that members are enrolled in case management and disease management programs and connected to community resources. As an example, one plan is using encounter notification system data to quickly identify people who have been admitted, readmitted, and visited the ED in order to specifically target those patients for care coordination services.

Population Health Management Strategies to address the Social Determinants of Health. The importance of population health management and social determinants of health was a prevalent theme, especially during the most recent reporting period. Plans are engaging their staff and associated processes to screen members for poverty-related challenges and working to connect members to community organizations.

Results

Program Effectiveness

In collaboration with the Agency, HSAG developed a PIP Validation Tool to assess the PIPs across the following sets of activities associated with PIP implementation:

I. Define the Study Topic
II. Define the Study Question(s)
III. Use a Representative and Generalizable Study Population
IV. Select the Study Indicator(s)
V. Use Sound Sampling Techniques
VI. Reliably Collect Data
VII. Data Analysis and Interpretation of Results
VIII. Implement Intervention and Improvement Strategies
IX. Real Improvement
X. Sustained Improvement

Reviews of the HSAG reports indicated that the PIPs are often in varying stages of adoption of 10 key validation elements. Most programs tend to demonstrate having addressed the first six components of the validation algorithm (i.e., defining a study topic, defining the study question, using a representative and generalizable study population, selecting appropriate study indicators, using sound sampling techniques, and reliably collecting data). However, among plans and their PIPs there is more variation in the attainment of the next four elements, which includes showing real and sustained improvement (elements IX and X).

In 2018, plan representatives identified during interviews what they thought were the least and most successful PIPs. Table 8 shows those projects thought to be the least successful. In 2018,

almost all plans interviewed thought the dental PIP was their most successful. Indeed the 2016-2017 HSAG Validation Study reports that 100 percent of the dental PIPs achieved statistically significant improvements over baseline for all study indicators. In comparison, only 27 percent of the prenatal care and well-child visits PIPs, 25 percent of the clinical PIPs, and 13 percent of the nonclinical PIPs saw improvement during this time period. However, in 2020 because of the relatively recent introduction of newly mandated PIPs, health plans were reluctant to identify those projects that were or were not successful.

Table 8. Least Successful Projects in 2018

Project	Reason given for lack of success
Behavioral Health Screening by a PCP	Lack of provider incentive to code behavioral health screenings.
Satisfaction with the health plan (CAHPS ratings)	Member ratings have nothing to do with the health plan specifically, but rather are a reflection of member interaction with providers. The plan has a limited ability to influence provider-patient experiences and therefore limited ability to impact plan ratings.
Diabetes Screening	Too many components associated with plan's approach to improving screening. It was difficult to manage.
Well child visits	Very hard to convince mothers to bring in children for these visits.
Social media campaign to improve dental screening	Members likely did not look at social media for advice about dental screenings.

Barriers and Facilitators to Effective Performance Improvement

Throughout the duration of the evaluation plan, representatives identified barriers and facilitators to effective performance improvement project implementation. Barriers include:

- *Problems associated with data* such as correct member contact information and the inability to share data across multiple plans and vendors.
- *Member receptivity, literacy, and non-compliance* with outreach and educational programs.
- *Physicians lacking resources* to act on plan reports on gaps in care.
- *Regulatory Environment/Administrative hurdles* such as privacy laws limiting the ability to coordinate care across multiple providers.
- *Member social determinants of health* including food and housing insecurity.

Finally, the COVID-19 pandemic significantly affected plans' quality improvement efforts and especially members' desire to engage in preventive health care.

Facilitators include:

- *Technology to improve the delivery of care* and enhance outreach strategies. Plans

have also employed telemedicine strategies to close gaps in care. Plans indicated they were forced to ramp up telemedicine strategies quickly in light of COVID-19, but they intend to maintain a telemedicine presence post-pandemic.

- *Community partnerships* aimed at meeting the needs of members. Plans are engaging in community partnerships, community access groups, and working collaboratively with other health plans to meet the needs of members.
- *Effective staff* including care managers, patient-care advocates, and quality practice advisors who work closely with providers and members to improve care coordination and ensure smooth transitions in care.
- *Increased data-sharing opportunities* and the availability of encounter and plan data from the health information exchange.
- *Engagement with Agency and HSAG staff* who provided a forum for plans to share ideas and best-practices with each other.

Research Question 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?

Data and Methods

Descriptive statistics for the two HEDIS measures related to timeliness of (1) prenatal care and (2) postpartum care for the pre-MMA period (CY 2011-2013) and the MMA period (CY 2015-2019) were used to compare the MMA program as a whole to Reform and 1915 (b) waiver plans.

Results

The timeliness of prenatal care for the MMA plans was higher than the timeliness of prenatal care for the Reform and 1915 (b) waiver plans. For MMA plans, annual scores ranged from 82 percent in 2017 to 92 percent in 2019 while annual scores for the Reform and 1915 (b) waiver plans ranged from 71 percent in 2013 to 73 percent in 2011. The timeliness of postpartum care followed a similar pattern, ranging from 59 percent in 2015 to 75 percent in 2019 for the MMA plans compared to 51 percent in 2013 to 52 percent in both 2011 and 2012 for the Reform and 1915(b) waiver plans.

Florida's performance on the timeliness of prenatal care was lower than the Medicaid Health Maintenance Organization (HMO) national performance prior to MMA (71 percent to 73 percent vs. 82 percent to 83 percent, respectively), but showed improvement during the MMA period, actually exceeding the Medicaid HMO national performance in 2016-2019. Florida's performance on the timeliness of postpartum care followed a similar pattern with respect to the national results.

Research Question 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)?

Data and Methods

To calculate Medicaid program expenditures, all facility, medical, and pharmacy claims or analogous HMO capitation payment amounts were obtained for all Medicaid enrollees from SFY 2011-12 through SFY 2019-20. Claims for all individuals in a qualifying eligibility category and Medicaid program who were enrolled for at least one month during the study period were included in the analysis.

The analysis used a person-month approach, meaning each observation corresponds to expenditures for a person in a month (or member-months). Average per-member per-month (PMPM) expenditures were calculated for each eligibility group (TANF, SSI, dual-eligible) by fiscal year (SFY 2011-12 through SFY 2019-20) as well as by pre-MMA (SFY 2011-12 through SFY 2013-14) and MMA (SFY 2014-15 through SFY 2019-20) periods. MMA expenditures in standard MMA plans and specialty MMA plans were also compared. The analysis of SSI and dual-eligible enrollees was based on data that incorporated all Medicaid enrollees who met the inclusion and exclusion criteria. However, because of the large size of the TANF population, the multivariate analysis of TANF enrollee used a 10 percent stratified random sample. For that analysis, 10 percent of all TANF enrollees were randomly selected for each member month (July 2011-June 2020) included in the data.

Multivariate Analyses

A two-part multivariate interrupted time-series analysis was conducted to control for any differences in the distribution of age, race, gender, or risk scores between the pre-MMA and MMA enrollees. The models were estimated using random-effects generalized least squares regression that account for correlation of observations over time. Because expenditures were calculated on a PMPM basis, this analysis used a person-month observation (one observation per person per month). Thus, an individual could provide up to 108 observations to the analyses.

Results

Multivariate Results

The adjusted PMPM expenditures from the multivariate analyses are presented in Table 9 and Table 10. When comparing adjusted mean and median PMPM expenditures between the pre-MMA and MMA periods, reductions in mean expenditures were seen for all eligibility groups. Mean adjusted PMPM expenditures decreased from $428 to $241 after MMA implementation for TANF enrollees, decreased from $1,448 to $1,230 for SSI enrollees, and decreased from $542 to $222 for dually eligible enrollees.

Table 9. Adjusted Per-Member Per-Month Expenditures Before and After MMA Implementation

	Pre-MMA (SFY 2011-12 through SFY 2013-14)		MMA (SFY 2014-15 through SFY 2019-20)	
	Mean	Median	Mean	Median
TANF	$428	$314	$241	$180
SSI	$1,448	$1,536	$1,230	$1,330
DUAL	$542	$512	$222	$203

When comparing standard MMA plans to specialty MMA plans (Table 10), mean PMPM expenditures were greater in specialty MMA plans for TANF and dual-eligible enrollees, but were lower for SSI enrollees in specialty MMA plans compared to standard MMA plans.

Table 10. Adjusted Per-Member Per-Month Expenditures for Standard MMA Plans and Specialty MMA Plans, SFY 2014-15 through SFY 2019-20

	Standard MMA		Specialty MMA	
	Mean	Median	Mean	Median
TANF	$232	$171	$430	$409
SSI	$1,238	$1,330	$1,152	$1,368
DUAL	$217	$201	$365	$343

Healthy Behaviors Programs (RQs 3A-3E)

Research Questions 3A-3D involve the evaluation of Healthy Behaviors programs offered by the MMA plans.

Data and Methods

MMA plans are required to offer three core Healthy Behaviors programs: a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse treatment program. Additionally, several plans offered optional Healthy Behaviors programs.

Data used in the evaluation of the Healthy Behaviors program was submitted to the Agency by the health plans. DY14 was the first year individual-level Healthy Behaviors encounter data were available for the Healthy Behaviors evaluation. Consequently, DY14 was the first year of the MMA evaluation where exploration of RQ 3E, comparing health-care utilization between Healthy Behaviors participants and non-participants, was possible. Prior to DY13, all data was submitted in aggregate, so it was not possible to identify an individual enrollee's participation in the Healthy Behaviors program.

Research Question 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 (the medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)?

Results

From DY9-DY14, 13 different types of Healthy Behaviors programs were offered across Florida's MMA plans. The most common optional programs offered were preventive well-child and adolescent visits and pregnancy/maternity/postpartum programs. Well-child programs encourage well-child visits for infants, children and adolescents. Members that completed the

recommended visits received rewards. Pregnancy/maternity/postpartum programs provided rewards to enrollees who attended appointments, increasing adherence with prenatal and postnatal care.

Additional programs included diabetes care, Baby Blocks, behavioral health follow-up, well-adult preventive/PCP visits, teen pregnancy prevention, dental, vision exams, and screening programs for lead, chlamydia and breast and cervical cancers. Diabetes care programs provided incentives for members to complete diabetes testing, eye exams, HbA1c control, and blood pressure control. The Baby Blocks program helped pregnant women and new parents with prenatal and well-baby care. The behavioral health follow-up program is for members age 6 and older who were hospitalized for treatment of select mental illness diagnoses and encourages follow-up visits after discharge from an acute behavioral or mental health inpatient setting or emergency department. Well-adult preventative/PCP visits included annual well visits, ambulatory or preventative care visits and health risk assessments.

Many plans offered more than one program in a single category. For example, several plans offered three well-child visit programs: one for infants to age 15 months, one for children aged 3-6 years, and one for adolescents. One plan offered both a maternity program and a postpartum program, while another plan offered three types of diabetes programs: eye exam, HbA1c control, and blood pressure control.

The types of Healthy Behavior programs increased from DY9-DY14, as did the number of plans offering optional programs. For example, in DY9 only four optional programs were offered (preventive well-child and adolescent visits, pregnancy/maternity/postpartum programs, well-adult preventive/PCP visits, and cancer screenings), whereas from DY11-DY14, 10 or more optional programs were offered.

Research Question 3B

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

Results

The MMA plans offered a variety of incentives to enrollees participating in Healthy Behaviors programs. Incentives included retail gift cards (CVS, Old Navy, Publix, Subway, Toys R Us/Babies R Us, or Walmart), Visa gift cards, points or rewards associated with monetary values (DY9-DY12), backpacks, clothing apparel (t-shirts and hats), health and fitness items, and items for infants and toddlers. Health and fitness items included such things as gym memberships, fitness trackers, scales, water bottles, cookbooks, and tape and BMI measures. Items for infants and toddlers included teething rattles, nursing covers, first-aid kits, digital or bath thermometers, feeding sets, dental care sets, childproofing kits, shower/bath accessories, toys, books, diaper bags, diapers, car seats, playpens and strollers. The incentives offered remained consistent from DY9-DY14, with only slight variations each year. The most noticeable difference was that plans no longer offered the gym membership or points, which converted to monetary values, beginning in DY13. Across all programs from DY9-DY14, gift cards or points were the most common forms of incentive offered by the plans for participating in the three mandated programs, as well as the additional optional programs. From DY9-DY14, reward or incentive values ranged from $1 (monetary points/water bottles) to $478 (triple stroller).

Research Question 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?

Data and Methods

To determine the number of enrollees in each Healthy Behaviors program from DY9-DY12, evaluators captured enrollee participation and completion rates from the Healthy Behaviors summary reports for each plan. Results are presented separately by DY given the inability to make comparisons across years with differing data and counts.

Results

In DY9, given that the summary reports for each plan reported cumulative, aggregate data for each quarter (rather than individual-level data), the information reported was obtained from the last reported quarter for each plan (Quarter 3). For DY9, the total number of enrollments in any Healthy Behaviors Program among all plans was 310,728. The total number of completions among all plans was 31,834. Of the core programs required by all plans, the medically directed weight loss program reported the highest number of current enrollees (22,295), as well as the highest number of enrollees who completed the program (1,709). Of all programs offered (core or optional), the program with the highest number of enrollees was the children's nutrition incentive program (142,758), followed by well-child visit programs (136,636).

For most plans in DY10, Quarter 4 summary reports were used with the exception of Integral Quality Care, South Florida Community Care Network and Preferred Medical Plan, Inc., wherein Quarter 3 reports were used due to missing/incomplete Quarter 4 summary reports. Of the core programs required by all plans, the medically directed weight loss program reported the highest number of current enrollees (25,105), as well as the highest number of enrollees who completed the program (2,170). Of all programs offered (core or optional), the program with the highest number of enrollees was the well-child visits program (134,735). The program with the second highest number of enrollees was the children's nutrition incentive program (134,162). The well-child visits program has the highest number of enrollees who completed the program (6,434) followed by the children's nutrition incentive program (4,250) and the medically directed weight loss program (2,170).

For DY11, the summary reports for each plan reported program participation data for each quarter (rather than individual-level data), so the information reported was obtained from a cumulative total of all four quarterly reports. An important limitation of this approach is that there will be duplication in counts as enrollees are captured multiple times if they participate across quarters. For most plans, all summary reports were used with the exception of Children's Medical Services (CMS), where Quarter 4 reports were missing. The total number of enrollments in any Healthy Behaviors Program among all plans was 4,561,975. The total number of completions among all plans was 215,841. Of the core programs required of all plans, 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). Of all programs offered (core or optional), the program with the highest number of enrollees was the dental program (1,867,974). The program with the second highest number of enrollees was the well-child visit program (1,325,921). The well-child visits program had the

highest number of enrollees who completed the program (124,608), followed by the dental program (58,273) out of all healthy behavior programs.

For DY12, the summary reports for each plan reported program participation data for each quarter (rather than individual-level data), so the information reported was obtained from a cumulative total of all four quarterly reports. As with DY11, an important limitation of this approach is that there will be duplication in counts as enrollees are captured multiple times if they participate across quarters. The total number of enrollments in any Healthy Behaviors Program among all plans was 2,055,553. The total number of completions among all plans was 45,328. Of the core programs required of all plans, the medically directed weight loss program reported the highest number of current enrollees (1,026) in DY12, as well as the highest number of enrollees who completed the program (124). Of all programs offered (core or optional) in DY12, the program with the highest number of enrollees was the MMA Backpack Project (523,085) followed by the well-child visit program (486,511). The program with the third highest number of enrollees was the dental program (485,688). Out of all Healthy Behavior programs, the well-child visits program had the highest number of enrollees who completed the program (36,126), followed by pregnancy/ maternity programs (3,209).

For DY13 and DY14, evaluators used Healthy Behaviors individual-level data for each plan to capture enrollments beginning in Quarter 3 of DY13. The total number of enrollments in any Healthy Behaviors program among all plans in Quarters 3 and 4 of DY13 was 28,009. The total number of enrollments in Quarters 1-4 of DY14 was 70,220. Of the core programs required by all plans, the medically directed weight loss program reported the highest number of enrollments in Quarters 3-4 of DY13 (320), and the smoking cessation program reported the highest number in DY14 (2,461). Of all programs offered (core or optional), the program with the highest number of enrollments in Quarters 3-4 of DY13 was preventive adult care visits (13,000) and well-child/adolescent visits in DY14 (33,571). The program with the second highest number of enrollments for DY13 was the well-child visit program (8,257) and for DY14 was the pregnancy/maternity program (12,197). The program with the third highest number of enrollments for DY13 and DY14 was the preventive adult care visits (4,282 and 12,078, respectively).

Because analyses in DY13 and DY14 were based on individual-level data rather than data from plan summary reports used in previous years, the evaluation team does not recommend comparing enrollment data with that of previous reports.

Research Question 3D

How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees?

Data and Methods

For DY9-DY12, Healthy Behavior summary reports for each plan were used to capture program participation and completion rates by gender and age. Because the summary reports did not include race/ethnicity, this information is not presented until individual-level data became available beginning in Q3 of DY13. However, the individual-level data did not include health status of enrollees, and thus this information is not presented.

Results

Participation by gender: Among the core programs, females were slightly more likely than males to be currently enrolled in and to have completed the programs. For example, from DY9-DY12, among all plans reported each year, about 65 percent of enrollees in the medically approved smoking cessation program were females and 35 percent were males. In DY13, about 71 percent of enrollees in the medically approved smoking cessation program were females and about 29 percent were males. In DY14, about 81 percent of all enrollees who completed the smoking cessation program were female.

Among optional programs for DY9 and DY10, the pregnancy/maternity and Baby Blocks programs consisted of 100 percent females. Among optional programs for DY11 and DY12, the pregnancy/maternity, Baby Blocks, breast cancer screening, and cervical cancer screening (and teen pregnancy prevention in DY12) programs consisted of almost 100 percent females. Among optional programs for DY13 and DY14, the pregnancy/maternity, Baby Blocks, breast cancer screening, cervical cancer screening, and chlamydia screening programs consisted of almost 100 percent females. For the other programs, current and completed enrollment rates between males and females were relatively equally distributed, with some exceptions (i.e., diabetes screening program in DY11 and DY12 had slightly higher rates of females).

Participation by age: Age distributions differed depending on the program type. For example, among the core programs from DY9-DY12, for example, the smoking cessation program consisted largely of current enrollees and completed program enrollees ages 41-60, followed by ages 21-40, over age 60, and ages 0-20. The smoking cessation program consisted largely of DY13 and DY14 enrollees ages 21-40 and ages 41-60, followed by those over age 60, and then ages 0-20.

Among optional programs for DY9, the pregnancy/maternity and baby blocks programs primarily consisted of those who were ages 21-40 (~90 percent of those currently enrolled and completed). For the nutrition and well-child visit programs, 100 percent of current enrollees and those who completed were ages 0-20. Among optional programs for DY10, the pregnancy/maternity and Baby Blocks programs primarily consisted of those ages 21-40. For the nutrition program, well-child visit program, and behavioral health follow-up program, 100 percent of current enrollees and those who completed were ages 0-20. For the comprehensive diabetes care program, current enrollees and enrollees who completed the program were largely ages 41-60 and over age 60, followed by ages 21-40 and ages 0-20. Among optional programs for DY11, the pregnancy/maternity and Baby Blocks programs primarily consisted of those ages 21-40. The following programs consisted mostly of those ages 0-20: well-child visits, child/adolescent immunizations, dental, behavioral health follow-up, health risk assessment, and MMA backpack. The following programs consisted mostly of those ages 41-60: diabetes, breast cancer screening, and cervical cancer screening. Among optional programs for DY12, the pregnancy/maternity and Baby Blocks programs primarily consisted of those ages 21-40. The following programs consisted mostly of those ages 0-20: well-child visits, child/adolescent immunizations, dental, behavioral health follow-up, lead screening, well-adult, MMA backpack, and teen pregnancy prevention programs. The following programs consisted mostly of those ages 41-60: vision, diabetes screening, breast cancer screening, and cervical cancer screening. Among optional programs for DY13/14, the following programs consisted mostly of those ages 0-20 in DY13 and DY14: well-child visits and lead screening. The pregnancy/maternity and Baby Blocks programs primarily consisted of those ages 21-40. In addition, the following programs were majority ages 21-40 enrollees: cervical cancer screening, chlamydia screening,

and adult preventive care. The following programs consisted mostly of those enrollees ages 41-60: diabetes care and breast cancer screening.

Participation by race/ethnicity: This data became available beginning in Q3 of DY13 when individual-level data was provided. Enrollee race/ethnicity distributions differed depending on the program type. For example, among the core programs in DY13 and DY14, White enrollees were most likely to be enrolled in the smoking cessation (45.2 percent and 51.3 percent, respectively) and alcohol or substance abuse recovery program (43 percent and 56.3 percent, respectively). Race/ethnicity was more evenly distributed in DY13 and DY14 for White, Black, and Hispanic enrollees for the weight loss program.

Among optional programs, race/ethnicity varied by program but was relatively equally distributed, with a few exceptions such as preventive adult care, which reported about 10-15 percent more White enrollees in DY13 and DY14 (36.2 percent and 36.6 percent, respectively) than Black enrollees, Hispanic enrollees, and enrollees of another race.

Research Question 3E

What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating?

Data and Methods

Data on the Healthy Behaviors programs from DY9-DY12 were aggregated by plan and not available at the level of the individual beneficiary. Therefore, estimates of participation in the Healthy Behaviors programs by specific enrollee could not be determined during those years. In addition, program participants could not be linked to enrollment, encounter and claims data to determine their service utilization. Individual-level data became available beginning in Q3 of DY13 so results are presented thereafter.

Results

For DY13/DY14, the evaluation team merged (based on enrollee ID) Healthy Behaviors individual-level data from each MMA plan with encounter data for SFY 2018-19 (Quarter 3 and 4 only) and SFY 2019-20 in order to compare Medicaid program service utilization for enrollees who participated in a Healthy Behaviors program to enrollees who did not participate in a Healthy Behaviors program. An enrollee was defined as a Healthy Behaviors participant if they enrolled in and/or completed a plan-sponsored Healthy Behaviors program during SFY 2018-19 or SFY 2019-20. Enrollees were defined as a Healthy Behaviors non-participant if they were enrolled in a MMA plan offering Healthy Behaviors programs during SFY 2018-19 or SFY 2019-20 but were not enrolled in a plan-sponsored Healthy Behaviors program. In order to calculate service utilization, encounters were obtained for all Medicaid enrollees in a qualifying eligibility category who were enrolled for at least one month during SFY 2018-19 (Quarter 3 and 4 only) and/or SFY 2019-20. For analysis, service utilization was placed into the following categories for the study period: inpatient visits, outpatient visits, ED visits and professional (physician) visits. Professional visits were further broken out by physician and specialist visits. All utilization is reported on a per-member per-month (PMPM) basis, meaning that it shows the average number of visits that an enrollee had in a month. Because services were calculated on a PMPM basis, this analysis used a person-month observation (one observation per person per month). Thus, for the DY13 analysis, an individual could provide up to 6 observations to the analysis

(representing monthly observations across Quarters 3 and 4 of SFY 2018-19). Using the same framework in DY14, an individual could contribute up to 12 observations (representing monthly observations across SFY 2019-20). Unadjusted and adjusted analyses were conducted, with adjusted analyses presented in Table 11 below:

Table 11. Adjusted Service PMPM Utilization Comparing Enrollees Participating in a Healthy Behaviors Program with Enrollees Not Participating in a Healthy Behaviors Program for DY13 and DY14

Demonstration Year (DY)	Healthy Behaviors Program (Non-Participating Enrollees)		Healthy Behaviors Program (Participating Enrollees)	
DY13: Q3-Q4	**Member-Months****	**18,262,238******	**Member-Months****	**113,945******
Service Type	**Mean**	**Median**	**Mean**	**Median**
Inpatient	0.007	0.002	0.008	0.002
Outpatient	0.053	0.038	0.077	0.055
ED	0.068	0.058	0.109	0.093
Professional	0.517	0.423	1.122	0.947
Physician	0.370	0.303	0.901	0.757
Specialist	0.085	0.065	0.060	0.045
DY14:	**Member-Months*****	**35,321,418******	**Member—Months*****	**576,623******
Service Type	**Mean**	**Median**	**Mean**	**Median**
Inpatient	0.008	0.006	0.014	0.010
Outpatient	0.056	0.036	0.093	0.062
ED	0.071	0.058	0.108	0.090
Professional	1.295	0.843	1.891	1.274
Physician	0.334	0.318	0.541	0.514
Specialist	0.961	0.518	1.364	0.783

*Analysis limited to Quarters 3 and 4 of SFY2018-19 as individual level data on Healthy Behaviors program participation was not made available until Quarter 3 of SFY2018-19.
** Represents 3,394,045 unique non-participant enrollees and 21,257 unique participant enrollees for a total of 3,415,302 unique enrollees who contributed to these member–months observations.
***Represents 3,665,496 unique non-participant enrollees and 55,241 unique participant enrollees for a total of 3,720,737 unique enrollees who contributed to these member months observations.
****Note that the first row for each DY shows member-months for that DY while the other table entries show the number of services per member per month for that DY. This difference in units accounts for the differences in magnitude across these rows.

In conclusion, mean PMPM service utilization was higher among enrollees participating in Healthy Behaviors programs versus enrollees not participating. This result is likely due to two factors: 1) selection bias: Differences in the health status of enrollees who participated in Healthy Behaviors programs compared to enrollees who did not participate are likely to lead to higher utilization during the initial period observation; and 2) lack of follow-up time: Given the chronic nature of the medical conditions addressed by several of the Healthy Behaviors programs, changes in per-member per-month (PMPM) service utilization will not be observable until additional individual-level data is available for analysis in the future.

Low Income Pool (RQs 4A-4F)

Project 3. Component 4 - Low Income Pool

Data and Methods

The Low Income Pool (LIP) program "provides government support for safety net providers for the costs of uncompensated charity care (UCC) for low-income individuals who are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, "bad debt", or Medicaid and CHIP shortfall." (Department of Health and Human Services Special Terms and Conditions 2017, p.27).

The units of analysis for the evaluation reports were the hospital, the FQHC, and the medical school physician practice. The Agency provided data on the LIP payments, the facilities that received LIP funding, charity care, and milestone data for all DYs. These data were used to report on 1) LIP funding and access to care and 2) the provision of health care services to uncompensated charity care patients in hospitals, FQHCs, and medical school physician practices in DYs 10 through DY14. The evaluation team conducted an independent review and analysis of data from the DY10 through DY14 LIP Annual Milestone Statistics and Findings Reports and FHURS. It is important to note that during the years of the evaluation the total amount of LIP dollars available, as well as the LIP payments to providers, the care recipients, services and facilities, changed from year to year. For example, care recipients in DY9 and DY10 included those with Medicaid, uninsured, and underinsured, while the care recipients in DY11 through DY14 were those who received uncompensated charity care. Moreover, in DYs 11 and 12, hospital providers were divided into four subgroups or tiers whereas in DYs 13 and 14, there were five tiers.

The LIP Annual Milestone Statistics and Findings Report includes data on the number of individuals served and the types and volume of services provided in LIP-funded hospitals. LIP-funded hospitals provide an unduplicated count of uninsured/underinsured individuals that received inpatient services, outpatient services, and a total unduplicated count of individuals that received inpatient and outpatient services. The total unduplicated count means that if an uninsured individual received both inpatient and outpatient services at a given hospital, the total count would report one individual served.

Available data was also provided for LIP-funded FQHCs and medical school physician practices to determine the number of individuals served, the types of services provided, and the number of encounters for the non-hospital providers receiving LIP supplemental payments that had submitted milestone data.

Results

Research Question 4A (sunset after DY10)

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?

In DY10, the 134 hospitals that received LIP supplemental payments reported providing

inpatient and outpatient services to approximately 4.7 million Medicaid, uninsured, and underinsured individuals. This is an 8 percent increase (from 4.3M to 4.7M) from DY9.

Research Question 4B (sunset after DY10)

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

In DY10 there were 15.7 million service encounters provided across six service categories (discharges, inpatient days, emergency department visits, outpatient visits, affiliated encounters, and filled prescriptions). Total encounters in DY10 showed a 12 percent increase from DY9 (approximately 13.7 million).

Both the DY9 and DY10 MMA evaluations documented increases in the total number of individuals served and in total service encounters (across six service categories) in hospitals that received LIP funding.

Research Question 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[25] of LIP funding?

- From DY11 to DY14 an average of 2.55 million unduplicated uncompensated charity care individuals received inpatient and outpatient services from hospitals that received LIP funding and reported milestone data.
- DY11: For inpatient and outpatient services, hospitals in Tier 2 served the fewest number of uncompensated charity care individuals (approximately 44,800), and hospitals in Tier 4 served the most UCC individuals (approximately 1.4 million).
- DY12: For inpatient and outpatient services, hospitals in Tier 1 served the fewest number of uncompensated charity care individuals (approximately 250,000), and hospitals in Tier 4 served the most UCC individuals (approximately 1.1 million).
- DY13: For inpatient and outpatient services, hospitals in Tier 4 served the fewest number of uncompensated charity care individuals (approximately 23,000), and hospitals in Tier 5 served the most UCC individuals (approximately 1.2 million).
- DY14: For inpatient and outpatient services, hospitals in Tier 4 served the fewest number of uncompensated charity care individuals (approximately 111,000), and

[25] As stated in the STCs that govern the demonstration years evaluated in this report and that were approved in March 2019, "Providers may be categorized in up to four groups: hospitals, medical school physician practices, FQHCs/RHCs, and Community Behavioral Health Providers. Each group may be divided into up to five tiered subgroups, any of which may be based on ownership, UC Ratio, or ownership and UC Ratio" (Department of Health and Human Services Special Terms and Conditions 2019, p. 32). Tiers for DYs 13 and 14 were as follows: Tier 1: Private Hospitals with a Uncompensated Care (UC) ratio greater than or equal to 17 percent; Tier 2: All Public Hospitals, All Children's Hospitals, and Statutory Teaching Hospitals with UC ratio greater than or equal to 17 percent; Tier 3: Statutory Teaching Hospitals with UC ratio less than 17 percent; Tier 4: Regional Perinatal Intensive Care Centers (non-Public and non-Statutory Teaching); Tier 5: Private Hospitals with a UC ratio less than 17 percent (Florida Agency for Health Care Administration, 2020).

hospitals in Tier 5 served the most UCC individuals (approximately 919,000)[26].

Research Question 4D

What types of services are being provided to uncompensated charity care recipients receiving care in LIP-funded hospitals?

Between DY11 and DY14, over 90 percent of hospitals provided diagnostic X-ray and laboratory services and speech, physical, and occupational therapy services and fewer than 10 percent of hospitals provided durable medical equipment, prosthetic and orthotic devices, or nursing home care.

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?

From DY11 to DY14, between 7.5 million and 8.0 million encounters were provided across six service categories (discharges, inpatient days, emergency department visits, outpatient visits, affiliated encounters, and filled prescriptions) for uncompensated charity care patients.

The services with the most encounters over this period were:

- Emergency department visits: 2.5 million total encounters.
- Inpatient days: 2.0 million total encounters.
- Outpatient visits: 1.7 million total encounters.

Research Question 4F

What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in Federally Qualified Health Centers (FQHCs), and Medical School Physician Practices (MSPP)?

DY12- DY14

FQHCs

- From DY12 to DY14 FQHCs reported serving an average of 547,000 uncompensated charity care patients and provided an average of 4.1 million service encounters for uncompensated charity care patients across ten service categories.

MSPPs

- In DY12, five medical school physician practices served approximately 241,000 uncompensated charity care patients and provided approximately 513,000 total service encounters for uncompensated charity care patients across ten service categories.
- Milestone data was not available for medical school physician practices in DY13.

[26] Hospitals that provided varying proportions of UCC were grouped into tiers and received LIP payments based on the tier group. Given that UC ratios could vary from year to year, hospitals could be in a different tier group each DY or not at all. Therefore, tiers are not comparable within or across DYs (Florida Agency for Health Care Administration, 2019).

- In DY14, the total amount of LIP funding paid to six medical school physician practices reported serving approximately 365,500 uncompensated charity care patients and providing 488,000 encounters.

Prepaid Dental Services (RQs 8A-8J)

Pre-paid Dental Services Utilization

Florida's Prepaid Dental Health Program (PDHP) was implemented in December 2018 through February 2019, partway through DY13. Consequently, the evaluation results for the PDHP program reflect the program's initial effects following its implementation in mid-DY13 through DY14. Longer-term impacts of the PDHP program will be forthcoming in DY15 and subsequent years of the evaluation.

Research Question 8A

How does enrollee utilization of dental services vary by age, gender, race/ethnicity, and geographic area?

Data and Methods

Dental encounter data from the MMA period were used to estimate two-part dental utilization models as described in the Methodology chapter. Predictions from these two-part dental utilization models were made for different values of age, gender, race/ethnicity, and geographic areas and the differences in predictions across age, gender, race/ethnicity, and geographic areas were tested statistically to produce the comparisons discussed below.

Results

Utilization of most dental services, measured as services per-member per-month (PMPM), increased gradually from birth before reaching a peak at age 6-9 years, and then declined gradually for older age groups. With respect to gender, statistical model results indicated that after controlling for age, race-ethnicity, geographical region, the presence of PDHP, and total acuity score, females had higher rates of dental utilization PMPM than males. Moving to differences in utilization across race and ethnicity, Hispanics and Asians had the highest dental utilization rates. Finally, with respect to geographic variation, South Florida (Regions 8-11) had the highest dental utilization rates in the state, while the Panhandle (Region 1) and North Central Florida (Region 3) had the lowest.

Research Question 8B

What changes in dental service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?

Data and Methods

Dental encounter data were used to measure dental service utilization categorized by Common Dental Procedure (CDT) codes. Both descriptive statistics and two-part utilization models (see the Methodology chapter for more details) were used to produce the results presented below.

Results

The impact of the PDHP depends on how utilization is measured. There was no detectable change in total dental encounters PMPM (i.e., dental visits) following the PDHP implementation. However, there is evidence that more dental services were provided during each visit following the implementation of PDHP. In particular, there was a statistically significant 3.7 percent increase in total dental services following PDHP implementation.

With respect to specific types of dental visits, preventive and other dental visit rates PMPM increased by 4.4 percent following PDHP implementation, with the largest increases occurring for younger children and adults.

Research Question 8C

What changes in quality of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?

Data and Methods

This question is addressed using dental performance measures submitted by the participating plans. CY 2019 was the first year in which performance measures were collected for the Statewide Medicaid Prepaid Dental Health Program. As this is the first year of the Dental Health program, there are no comparator years. Changes in quality will be assessed in the future by comparing adjusted rates across years for each plan and for the PDHP overall.

Results

Dental plans were assessed across a total of 11 measures for child and adult enrollees (

Table 12). Two measures – Annual Dental Visits and Oral Evaluations – pertained to all program enrollees. Six measures were specific to child enrollees and three were specific to adult enrollees.

For child-specific services in CY 2019, the enrollee use rate for annual dental visits was 50.92 percent and the adjusted use rate for oral evaluation services was 39.72 percent. For adult-specific services, the adjusted event rate for ambulatory care for dental caries not requiring inpatient services for the PDHP program overall was 6.72 per 100,000 member months. Liberty Dental Plan had the lowest rate among the plans on this measure at 2.28 per 100,000 member months.

Table 12. Adjusted Dental Event Rates across All Dental Plans in the Statewide Medicaid PDHP

Child-Specific Performance Measures	DentaQuest	Liberty Dental Plan	Managed Care of North America	Adjusted Overall Event Rate
Annual Dental Visits [%]	51.94	49.44	49.47	50.92
Oral Evaluation [%]	40.35	38.70	38.81	39.72
Topical Fluoride for Children at Elevated Caries Risk [%]	32.58	29.10	36.37	32.72
Ambulatory-care-sensitive ED Visits for Dental Caries in Children [per 100,000 member months])	3.27**	0.32**	1.19	2.03
Follow-up after ED Visits for Dental Caries in Children (7-day Follow-up) [per 100,000 member months]	17.95**	*	34.00	34.00
Follow-up after ED Visits for Dental Caries in Children (30-day follow-up) [%]	26.67**	*	58.00	58.00
Dental Sealants for Children at Elevated Caries Risk [%]	29.53	36.53	39.27	31.11
Adult-Specific Performance Measures				
Ambulatory-care-sensitive ED Visits for Dental Caries in Adults [per 100,000 member months]	8.05**	2.28**	8.02	6.72

* The plan only had ED visit data for part of the year and had a denominator less than 30 for these measures, thus not having reportable rates

** These rates are biased due to the plan having ED visit data for only part of the year. For the measure per member months, only member months for that part of the year are included in the calculations.

Research Question 8D

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

Data and Methods

The accessibility of PDHP services was assessed using selected items related to accessibility from the annual CAHPS surveys. Each plan administered the CAHPS survey to the parents/guardians of child patients enrolled in the plan, and the reported satisfaction measure is based on the percentage of respondents who responded positively to the survey item in question.

Results

Three health plans offered prepaid dental services including: DentaQuest, the Liberty Dental Plan and Managed Care of North America (MCNA) Dental (see Table 13). In terms of satisfaction with access to dental services, results varied across both CAHPS survey items and PDHP dental plan. For example, when parents were asked about their child seeing a dentist, over 90 percent of respondents for DentaQuest and Liberty Dental were satisfied while only 54 percent of MCNA respondents were satisfied. Measures such as clinic wait times of 15 minutes or more, which can impede access to care, were experienced by a minority of respondents (i.e., less than 37 percent across all three plans). There is broad variation across the plans for some access measures. For example, 86 percent of respondents with DentaQuest reported seeing a provider if their child had a dental emergency, compared to 50 percent of respondents from Liberty Dental, and 39 percent from MCNA. Similarly, 71 percent of DentaQuest respondents reported seeing a specialist when needed compared to 49 percent and 41 percent for Liberty Dental and MCNA, respectively. Other areas of concern include the ease of finding a dentist. The calculated satisfaction across the plans was 57-59 percent, suggesting that roughly 40 percent of respondents were not satisfied with the ease of finding a dental provider for their child.

Table 13. Respondent Satisfaction with Dental Plans, CAHPS Accessibility Measures

	Respondent Satisfaction with Dental Plans		
	DentaQuest	**Liberty Dental**	**MCNA**
Does the child receive dental care∇	100%	92%	54%
Does the child have a regular dentist∇	97%	97%	88%
Has the child seen regular dentist recently	97%	96%	94%
Dental appointments available when needed∇	82%	55%	80%
Able to see dentist during emergency♣	86%	50%	39%
Able to see specialist when needed	71%	49%	41%
Spend more than 15 minutes in waiting room	28%	37%	28%

	Respondent Satisfaction with Dental Plans		
	DentaQuest	**Liberty Dental**	**MCNA**
An explanation provided for the delay	37%	22%	28%
Access information on care from sources	75%	61%	74%
Use available information for new dentist$^{\nabla}$	17%	19%	20%
Available info helps find dentist child is happy with$^{\clubsuit}$	82%	65%	87%
Ease of finding a dentist$^{\Psi}$	59%	57%	57%
Getting information from customer service$^{\nabla}$	18%	18%	24%

$^{\Psi}$Response options ranged from 0 to 10, where 0 was the worst dental care possible and 10 is the best dental care possible. Satisfaction references the percent of respondents who selected 8, 9 or 10.
$^{\clubsuit}$ Response options ranged from 1 to 4, *definitely no* to *definitely yes*. Satisfaction references the percent of respondents who selected 3 and 4 (somewhat yes, and definitely yes).
$^{\nabla}$ Response options were binary Yes/No. Satisfaction references the percent of respondents who selected Yes.

Research Question 8E

What barriers do enrollees encounter when accessing dental services?

Data and Methods

The evaluation team employed data from the Medicaid Complaints Operations Center taken by telephone or through their website. The reported data accounted for CY2019/CY2020.

Results

Many of the complaints (66.2% of respondents) centered on finding a dental provider. About 17 percent of respondents contacted the operations center to report not receiving a specific service from their provider, and 10.6 percent noted not being able to see a particular provider.

Research Question 8F

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

Data and Methods

The evaluation team used encounter and eligibility data from DY14 in combination with procedure codes provided by the dental health plans to identify how many enrollees utilized expanded dental benefits and which expanded benefits were most commonly used.

Enrollees were counted as having used an expanded benefit provided by the dental health plans if they were: (1) 21 years of age or older[27] and (2) had at least one encounter with a procedure code contained in the Provider Expanded Benefits List (Dental) for SFY 2019-20. Frequencies of expanded benefits most commonly used were obtained by counting encounters as an expanded benefit based on a unique combination of enrollee ID, encounter date of service and procedure code.

Results

In DY14, of the 2,858,631 enrollees who used any health service, 85,021 (2.97%) utilized an expanded benefit provided by the dental health plans. Dental health plans delivered a total of 252,031 expanded benefits during SFY 2019-20. The most commonly used categories of dental expanded benefits (See Table 14) were Preventive and Restorative procedures, each representing 54 percent and 36 percent of the total expanded benefits delivered by health plans in SFY 2019-20. The dental expanded benefits procedures most commonly used during SFY 2019-20 include Dental Prophylaxis Adult (Preventive) followed by Oral Hygiene Instruction (Preventive) and Posterior 2 Surface Resin-based Composite (Restorative).

Table 14. MMA Expanded Benefits Provided by Dental Plans by Procedure Category – SFY 2019-20

Expanded Benefit Category	Count	Percent
Preventive	135,997	54%
Restorative	90,167	36%
Periodontics	17,731	7%
Adjunctive General Services	6,647	3%
Diagnostic	1,225	<1%
Practice Acclimation for Individuals with Intellectual Disabilities	178	<1%
Diabetic Testing	70	<1%
Oral and Maxillofacial Surgery	36	<1%
Total EB Encounters (Dental)	**252,051**	

*Descriptions in table provided by the Agency.

In the first year of implementation of the statewide Medicaid PDHP, 85,021 enrollees used 252,031 expanded benefits provided by the health plans, of which the most commonly used included preventive (54%) and restorative procedures (36%). Additional demonstration years of the PDHP are required to analyze trends in the use of expanded benefits provided by the dental health plans.

Research Question 8G

(a) *How does enrollee utilization of dental services impact dental-related hospital events (e.g., emergency department, inpatient hospitalization)?* ***(b)*** *How does utilization of expanded benefits*

[27] Expanded benefits for dental services limited to adults 21 years of age or older. https://www.flmedicaidmanagedcare.com/dental/dentalplaninformation.

offered by the dental health plans impact dental-related hospital events?

Data and Methods

Dental encounter data were used to measure dental service utilization categorized by Common Dental Procedure (CDT) codes. Expanded benefits were identified using the CDT codes corresponding to each expanded benefit. Hospital and emergency department utilization related to dental events were identified using medical diagnostic codes related to dental diseases for both principal and secondary diagnoses. Both descriptive statistics and two-part utilization models (see the Methodology chapter for more details) were used to produce the results presented below.

Results

Some evidence exists from the first year of PDHP operation that PDHP implementation was associated with an 11.3 percent reduction in dental-related ED visits. While not statistically significant at conventional levels, these results bear scrutiny since they are unlikely to have occurred via random chance.

Because dental-related hospital stays were exceedingly rare in Florida both before and after the PDHP implementation[28], it is not possible to measure any PDHP impact on dental-related hospital stays. Finally, no evidence was found that dental utilization (either total or expanded benefit encounters) influenced dental-related ED visits either before or after PDHP implementation.

Research Question 8H

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

Data and Methods

To determine changes in per-enrollee costs for dental services with the implementation of the PDHP, the evaluation team used all encounter or analogous HMO capitation payment amounts for all Medicaid enrollees from SFY 2017-18 through SFY 2019-20.

Individual enrollee encounter records were summarized to show dental health service expenditures for each enrollee in each month of their MMA enrollment[29]. Average per-member per-month (PMPM) expenditures were calculated by fiscal year (SFY 2017-18 and SFY 2019-20) as well as by pre-PDHP (SFY 2017-18) and PHDP (SFY 2019-20) periods. A multivariate interrupted time-series analysis was conducted to better understand the pattern of changes in expenditures, as well as to control for any differences in the distribution of age, race, gender, or risk scores between the pre-PHDP and PHDP enrollees. As with the univariate analysis, the multivariate analysis examined whether these trends significantly differed between the pre-PHDP and PHDP time periods for all dental health plans.

[28] Analyses not reported here indicated that dental-related hospital stays averaged one per 10,000 enrollee-years or less in both the pre-PDHP and PDHP periods.
[29] Data summarized in such a way are referred to as organized by "member-months" with expenditures measured "per-member per-month", abbreviated PMPM. Such organization ensures the comparability of cost, encounter, and utilization measures across enrollees with different lengths of MMA enrollment.

Results

The univariate and multivariate results are shown in Table 15. In the univariate (unadjusted) model, mean PMPM dental health expenditures decreased from $152 in the pre-PDHP period to $95 in the PDHP period. In the multivariate model, mean adjusted PMPM expenditures decreased from $157 to $143 after the statewide Medicaid PDHP implementation.

Table 15. Per-Member Per-Month Dental Expenditures Before and After PHDP Implementation among Enrollees with Any Dental Expenditure

Model	Pre-PDHP (SFY 2017-18)		PDHP (SFY 2019-20)	
	Mean	Median	Mean	Median
Univariate	$152	$95	$139	$89
Multivariate	$157	$168	$143	$154

In the first year of implementation of the Statewide Medicaid PDHP, dental health service expenditures decreased between the pre-PHDP (SFY 2017-18) and PHDP (SFY 2019-20) time periods. Additional years of data are needed to determine the long-term association between the PDHP and dental health costs as well as to identify trends in expenditures by SFY.

Research Question 8I

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

Data and Methods

CY 2019/CY 2020 was the first year assessing performance measures for the Statewide Medicaid PDHP. The assessment of experiences and satisfaction was completed using the annual CAHPS surveys. The reported data was based on composite questions.

Results

Approximately 81 percent of respondents reported that their dental health plan covered all expected services, while 82 percent reported covering all needed services. The overall rating of dental health plans showed a net positive, with approximately 74 percent of respondents rating their dental health plan as an eight or higher on a scale of 1 through 10 (with 10 being the best dental plan possible). Similarly, 81 percent had a favorable rating of their specific provider/dentist, rating them an eight or higher (with ten the best dental provider possible). Lastly, 75 percent of respondents rated their dental health care as an eight or higher (with '10' as the best dental care possible).

Research Question 8J

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

Data and Methods

To determine enrollees' experiences and satisfaction with the expanded benefits offered by their dental health plans, the UF Survey Research Center conducted telephone-based surveys of 291 MMA enrollees who received expanded dental services in DY13 and DY14. Survey participants included enrollees in Liberty (n=100), MCNA (n=100) and DentaQuest (n=91) dental health plans.

Enrollees were asked 1) "How satisfied are you with the types of expanded benefits offered by your dental plan?"; 2) "How satisfied were you with the information and customer service provided to you by your dental plan on the expanded benefits offered?"; 3) "How easy was it to access the expanded benefits offered by your dental plan?"; and 4) "How satisfied were you with expanded dental benefits that you used?"

For survey questions 1, 2, and 4, enrollees were asked to rate their satisfaction with expanded benefits offered, information and customer service provided, and expanded benefits used on a global, 4-point scale ranging from "1-Very satisfied" to "4-Very dissatisfied." For Question 3 concerning ease of access to services, participants were asked to rate their experiences on a global, 4-point scale ranging from "1-Very easy" to "4-Very difficult."

Results

Satisfaction with Types of Expanded Benefits Offered by Dental Health Plan

- Of all the enrollees interviewed (n=291), 27 percent reported they were unaware that their health plan offered expanded benefits (n=80), while 10 individuals refused to respond.
- Of the enrollees who responded that they were aware of the expanded benefits, most (79%, n=158) reported being satisfied (i.e. responding "1-Very satisfied" or "2-Satisfied") with the types of expanded benefits offered.
- The remaining 43 enrollees who responded reported being dissatisfied (i.e. responding "3-Dissatisfied" or "4-Very Dissatisfied") with the types of expanded benefits offered.
- Among the enrollees in the three plans who responded, DentaQuest enrollees reported the highest levels of satisfaction with the types of expanded benefits offered by their dental health plan.

Satisfaction with Customer Service and Information Provided

- Of the enrollees who responded that they were aware of the expanded benefits offered by their dental health plan (n=198), a majority (79%; n=157) reported being satisfied with the information and customer service provided by their dental health plan on the expanded benefits offered.
- Only 21 percent of enrollees (n=41) reported being dissatisfied with the customer service and information provided by their dental health plan.
- Among enrollees in the three plans who responded, DentaQuest and Liberty enrollees both reported the highest levels of satisfaction with the customer service and

information provided by their dental health plan.

Ease of Access to Expanded Benefits Offered by Health Plan

- Of enrollees who responded that they were aware of the expanded benefits, (n=197), a minority (42%; n=83) reported using any of the expanded benefits offered by the dental health plan.
- Of the enrollees who responded that they had attempted to use expanded benefits, (n=70), a vast majority (80%; n=56) reported the benefits were easy to access through their dental health plan (i.e. responding "1-Very easy" or "2-Easy").
- Among the enrollees in the three plans who responded, DentaQuest enrollees reported the highest levels of ease in accessing benefits through their dental health plan.

Satisfaction with Expanded Health Benefits Used

- Of the enrollees who responded that they used the expanded benefits offered by their dental health plan (n=70), over three-quarters (76%, n=53) reported being satisfied with their use of the expanded health benefits offered by their dental health plan.
- Among the enrollees in the three plans who responded, MCNA enrollees reported the highest levels of satisfaction with the expanded health benefits they used.

Retroactive Enrollment Eligibility (RQs 9A-9H)

Project 6. Component 9- Retroactive Enrollment Eligibility

Research Question 9A

How will eliminating retroactive eligibility change enrollment continuity?

Data and Methods

RQ 9A examined how limiting retroactive enrollment eligibility in Florida Medicaid to pregnant women and children changes enrollment continuity, as measured by the change in the predicted probability of renewal success in the post-policy period (February 2019 to January 2020) compared to the pre-policy period (February 2018 to January 2019) controlling for potential factors affecting enrollment renewal. Surveys and in-depth interviews with key officials from nursing homes and hospitals were used to conduct the evaluation.

Results

- The renewal success rate increased in the month and year of the policy change (February 2019), but the increase is similar to the corresponding increase seen in early 2018. Overall, monthly renewal success rates were similar before and after the policy change.
- The proportions of successful Medicaid renewals before (84.3%) and after (85.6%) the policy change are very close. Thus, the policy change had minimal effect on the probability of successful enrollment renewal.

The surveys and in-depth interviews with key officials from nursing homes and hospitals revealed the following themes regarding providing enrollment assistance and community outreach, and changes in enrollment procedures as a result of the policy change.

Providing enrollment assistance

- Prior to the February 1, 2019, policy change, all 59 hospitals/acute care facilities participating in the survey reported helping patients enroll in retroactive Medicaid, including helping with eligibility determination, income verification, and application completion and submission. In addition, of 125 skilled nursing facilities surveyed, 117 nursing homes (94%) provided enrollment assistance and 77 (61.6%) reported specifically assisting with income verification.
- Following the February 1, 2019, policy change, both hospitals and skilled nursing facilities provided increased assistance to those who might be eligible for Medicaid, but have not enrolled. Among the 43 hospitals that reported an organizational response to the policy change, 20 (46.5%) said they increased the amount of enrollment assistance they provided to patients potentially eligible for Medicaid following the policy change. Among the 84 skilled nursing facilities that said they had an organizational response to the policy change, 40 (47.6%) reported increasing their amount of enrollment assistance.

Outreach assistance

- The in-depth interviews revealed that prior to the policy change, most (but not all) organizations focused their outreach efforts on patients who were actively receiving care. Organizations reported that they did not engage in community outreach to enroll potentially Medicaid-eligible patients who were not currently seeking services at their institution. However, following the policy change, 39 (46.4%) out of 84 skilled nursing facilities reported implementing community outreach to identify patients who might be eligible for Medicaid prior to the receipt of services. Such community outreach may have stemmed at least in part from the restrictions on retroactive enrollment and the need for Medicaid eligible members of the community to be enrolled prior to admission. However, only 5 (11.6%) out of 43 hospital/acute care facilities reported doing community outreach to potential patients prior to the receipt of services.

Changes in enrollment procedures

- During the in-depth interviews, several institutions noted changes to their organizational processes to help identify patients who might be Medicaid eligible, but not yet enrolled. This included the development of new forms, tracking systems, and the use mobile devices at the bedside to assist enrollment.
- In 2020, as a result of the COVID-19 pandemic, the Agency maintained continuous enrollment for all beneficiaries. As a result, the impact of the retroactive enrollment policy change could not be ascertained over the long-term.

Research Question 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?

This question was unable to be addressed because of the lack of new enrollee health status information from prior to the retroactive enrollment policy change in February 2019.

Research Question 9C

How will eliminating retroactive eligibility affect new enrollee financial burden?

Data and Methods

To evaluate the impact of eliminating retroactive eligibility in February 2019 on new enrollee financial burden, monthly credit history reports from TransUnion LLC (TU) were merged with enrollment and socio-demographic data from Medicaid recipients who were newly enrolled in the 12 months immediately prior to the February 2019 policy change (pre-policy change period) and the 12 months immediately following the February 2019 policy change (post-policy change period). For details on the data-matching rules and privacy-preserving methodology used to merge new Medicaid enrollee data with credit reporting history from TU, along with specific state assistance categories included in the analysis, see the Appendix for Research Question 9C.

The main outcome for this analysis was new enrollee unpaid medical debt, defined as the total dollar amount of third-party medical bills placed for collections in the three months prior to the

month in which the recipient applied to and was enrolled in Medicaid. To identify the appropriate credit report that contained the medical debt for the three months prior to the Medicaid enrollment month, the evaluation team assumed medical bills were declared delinquent and sent to collections after the bill was 30 days past due. However, because medical practices may vary in their policy for declaring a bill delinquent, a sensitivity analysis was run assuming 60 days past due and 90 days past due as time frames to declare an unpaid medical bill delinquent. Additionally, because credit reporting agencies are prohibited from reporting medical debt on an individual's credit report until six months after the date of first delinquency, an additional six-month delay was incorporated when matching credit reports to an enrollee application month. The secondary outcome in this analysis was enrollee non-medical debt, defined as the total dollar amount of non-medical debt (e.g., revolving credit balances or mortgages) verified in the 12 months prior to the month in which the enrollee applied and was approved for Medicaid assistance.

Results

After adjusting for differences in demographics and inflation, average medical debt accrued in the three months prior to Medicaid enrollment increased by an average of $12 after implementation of the new retroactive eligibility policy among all new enrollees, an increase of 5.9 percent (see Table 16). On the other hand, average non-medical debt accrued during the 12 months prior to new Medicaid enrollment remained the same after implementation of the new retroactive eligibility policy (Table 17).

In the first year immediately following February 2019 (post-policy change period), the analysis showed an increase in average medical debt accrued in the three months prior to Medicaid enrollment. Sensitivity analysis show that if longer time periods occurred before debt was turned over, the amount of additional medical debt associated with implementation of the policy declined.

Some limitations should be considered when interpreting these results. It was not possible to assess newly accrued non-medical debt in the three months prior to new enrollment, as this information was not included in the credit report data. Only debt accrued in the previous twelve months could be examined. Additionally, the statistical models used could not directly assess causality, so any changes in medical debt pre- and post-implementation of the policy may not be directly due to the policy. Other factors may have also impacted medical and non-medical debt beyond implementation of the retroactive eligibility policy, such as differences in the likelihood of needing medical care between the two time periods examined and changes in employment. Additional years of follow-up are recommended to understand the longer-term impact of the retroactive enrollment policy change on enrollee financial burden.

Table 16. Adjusted New Enrollee Mean Unpaid Medical Debt before (Pre) and after (Post) the Retroactive Eligibility Waiver Policy Implementation (February 2019)

Model	Pre-Policy Change Period		Post-Policy Change Period		Post-Pre Difference in Means
Unpaid Medical Bill Delinquency Assumption	Mean	Median	Mean	Median	Difference
30 Days	$203	$188	$215	$198	$12

Model	Pre-Policy Change Period		Post-Policy Change Period		Post-Pre Difference in Means
60 Days	$205	$188	$200	$183	($5)
90 Days	$205	$192	$193	$180	($12)

Table 17. Adjusted New Enrollee Mean Non-Medical Debt before (Pre) and after (Post) the Retroactive Eligibility Waiver Policy Implementation (February 2019) among All Matched Enrollees

	Pre-Policy Change Period		Post-Policy Change Period		Post-Pre Difference in Means
	Mean	Median	Mean	Median	Mean
Verified Non-Medical Debt (Past 12 Months)	$917	$1,041	$917	$1,041	$0

Fiscal Impact Questions (RQ 9D-RQ 9F)

Data and Methods

Research questions 9D through 9F examined the impact of the retroactive enrollment policy change on hospital financial condition as measured by uncompensated care (UCC) (RQ 9D), financial margins (both total and operating margins) (RQ 9E), and operating margins net of Low Income Pool (LIP) payments (RQ 9F). Each question examined descriptive time trends in financial condition over the 2015-2019 period to determine if there was a shift or change in trend in financial condition following the change in retroactive enrollment policy. To control for other factors that influence financial condition, each question also examined multivariable statistical models that controlled for year, Medicaid patient-days as a percentage of total patient-days, average acute length-of-stay, type of hospital control (nonprofit, for-profit, and government), acute bed occupancy rate, staffed bed capacity, and teaching status.

Results

Research Question 9D

How will eliminating retroactive eligibility affect provider uncompensated care amounts?

- The descriptive time trend in UCC in short-term Florida hospitals remained flat over the 2015-2019 period, ranging from a low of 6.10 percent in 2016 to a high of 6.46 percent in 2019, and demonstrating no clear positive or negative shift or trend.
- The multivariable statistical models controlling for other factors influencing UCC also failed to find any clear positive or negative shift or trend in UCC over 2015-2019.

Research Question 9E

How will eliminating retroactive eligibility affect provider financial performance (income after expenses)?

RQ 9E examined hospital financial margins (defined as the difference between revenues and expenses expressed as a percentage of revenues) as measures of financial performance. Hospital total and operating margins were examined to capture financial condition both overall and based on the hospital's core business (patient care), respectively.

- Descriptively, both operating and total margins showed an initial decline in financial performance over the 2015-2017 period followed by an upswing in financial performance in 2018 and 2019. Operating margin ranges from a high of 4.29 percent in 2015 to a low of 2.01 percent in 2017 with a recovery to 2.79 percent in 2019. Total margin shows a more pronounced trend, starting at 5.17 percent in 2015, declining to 1.39 percent in 2018, and then increasing to 6.13 percent in 2019.
- The statistical models for total margin found that total margin was 4.25 percent higher in 2019 compared to 2018 after controlling for other factors influencing hospital profitability. This model result is broadly consistent with the descriptive results where total margin increases from 1.39 percent in 2018 to 6.13 percent in 2019. While this result cannot be attributed to the change in retroactive enrollment policy, the increase in total margin in 2019 was in the opposite direction to what would be expected if the change in retroactive enrollment policy had reduced hospital financial performance.

Research Question 9F

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

- Descriptively, LIP payments as a percentage of hospital revenue remained steady over the 2015-2019 period, ranging from a low of 1.02 percent in 2017 to a high of 1.51 percent in 2016. While LIP payments do improve hospital financial performance by 1 to 2 percent annually over the 2015-2019 period, there is no evidence that LIP payments materially affected hospital financial performance differently following the retroactive enrollment policy change.
- The statistical models for operating margin adjusted for LIP showed that operating margin adjusted for LIP was 4.39 percent higher in 2019 compared to 2018 after controlling for other factors influencing hospital profitability. In addition, hospitals with greater Medicaid patient-days as a percentage of total patient-days had lower operating margins adjusted for LIP in 2019.

The net effect of these opposing forces indicates that for both the mean and median Florida hospital, operating margins exclusive of LIP payments were higher in 2019 than in 2018 by 1.33 percent and 1.69 percent, respectively.

In summary, these analyses of UCC, hospital financial margin, and LIP payments provide no evidence of any adverse effect of the change in retroactive enrollment policy on hospital financial performance.

Research Question 9G

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

Research Question 9H

What are common barriers to timely renewal for those subject to the retroactive eligibility waiver?

Data and Methods

With research questions 9G and 9H the evaluation team assessed the extent to which Medicaid enrollees were aware of the retroactive enrollment policy change and investigated barriers to timely renewal of coverage as experienced by Medicaid members. 9G and 9H were answered qualitatively based on random telephone interviews of men and non-pregnant women subject to the new retroactive enrollment policy. Details about these interviews and participant involvement are discussed below.

Enrollee In-Depth Interviews*.* Qualitative interview techniques allowed interviewers to engage in probing conversations with Medicaid members in order to ascertain respondent depth of understanding on the topics addressed. The qualitative data collection on (1) enrollee understanding of their lack of coverage during enrollment gaps under the new retroactive enrollment policy (Research Question 9G) and (2) enrollee perceptions of barriers to timely enrollment renewal (Research Question 9H) were collected by the UF Survey Research Center (UFSRC). The center conducted 20-minute telephone interviews with 67 Medicaid enrollees impacted by the February 2019 retroactive enrollment policy change. The sampling approach was designed to divide the 67 respondents in three groups (20 per group A, 20 per group B, and 27 per group C):

- **Group A** included beneficiaries who have been continuously enrolled in Medicaid without experiencing any enrollment gap at the time of the data pull.
- **Group B** included beneficiaries who have experienced some enrollment gaps, although they were covered by Medicaid at the time of the data pull.
- **Group C** included individuals who had prior enrollment with Medicaid but were not covered by Medicaid at the time of the data pull (June 2020). Compared to groups A and B, group C included beneficiaries who appeared to experience greater enrollment barriers. Therefore, the evaluation team decided to oversample that group by 7 additional respondents.

Interviews with beneficiaries across Florida were collected, transcribed, and imported as texts in MAXQDA and NVivo, software programs employed for thematic analysis which examines the content and meaning of texts. Following thematic analysis techniques, beneficiaries' narratives were divided into chunks of text to which the evaluation team assigned "themes" that best represented the meaning of that specific experience shared by the beneficiary. At the end of this process, the evaluation team collected a set of three main themes: renewal facilitators, renewal barriers, and policy change awareness.

Results

In-depth interviews with beneficiaries revealed that the majority of beneficiaries (81 percent) did understand that they will not be covered during gaps in enrollment. These interviews also identified common barriers to renewal, including difficulty understanding communication from the agencies responsible for determining Medicaid eligibility, burdensome documentation requirements, lack of transportation to the enrollment site, and miscommunication with a social worker or Medicaid office and Helpline. In addition, a number of beneficiaries noted that they were unaware of enrollment-related communications sent to them by the state agencies and that they were not aware of when they needed to renew their Medicaid coverage. Among the facilitators for timely renewal, beneficiaries discussed notifications received by the state via mail or email, access to the Internet and technology, and social support.

Supportive Housing Pilot Program (RQs 10A-10G)

Research Question 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?

10 A (I) - *How did MMA plans implement the pilot programs?*

Data and Methods

Contract managers for each plan provided contact information for the housing pilot key informants. A total of 10 names were provided: one from Plan A (comprehensive health plan), two from Plan B (specialty plan-serious mental illness), six from Plan C (Comprehensive/Specialty plan- HIV/AIDS), and one from Plan D (comprehensive/specialty plan-serious mental illness).

A total of eight individuals participated in the interview: one from Plan A, two from Plan B, four from Plan C, and one from Plan D. The interview guide asked questions concerning implementation of the pilot program (e.g., why the plan decided to participate in the pilot, how the plan identified program participants, and how the program implemented each of the five components of the pilot), additional support services, specific supports for individuals who have frequent/recurring contact with the criminal justice system, discharge planning process, barriers and facilitators to pilot program implementation, program outcomes, and member stories.

Interviews were transcribed using Otter.ai and qualitative analyses were conducted in NVivo 12. For the analyses, the unit of analysis was at the plan level (n=4).

Results

Plan Participation and Identification of Program Participants

Reasons for Participation

- When probed about the reasons each plan decided to participate in the pilot, there were two overarching themes: prior experience with population (n=4) and need within member

population (n=2).

Strategies Used to Identify Program Participants

- When probed about how their plan identifies potential program participants (i.e. being identified as homeless or at risk for being homeless), each of the plans described a combination of internal and external strategies to achieve this purpose which included the following: AHCA enrollment files (n=4), collaboration with community partners (n=4), referrals from provider network (n=4), member outreach (n=3), and organizational strategies (n=3).

Implementation of the Components

- For transitional housing, tenancy sustaining services and mobile crisis management services, one commonality among the plans was in contracting with in-network providers to provide services. Additionally, these network providers would contract with community organizations or local/regional bodies to provide transitional housing services.
- For self-help/peer support, the same in-network providers are involved in contracting services for transitional housing and tenancy sustaining services; however, all four plans reported that not all providers offer peer support services, and peer-support services are not as widely available as the plans desire.

Payment for Moving Expenses

- Just like the other components of the pilot program, the payment for moving services (a.k.a. incidentals) also uses in-network providers to contract for these services and the providers collaborate with community partners to execute these services.
- The categories of incidentals cited by the plans included the following: security deposit (n=4), furnishing apartment (n=3), utilities (n=2), and partial rent assistance (n=1).

Additional Social Services

- When asked about what additional social services (i.e. services that are generally designed to improve the well-being or quality of life of a beneficiary) the plan provide to the participants, there were seven distinct categories identified within the interviews: Medicaid transportation benefits (n=4), Phones (n=3), Healthy Behaviors Program (n=2), Food Assistance (n=2), Social Security Assistance (n=1), Social Events (n=1) ,and Over the Counter Drug Benefits (n=1).

Barriers and Facilitators to Pilot Program Implementation

- The barriers to overall pilot implementation as gleaned from the interviews included the following: COVID-19 (n=4), reporting requirements (n=4), member issues or member hesitancy (n=3), demographic challenges (n=2), availability of housing (n=2), provider or

continuum of care issues (n=2), and non-SMI status (n=1).

- The facilitators to overall pilot implementation as gleaned from the interviews included the following: collaborations with stakeholders (n=4), cooperation with other plans (n=3), and staffing (n=2).

Program Outcomes

- For housing stability, with the exception of Plan A, all plans mentioned improving their performance through the course of the pilot thus far.
- All four plans reported a steady decrease in ER utilization and inpatient hospitalizations through the course of the pilot.
- According to a joint presentation of all four plans titled "Florida Housing Waiver Pilot Program Stakeholder Meeting" shared by the key informant for Plan B, the composite average reduction in ER visits hovered around 55 percent for the first year of the pilot while the reduction in hospital admissions averaged approximately 64 percent.

10A (II), *How many enrollees are participating in the Housing Assistance Pilot, by plan?*

Table 18 below shows the number of participants by plan and specific service type. Note that many participants received more than one type of service, so the counts of specific service types may add up to more than the total number of participants.

Tenancy sustaining services were the most prevalent among all participants, with 76.44 percent of the 208 participants receiving this service. When examining specific service types by plan, this pattern continued, with at least half of all participants in each of the six plans receiving tenancy sustaining services. Additionally, participants of all six plans used both transitional housing services (which includes incidental and support services) and tenancy sustaining services. Simply Healthcare, Magellan, Staywell, and Staywell-SMI participants used self-help/peer support services in addition to both transitional housing services (which includes incidental and support services) and tenancy sustaining services. Magellan was the only plan with participants who used mobile crisis management services (in addition to the three other types of services), though utilization remained low (7.41 percent).

Table 18. Number of Enrollees Participating in the Housing Assistance Pilot in DY14 (SFY 2019-20), by Plan and Type of Service

	Cha[ka]	COV	MCC	SHP	STW	STW-SMI	Total[b]
Transitional Housing Services[c]	1 (50.0%)	22 (91.67%)	33 (40.74%)	3 (20%)	10 (23.26%)	19 (44.19%)	88 (42.31%)
Tenancy Sustaining Services	1 (50.0%)	14 (58.33%)	64 (79.01%)	13 (86.67%)	37 (86.05%)	30 (69.77%)	159 (76.44%)
Mobile Crisis Management	0 (0.0%)	0 (0.0%)	6 (7.41%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	6 (2.88%)
Self-help/Peer Support	0 (0.0%)	0 (0.0%)	23 (28.4%)	6 (40.00%)	19 (44.19%)	5 (11.63%)	53 (25.48%)
Total Participants	2 (100%)	24 (100%)	81 (100%)	15 (100%)	43 (100%)	43 (100%)	208 (100%)

[a] The full plan names can be found in the List of Acronyms at the beginning of this report.
b Frequencies of service types may not add to "total participants" in the bottom row as many participants received more than one type of service.
[c] "Transitional housing services" includes incidental services and support services as they both had the same procedure code (H0043).

Research Question 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?

Data and Methods

For duration of service, the unit of measurement is "encounter episodes." A single encounter episode includes all encounters (of a specific service type) for an individual until a gap in service of 60 days or more is reached. If an individual had additional encounters after the 60-day gap, those are counted as the next distinct observation of encounter episode. Duration of service was determined by using the date of service at the start and end of each encounter episode to get the length of service.

Results

Table 19 shows the average duration of service by service type and plan. For all service types, 247 encounter episodes showed an average duration of service lasting 76.62 days. Self-help/peer support services had the longest average duration of service at 130.95 days, transitional housing services had the shortest at 48.98 days. For all service types, Coventry had the shortest average duration of service at 47.64 days, and Magellan Complete Care had the longest average duration at 88.11 days. For transitional housing services, the average duration ranged from 27.82 days for Simply Healthcare to 55.18 days for Staywell-SMI. For tenancy sustaining services, the average duration ranged from 10.5 days for Simply Healthcare to 86.51

days for Staywell. For self-help/peer support services, the average duration ranged from 72 days for Staywell-SMI to 157 days for Magellan Complete Care.

Table 19. Average Duration of Service (in Days) in the Housing Assistance Pilot in DY14 (SFY 2019-20), by Plan and Type of Service

	CHA	COV (N=28)	MCC (N=101)	SHP (N=16)	STW (N=58)	STW-SMI (N=44)	All Plans (N=247)
Transitional Housing Services*	--	50.16	49.77	27.82	44.29	55.18	48.98
Tenancy Sustaining Services	--	43.1	85.10	10.5	86.51	69.03	74.97
Mobile Crisis Management	--	--	--	--	--	--	--
Self-help/Peer Support	--	--	157.00	152.67	107.29	72.0	130.95
All service types	**--**	**47.64**	**88.11**	**49.06**	**86.43**	**65.77**	**76.62**

Note: For duration of service, the unit of measurement is "encounter episodes." A single encounter episode includes all encounters (of a specific service type) for an individual until a gap in service of 60 days or more is reached. Mobile Crisis Management is not included because there were only 6 encounters total, and none had a consecutive encounter in under 60 days. Clear Health Alliance also did not have any encounter episode spans to record.

*"Transitional housing services" includes incidental services/support services as they both had the same procedure code (H0043).

Research Question 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?

Data and Methods

To compare avoidable hospitalizations and ED visits that occurred prior to enrollment in the pilot program (pre-enrollment period) to those that occurred after enrollment in the pilot program (post-enrollment period), the evaluation team used enrollee IDs to merge the Enrollee Housing Roster data file provided by the health plans with Medicaid encounter data from SFY2019-20.

The evaluation team used the 3M™ Health Information Systems' Potentially Preventable Events Classification System[30] to identify which Medicaid encounters were potentially avoidable hospitalizations and ED visits. Potentially avoidable hospitalizations and ED visits were measured on a per-member per-month (PMPM) basis, meaning the number of potentially avoidable hospitalizations and ED visits that an enrollee had were summed for each month in

[30] https://www.3m.com/3M/en_US/health-information-systems-us/drive-value-based-care/patient-classification-methodologies/

SFY2019-20. For univariate analysis, average (mean) PMPM counts of avoidable hospitalizations and ED visits that occurred during the pre-enrollment period were compared to average PMPM avoidable hospitalizations and ED visits that occurred in the post-enrollment period. Additionally, the evaluation team conducted a multivariate logistic regression analysis (controlling for differences in age, race, gender, and risk scores) to estimate and compare the predicted probability of an enrollee having any potentially avoidable hospitalization or ED visit in any given month in the pre-enrollment period to that observed in the post-enrollment period[31]. As such, results for this analysis are expressed as percentages.

Results

As shown in Table 20, when comparing mean and median PMPM avoidable hospitalizations between the pre-enrollment and post-enrollment periods, a slight increase was observed (0.05 vs 0.06). Conversely, a decrease in avoidable ED visits was also observed between the pre- and post-enrollment periods (0.18 vs 0.14).

Table 20. Unadjusted PMPM Count of Avoidable Hospitalizations and ED Visits Pre- vs Post-Enrollment in the Housing Assistance Pilot (SFY2019-20)

Avoidable Event	Pre-Enrollment Period N=5,920		Post-Enrollment Period N=1,857	
	Mean	Median	Mean	Median
Hospitalizations	0.05	0	0.06	0
ED visits	0.18	0	0.14	0

In the multivariate analysis (Table 21), the adjusted PMPM predicted probability of having any avoidable hospitalization in a given month decreased from 3.94 percent in the pre-enrollment period to 3.14 percent in the post-enrollment period. Additionally, the adjusted PMPM predicted probability of having any ED visit in a given month decreased from 12.39 percent in the pre-Enrollment period to 8.41 percent in the post-enrollment period.

Table 21. Adjusted PMPM Predicted Probability of Any Avoidable Hospitalization or ED Visit Pre- vs Post-Enrollment in the Housing Assistance Pilot (SFY2019-20)

Avoidable Event	Pre-Enrollment Period N=5,920		Post-Enrollment Period N=1,857	
	Mean	Median	Mean	Median

[31] The frequency of avoidable hospitalizations and ED visits for participants in the Housing Pilot was too few to complete a 2-part model that generates mean PMPM counts of encounters in the multivariate analyst. Therefore, the evaluation team modeled the probability of having any avoidable hospitalization and ED visit in a given month using multivariate logistic regression. As such results in the multivariate section are presented as adjusted mean PMPM (median) probabilities.

Hospitalizations	3.94%	3.23%	3.14%	2.59%
ED visits	12.39%	11.51%	8.41%	7.74%

In summary, potentially avoidable hospitalizations and ED visits PMPM decreased after enrollment in the pilot program.[32] Given the limited time period under which the pilot program has operated and generated data for evaluation, it is premature to draw any definitive conclusions regarding changes in avoidable or medically unnecessary hospitalizations and emergency department visits that occurred after enrollment in the pilot program.

Research Question 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?

Data and Methods

To compare enrollee MMA service utilization that occurred prior to enrollment in the pilot program (pre-enrollment period) to service utilization that occurred after enrollment in the pilot program (post-enrollment period), the evaluation team used enrollee ID numbers to merge the enrollee housing roster data file provided by the health plans with Medicaid encounter data from SFY2019-20.

For the analysis, Medicaid encounters were counted and placed into the following service utilization categories: PCP (physician) visits, outpatient visits, pharmacy services and behavioral health services. Service utilization is reported on a PMPM basis, meaning that it shows the average number of encounters that an enrollee had in a month for each service category. For univariate analysis, average (mean) PMPM counts of MMA service utilization that occurred during the pre-enrollment period were compared to average PMPM counts of MMA service utilization in the post-enrollment period. To better understand the association between service utilization and participation in the pilot program, a two-part multivariate interrupted time-series analysis was conducted that controlled for differences in age, race, gender, and risk scores between the pre-enrollment period and post-enrollment period.

Results

The results of the univariate analysis are presented in Table 22. When comparing mean and median PMPM service utilization between the pre-enrollment and post-enrollment periods, increases were seen in the mean number of PCP visits, pharmacy services and behavioral services. Mean PMPM outpatient visits increased slightly from 0.16 to 0.17 visits between the pre- and post-enrollment periods.

[32] Note that Table 21 deals with *avoidable hospitalizations and ED visits as opposed to total* hospitalizations and ED visits as discussed on p. 73 above.

Table 22. Unadjusted Service Utilization PMPM Pre- vs. Post-Enrollment in the Housing Assistance Pilot (SFY2019-20)

	Pre-Enrollment Period N=5,920		Post-Enrollment Period N=1,857	
	Mean	Median	Mean	Median
PCP (Physician)	1.36	0	1.57	0
Outpatient	0.16	0	0.17	0
Pharmacy	4.71	3	5.72	4
Behavioral	1.45	0	2.73	0

In the multivariate analyses (Table 23), reductions in mean PMPM PCP (physician) visits, outpatient visits and pharmacy services were observed between the pre- and post-enrollment periods. On the other hand, behavioral service PMPM utilization increased for enrollees after participation in the pilot program with an average of 1.29 visits per-month observed in the pre-enrollment period compared to 1.64 visits per-month in the post-enrollment period.

Table 23. Adjusted Service Utilization PMPM Pre- vs. Post-Enrollment in the Housing Assistance Pilot (SFY2019-20)

	Pre-Enrollment Period N=5,920		Post-Enrollment Period N=1,857	
	Mean	Median	Mean	Median
PCP (Physician)	1.28	1.18	0.89	0.80
Outpatient	0.16	0.13	0.14	0.12
Pharmacy	4.49	4.48	4.15	4.13
Behavioral	1.29	1.24	1.64	1.59

In the first year of the Housing Assistant Pilot, PMPM PCP visits, outpatient visits and pharmacy service utilization decreased after enrollment in the pilot program while PMPM behavioral service utilization increased after enrollment in the pilot program. Given the limited time period under which the pilot program has operated and generated data for evaluation, it is premature to draw any definitive conclusions regarding participation in the pilot program and changes in MMA service utilization.

Research Question 10E

Is care coordination more effective for the study population as a result of the pilot program?

Data and Methods

The survey was developed and administered to 14 care coordinators across the different plans. Eleven care coordinators completed the survey.

The care coordinators answered questions concerning the study population which consisted of 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.

Results

Effectiveness of Care Coordination for the Study Population

Care coordinators were asked to rate their level of agreement with the idea that care coordination is more effective for the study population on a four-point scale ranging from "1-Strongly disagree" to "4-Strongly agree."

- All of the care coordinators agreed (i.e. responding "3-Agree" or "4-Strongly Agree") that care coordination is more effective for the study population (n=11).

Care coordinators were also asked about the factors that facilitated or hindered the effectiveness of care coordination.

- Factors that facilitated the effectiveness of care coordination included: a) Linkage of services/community partnerships (n=6); b) Meetings with housing specialist (n=3); and c) Communication with members (n=2).
- Factors that hindered the effectiveness of care coordination included: a) Difficulty in communication with enrollees (n=4); b) Lack of community/financial resources (n=4); c) COVID-19 (n=3) and d) Regulatory difficulties (n=3).

Measures Used for Care Coordination

The care coordinators were asked whether they used specific process measures to evaluate care coordination along with whether they used specific national measures for care coordination.

- Process measures (with care coordinator responses in parentheses) included the following: a) Number of duplicated/unduplicated encounters (n=11); b) Number of care coordinators trained to serve patients using an evidence-based curricula (n=9); c) Number of healthcare providers offering care coordination services (n=10); d) Number and level of participation of organizations involved in the program (n=10); e) Number of referrals to other providers (n=8); f) Number of people receiving services from a care coordinator (n=9); g) Number of patients enrolled in a case management program (n=10); h) Number of case managed patients who have had [number of] visits with their provider [during a particular time period] (n=8); i) Number of participants who have a self-management plan (n=7).
- National measures for care coordination (with responses in parentheses) included the

following: a) Timely transmission of transition record (discharges from an inpatient facility to home/self-care or any other site of care) to the health care professional designated for follow-up care within 24 hours of discharge (n=11); b) Post-discharge continuing care plan created for patients discharged from a hospital-based inpatient psychiatric setting (n=9); c) Post-discharge continuing care plan transmitted to next level of care provider upon discharge (n=10).

Care coordinators were also asked to provide any additional measures they use for care coordination and relevant outcomes from the pilot program that were measured and collected by their plan.

- Additional measures mentioned by the care coordinators included the following: a) Decrease in inpatient re-admissions for both BH and medical; b) Upgrade in housing status; c) Level of engagement in services; d) Biweekly home meetings; e) Health Risk Assessments; f) Number of participants receiving core services each month; g) Number of participants having an SUD diagnosis: h) Number of participants having an opioid use disorder; i) Number of participants having an SMI diagnosis; j) Number of participants who are medication compliant; and k) Monthly tracking of member and provider touches.
- Relevant outcomes from the pilot program that were measured and collected by their plan (with coordinators' responses in parentheses) included the following:: a) Number of members finding stable housing (n=4); b) Housing condition upgrades (n=3); c) Program growth (n=2); d) # of members who are employed (n=2); e) Reduction in ER visits (n=2); f) Reduction in hospital admissions/readmissions (n=2) g) Provider response to referrals (n=1); h) Monthly outreach calls to members to obtain information on successful linkage (n=1); and i) Monthly updates on members (n=1)

Research Question 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?

Data and Methods

The evaluation team asked care coordinators from each of the health plans to administer surveys to pilot program enrollees to assess their satisfaction with the four types of housing services provided (transitional housing services, mobile crisis management, self-help/peer support, tenancy sustaining services), as well as the ease of accessing these services, their involvement in getting and using housing support services, and their satisfaction with how well their health plan worked with them to get these services.

Results

Survey Administration and Demographics

- The 14 case managers across the different plans were responsible for directly contacting and administering the survey to the housing pilot enrollees.
- A total of 101 enrollees completed responses to the Housing Pilot Survey, most of whom identified as female (57%; n=54), White (58%; n=55), and non-Latino (77%; n=73).

- When asked about their current living situation, the highest percentage of enrollees reported living with other people in a house, apartment, condo, or trailer (41%; n=39).

Enrollee Satisfaction with Housing Support Services Provided by Plan

Enrollees were asked to rate their satisfaction with housing support services on a four-point scale ranging from "1-Very dissatisfied" to "4-Very satisfied."

- The highest levels of satisfaction (i.e. responding "3-Somewhat satisfied" or "4-Very satisfied") were reported for self-help/peer services (100%; n=16) followed by mobile crisis management (93%; n=14), tenancy sustaining services (87%; n=26), and transitional housing services (78%; n=44).
- When asked to rate their general level of satisfaction with the health plan's efforts to help enrollees get housing support services, a vast majority (89%; n=82) reported being satisfied.

Enrollee Ease of Using Housing Services

Enrollees were also asked to rate the ease of using house housing support services on a four-point scale ranging from "1-Very difficult" to "4-Very easy."

- Highest levels of ease (i.e. responding "3-Somewhat easy" or "4-Very easy") were reported for self-help/peer support (100%; n=17) followed by tenancy sustaining services (86%; n=30), mobile crisis management services (80%; n=12), and transitional housing services (75%; n=47).
- When asked to rate how easy it was for them to begin helping themselves as a result of the housing pilot program, a slight majority of enrollees reported it was difficult (i.e. responded "Somewhat difficult" or "Very difficult") to begin helping themselves (53%; n=49).

Enrollee Housing Service Needs Met or Not

Enrollees were asked whether there were housing-related services they needed and had not received through the health plan.

- A majority of enrollees reported there were not any housing-related services they needed and did receive through the health plan (73%; n=66).
- The rest (n=25) reported the following housing-related services under three categories: a) General housing assistance (n=8); b) Housing/rent financial assistance (n=7); and c) General financial assistance (n=4).

Enrollee Involvement and Experiences

- Nearly all enrollees reported being involved with getting and using housing support services provided by their health plan (95%; n=86).

COVID

Enrollees were asked how COVID-19 contributed to their current living situation on a four-point scale ranging from "1-Not at All" to "4-Significantly."

- A majority of enrollees (71%; n=66) reported COVID-19 contributed to their current living situation (i.e. responded "Slightly", "Moderately", or "Significantly"). Of those respondents, 41 percent (n=38) reported that COVID-19 significantly contributed to their living situation.

Research Question 10G

What are the costs of the pilot program, including the costs of services provided to enrollees and the costs to administer the program?

To calculate costs of the housing pilot program, the evaluation team used enrollee ID numbers to merge the enrollee housing roster data file provided by the health plans with Medicaid encounter data from SFY2019-20.

Total, mean, and median costs of services provided to enrollees were captured using housing roster reports to identify enrollees in the housing assistance pilot program and encounter data to identify the use of any of the four housing services: transitional housing services, mobile crisis services, peer support services, and tenancy services and the amount paid per person per service encounter. The analysis used a person-month approach, meaning each observation corresponds to expenditures for a person in a month (or member-months).

Results

As shown in Table 24, the total cost of housing assistance services across all participating plans was $178,256. Additionally, the average PMPM expenditures for SFY 2019-20 were $244.

Table 24. Housing Assistance Pilot Program Services Total and Per-Member Per-Month Costs for SFY 2019-2020

	SFY 2019-2020
Total Costs	$178,256
SFY Overall Mean	$857
SFY Overall Median	$394
Per-Member Per-Month Mean	$244
Per-Member Per-Month Median	$135

In the first year of implementation of the housing pilot program, PMPM costs for services provided averaged $244, with a median of $135. A total of $178,256 was spent for all housing

assistance services provided through the housing pilot program across all plans combined. Additional years of data are required to detect trends in the housing pilot program's costs.

Other Evaluation Questions

This section includes MMA evaluation results for expanded benefits, joint eligibles, express enrollment, and dual-eligibles. In general, the evaluation team viewed the results for these questions as less conclusive than the results presented above with fewer clear-cut policy implications.

Expanded Benefits (RQs 2A-2D)

Project 1, Component 2 evaluated the effect of expanded benefits on enrollees' utilization of services, access to care, and quality of care.

Research Question 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?

Data and Methods

The types of expanded benefits offered by MMA standard and specialty plans were compared using data from benefit charts provided by the health plans for each demonstration year.

Results

All participating plans offered at least some expanded benefits in all years of the demonstration (see Table 25). The total number of unique expanded benefits offered by plans remained relatively constant in DY9 through DY12, with about 20 unique expanded benefits offered across all plans, with an average of about 17 expanded benefits offered per plan. The total number of expanded benefits offered increased significantly in DY13 and DY14 to a total of 45 expanded benefits. The average number of expanded benefits offered per plan was comparable between standard and specialty plans for DY9 through DY12, however in DY13 and DY14, standard plans offered an average of 37 different expanded benefits, while specialty plans offered an average of 23 different expanded benefits.

Some of the most commonly offered expanded benefits included home delivered meals, discounts on over the counter medication, acupuncture, chiropractic services, hearing services, occupational therapy, physical therapy, speech therapy, respiratory therapy, vision services, waived copayments, and adult vaccines. Other expanded benefits offered included things like cellular service, swimming lessons, art therapy, pet and/or equine therapy, behavioral health services, durable medical equipment, and transportation services. While specialty plans tended to offer fewer expanded benefits to enrollees than standard plans, those benefits were often tailored to the population that the specialty plan served (e.g., children with special health care needs or individuals with severe mental illness.). For example, specialty plans that only served children did not include any of the expanded benefits meant for adults, while plans that serve individuals with severe mental health offered behavioral health expanded benefits, such as behavioral health intensive outpatient treatment.

All MMA plans offered expanded benefits during the demonstration period, and the total number of unique expanded benefits offered by plans and the average number of expanded benefits offered per plan remained relatively constant during the first four years of the demonstration (DY9-DY12). However, the total number of unique expanded benefits offered nearly doubled in DY13 and DY14. There was essentially no difference in the average number of expanded benefits offered between standard and specialty MMA plans in DY9-DY12, but in DY13 and DY14, standard plans offered significantly more expanded benefits than specialty plans. Although the number of expanded benefits was lower in specialty plans compared to standard plans, the expanded benefits offered in specialty plans were tailored to the population being served, such as limiting expanded benefits to those applicable to children in specialty plans that only served children and behavioral health expanded benefits in plans that specialized in serving individuals with severe mental illness.

Table 25. Expanded Benefits Offered by Standard and Specialty Plans by Demonstration Year

	All Participating Plans		Standard MMA Plans			Specialty Plans		
Demonstration Year	Number of Plans Offering Expanded Benefits	Total Expanded Benefits Offered	Number of Plans Offering Expanded Benefits	Total Expanded Benefits Offered	Average Expanded Benefits Across Plans	Number of Plans Offering Expanded Benefits	Total Expanded Benefits Offered	Average Expanded Benefits Across Plans
DY9	18	20	14	20	16	4	20	17
DY10	17	20	13	20	15	4	20	17
DY11	15	21	11	21	18	4	21	17
DY12	15	22	11	20	17	4	20	17
DY13/14	18	45	14	45	37	4	42	23

Research Question 2B

To what extent do enrollees use these expanded benefits?

Data and Methods

The types of expanded benefits offered by MMA standard and specialty plans were compared using data from benefit charts provided by the health plans for each demonstration year. These questions were not fully developed beginning in DY10 so results for DY9 are not presented.

Results

As depicted in Table 26, the percent of enrollees using expanded benefits has increased steadily from 67.4 percent in DY10 to 85.2 percent in DY14, with some slight fluctuations in between.

Table 26. MMA Expanded Benefits by Enrollees, DY10-DY14

Demonstration Year	DY10 (SFY 2015-16)	DY11 (SFY 2016-17)	DY12 (SFY 2017-18)	DY13 (SFY 2018-19)	DY14 (SFY 2019-20)
Enrollee Expanded Benefit Category	**Number (Percent)**	**Number (Percent)**	**Number (Percent)**	**Number (Percent)**	**Number (Percent)**
Enrollees Using Expanded Benefits	2,549,354 (67.4%)	2,222,946 (66.3%)	2,538,621 (76.1%)	2,772,477 (88.1%)	2,529,848 (85.2%)
Total Enrollees	3,781,049 (100%)	3,353,163 (100%)	3,334,629 (100%)	3,148,714 (100%)	2,968,426 (100%)

Of the 65,505,271 encounters in DY10, 20.5 percent pertained to expanded benefits. That is, 67.4 percent of the 3,781,049 MMA enrollees in DY10 were using expanded benefits. Of those expanded benefits, 17.6 percent of encounters pertained to services related to primary care, physician home visits, prenatal care, newborn circumcision, home health, home-delivered meals, vision, hearing, vaccines, nutrition counseling, pet therapy, art therapy, outpatient services, and dental services.

Of the 72,539,344 encounters in DY11, 21.6 percent pertained to expanded benefits. That is, 66.3 percent of the 3,353,163 MMA enrollees who used any service in DY11 used expanded benefits. Of those expanded benefits, 19.9 percent of encounters pertained to services such as primary care, physician home visits, prenatal care, newborn circumcision, home health, home-delivered meals, vision, hearing, vaccines, nutrition counseling, pet therapy, art therapy, outpatient services, and dental services.

Of the 72,937,921 health care services that enrollees received in DY12, 19.9 percent pertained to expanded benefits. Of those expanded benefits, 18 percent pertained to services related to dental, hearing, home delivered meals, home health, newborn circumcision, nutrition counseling, outpatient, physician home visits, prenatal care, primary care, therapies (pet/art), vaccines, and vision. The most common of these were primary care services (59.1 percent) and dental services (13.5 percent). In addition, 1.9 percent of the expanded benefits corresponded to National Drug Codes, which refer to pharmaceutical services and over-the-counter drugs/supplies.

Of the 102,996,752 health care services that enrollees received in DY13, 17.8 percent pertained to expanded benefits. Of those expanded benefits, the majority pertained to services related to behavioral health, dental, general health benefits (e.g., home care, vaccines), occupational therapy, primary care, and speech therapy. The most common of these were behavioral health services (30.9 percent) and primary care services (24.7 percent). In addition, 2.1 percent of the expanded benefits corresponded to AHCA's provided list of National Drug Codes, which refer to pharmaceutical services and over-the-counter drugs/supplies.

Of the 95,925,256 health care services that enrollees received in DY14, 26.5 percent pertained to expanded benefits. Of those expanded benefits, the majority pertained to services related to general health benefits (41.8 percent), behavioral health (23.5 percent), and primary care (14.8 percent). In addition, 3.1 percent of the expanded benefits corresponded to AHCA's provided list of National Drug Codes, which refer to pharmaceutical services and over-the-counter drugs/supplies.

Research Question 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?

Data and Methods

The types of expanded benefits offered by MMA standard and specialty plans were compared using data from benefit charts provided by the health plans for each demonstration year.

Results

This question was developed beginning in DY10 so results for DY9 are not presented. For DY10, DY12, DY13, and DY14, in contrast to the hypothesis, those who used expanded benefits had higher percentages of inpatient and ED visits than non-users (Table 27). For DY11, in accordance with the hypothesis, enrollees who used expanded benefits had relatively equal, and slightly lower, percentages of inpatient and ED visits than non-users (Table 27).

Table 27. MMA Inpatient and ED Visits by Enrollees who Used Expanded Benefits vs. Enrollees who Did Not Use Expanded Benefits, DY10-DY14

	Number	Percent
Expanded Benefits Users, DY10		
Inpatient Visits	286,536	11.2%
ED Visits	955,165	37.4%
Expanded Benefits Non-Users, DY10		
Inpatient Visits	51,256	4.2%
ED Visits	252,294	20.4%
Total Enrollees, DY10	**3,781,049**	**--**
Expanded Benefits Users, DY11		
Had Inpatient Visit	216,723	6.5%
Had ED Visit	844,737	35.7%
Expanded Benefits Non-Users, DY11		

	Number	Percent
Had Inpatient Visit	74,785	6.6%
Had ED Visit	403,233	38.0%
Total Enrollees, DY11	**3,353,163**	**--**
Expanded Benefits Users, DY12		
Had Inpatient Visit	190,887	7.5%
Had ED Visit	935,116	36.8%
Expanded Benefits Non-Users, DY12		
Had Inpatient Visit	41,878	5.3%
Had ED Visit	256,469	32.2%
Total Enrollees, DY12	**3,334,629**	**--**
Expanded Benefits Users (N = 2,772,477), DY13		
Had Inpatient Visit	225,683	8.1%
Had ED Visit	1,174,102	42.4%
Expanded Benefits Non-Users (N = 376,237), DY13		
Had Inpatient Visit	12,411	3.3%
Had ED Visit	61,110	16.2%
Total Enrollees, DY13	**3,148,714**	**--**
Expanded Benefits Users (N = 2,529,848), DY14		
Had Inpatient Visit	212,965	11.6%
Had ED Visit	891,580	48.7%
Expanded Benefits Non-Users (N = 438,578), DY14		
Had Inpatient Visit	523	0.1%
Had ED Visit	225,207	21.9%
Total Enrollees, DY14	**2,968,426**	**--**

Research Question 2D

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

Data and Methods

The primary data source for Research Question 2D is the responses to the telephone-based surveys completed by MMA enrollees who received additional services in DY13 and DY14. To measure enrollee experiences and satisfaction with expanded benefits, enrollees were specifically asked the following questions: 1) "How satisfied are you with the types of expanded

benefits offered by your health plan?"; 2) "How satisfied were you with the information and customer service provided to you by your health plan on the expanded benefits offered?"; 3) "How easy was it to access the expanded benefits offered by your health plan?"; and 4) "How satisfied were you with expanded health benefits that you used?"

Survey questions 1, 2, and 4 concerning satisfaction were all probed on a global, 4-point scale ranging from "1-Very satisfied" to "4-Very dissatisfied." Question 3 concerning ease of access to services was asked on a global, 4-point scale ranging from "1-Very easy" to "4-Very difficult."

Results

Satisfaction with Types of Expanded Benefits Offered by Health Plan

- Of all the enrollees interviewed, 33 percent reported they were unaware that their health plan offered expanded benefits (n=431)
- Of the enrollees that were aware of these expanded benefits, a vast majority (94%, n=819) reported being satisfied (i.e. responding "1-Very satisfied" or "2-Satisfied") with the types of expanded benefits being offered by their health plan.

Satisfaction with Customer Service and Information Provided

- Of the enrollees who were aware of the expanded benefits and responded (n=835), a vast majority (92%; n=770) reported being satisfied with the information and customer service provided by their health plan on the expanded benefits offered.

Ease of Access to Expanded Benefits Offered by Health Plan

- Of the enrollees who were aware of the expanded benefits and responded (n=802), a slight majority (57%; n=461) reported using any of the expanded benefits offered by their health plan.
- Of the enrollees who reported using expanded benefits (n=461), most (83%; n=381) reported the benefits were easy to access through their health plan (i.e. responding "1-Very easy" or "2-Easy").

Satisfaction with Expanded Health Benefits Used

- Of the enrollees who used the expanded benefits and responded (n=420), nearly everyone (96%, n=404) reported being satisfied with the utilized expanded health benefits.

Joint Eligibles (RQs 5A-5C)

Project 1, Component 5, which included Research Questions 5A-5C, evaluated the effect of having separate managed care programs for acute care and LTC services on enrollment and utilization. This component was sunset after DY12.

Research Question 5A

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

Research Question 5B

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

Data and Methods

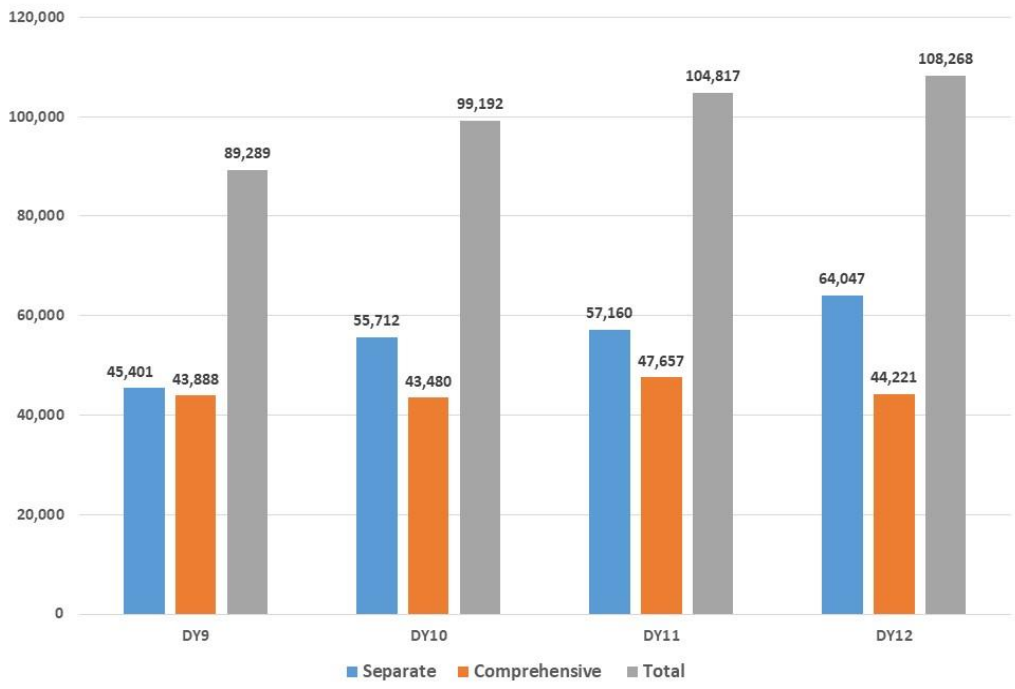
Data from Statewide Medicaid Monthly Enrollment Reports were used to calculate the descriptive statistics reported below on enrollments in separate and comprehensive plans over DY9-DY12.

Results

As shown in Figure 4, joint enrollment in both the MMA and LTC programs grew substantially from 89,289 in June 2015 to 108,268 in June 2018, or 21.3 percent. Enrollment in separate MMA and LTC plans grew even faster over the same period, from 45,401 to 64,047, or 41.1 percent.

By contrast, total enrollment in comprehensive MMA-LTC plans remained fairly constant over the same period, increasing from 43,888 to 45,401, or 0.8 percent (not shown in Figure 4).

Figure 4. Separate vs. Comprehensive Plan Enrollments for Joint MMA-LTC Eligibles in DY9, DY10, DY11 and DY12



Research Question 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?

Data and Methods

Medicaid encounter data were used to calculate the descriptive utilization statistics reported below for comprehensive vs. separate plans over DY9-DY12. Two-part statistical models were estimated using the same encounter data to produce the adjusted results.

Results

Figure 5, Figure 6, Figure 7 and Table 28 present the unadjusted and adjusted mean service utilization by type of service for separate versus comprehensive health plans for Medicaid enrollees receiving both MMA and LTC services during DY9, DY10, DY11, and DY12.

DY11 and DY12 show marked increases in utilization for certain types of services. After investigation, it was determined that these spikes in use likely stem from automated crossover[33] claims from Medicare to Medicaid rather than patient-generated increases in the demand for services. For purposes of this summarization, the evaluation team ignored these spikes in crossover claims and focused on adjusted utilization since these measures control for important enrollee characteristics (such as demographics and case-mix) that influence utilization.

In general, the table reveals that enrollees in comprehensive MMA-LTC plans appear to have higher inpatient utilization (admissions and hospital days) than enrollees in separate MMA and LTC plans. By contrast, the adjusted ambulatory utilization (physician primary and specialist visits, ED visits, and hospital outpatient visits) for comprehensive MMA-LTC plans appear to be lower than in separate MMA and LTC plans. Pharmacy claims also appear to be lower for comprehensive plans compared to separate plans.

[33] Automated crossover claims refer to when Medicare pays a claim for a dual-eligible enrollee, calculates the appropriate coinsurance/deductible and co-pay, and then automatically bills Medicaid for this amount. Previously, providers were responsible for handling crossover claims manually, and automating these crossover claims increased the volume of such claims.

Figure 5. Adjusted MMA Service Use for Separate vs. Comprehensive Plans (DY9-DY12)

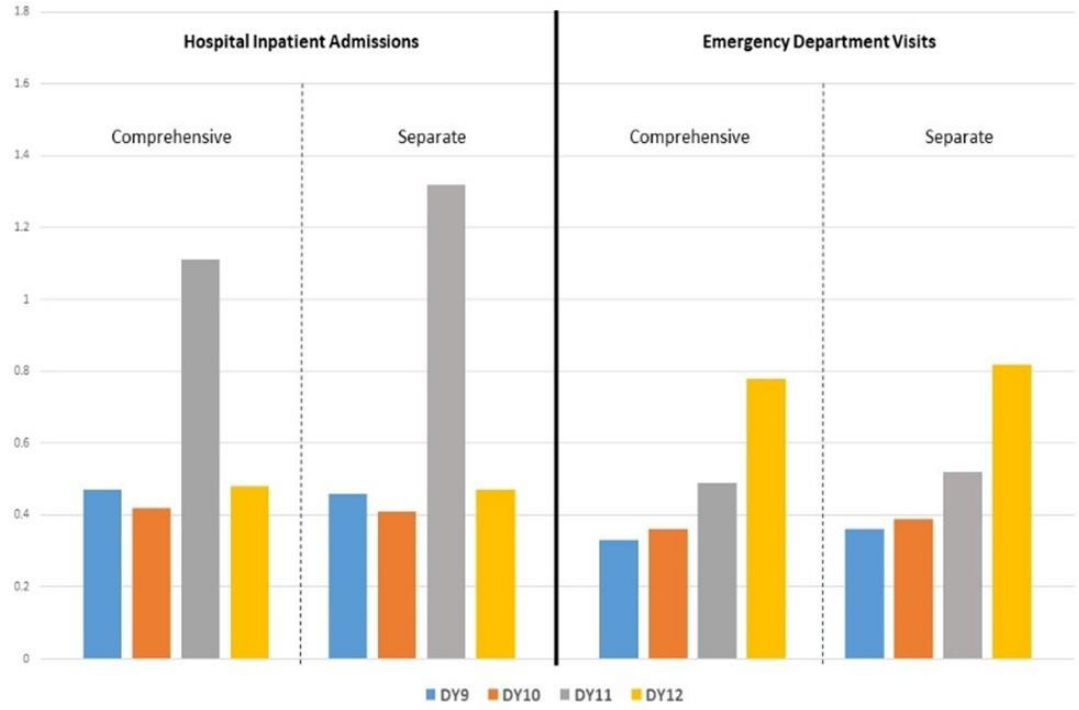


Figure 6. Adjusted MMA Service Use for Separate vs. Comprehensive Plans (DY9-DY12)

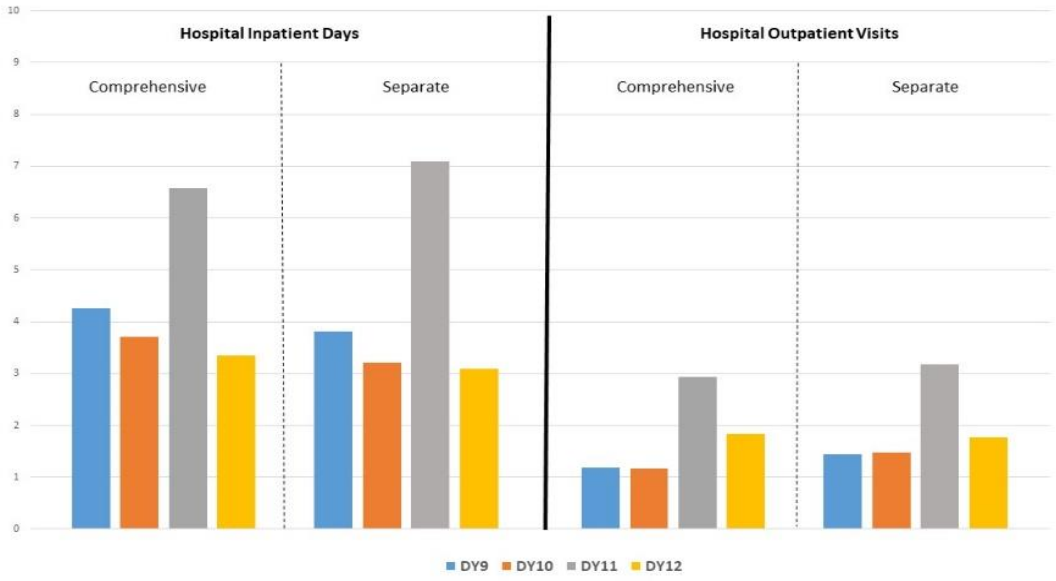
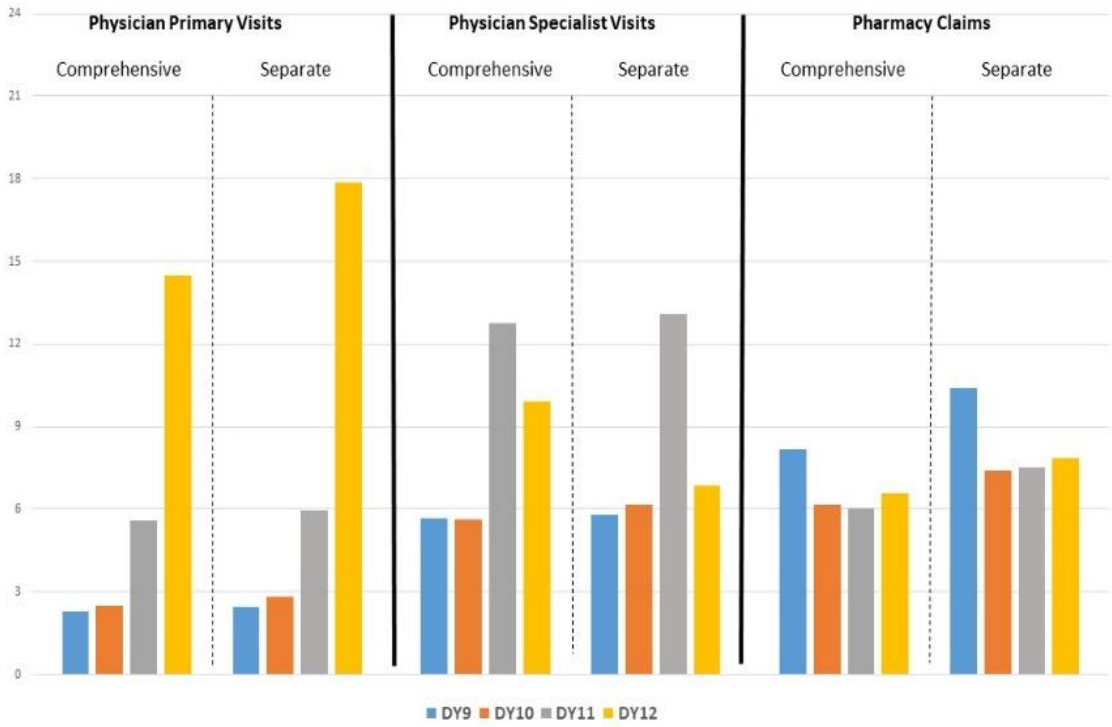


Figure 7. Adjusted MMA Service Use for Separate vs. Comprehensive Plans (DY9-DY12)



No attempt was made to measure the appropriateness of care for enrollees who are eligible for both MMA and LTC services because of the lack of comprehensive utilization data. Because the majority of enrollees who are eligible for both MMA and LTC services are also dually eligible for Medicare and Medicaid, the evaluation team would need Medicare Advantage encounter data to observe the full picture of acute-care utilization in order to gauge appropriateness. At the time these analyses were performed, CMS had not yet released encounter data for Medicare Advantage enrollees for DY9-DY12.

In summary, joint enrollees in comprehensive MMA-LTC plans had higher inpatient utilization and lower ambulatory utilization compared to joint enrollees in separate MMA and LTC plans after accounting for differences in demographics (age, race, and sex) and case-mix scores.

Table 28. DY9 – DY12 Mean Service Use for Separate vs. Comprehensive Plans

	DY9 Unadjusted			DY10 Unadjusted			DY11 Unadjusted[a]			DY12 Unadjusted[a]		
Use Category	**Comp**	**Separate**	**% Diff[c]**	**Comp**	**Separate**	**% Diff[b]**	**Comp**	**Separate**	**% Diff**	**Comp**	**Separate**	**% Diff**
Hospital Inpatient Admissions	0.47	0.45	3.50%	0.43	0.41	4.8%	0.84	1.53	-45.1%	0.49	0.46	6.5%
Hospital Inpatient Days	4.74	3.32	42.77%	4.23	2.78	52.1%	5.81	7.62	-23.8%	3.68	2.86	28.7%
Hospital Outpatient Visits	0.82	1.51	-45.70%	0.75	1.59	-52.7%	2.54	3.29	-22.8%	1.91	1.68	13.7%
Physician Primary Visits	2.08	2.63	-20.91%	2.07	2.97	-30.3%	5.09	6.30	-19.2%	9.93	20.39	-51.3%
Physician Specialist Visits	5.28	5.62	-6.05%	4.98	6.58	-24.3%	12.35	13.36	-7.6%	13.94	4.41	216.1%
Pharmacy Claims	4.61	9.56	-51.78%	3.76	9.02	-58.3%	4.30	8.88	-51.6%	4.82	8.99	-46.4%
Emergency Dept. Visits	0.3	0.38	-21.05%	0.32	0.40	-19.3%	0.45	0.54	-16.7%	0.72	0.84	-14.3%
	DY9 Adjusted			**DY10 Adjusted**			**DY11 Adjusted[b]**			**DY12 Adjusted[b]**		
Use Category	**Comp**	**Separate**	**% Diff**	**Comp**	**Separate**	**% Diff**	**Comp**	**Separate**	**% Diff**	**Comp**	**Separate**	**% Diff**
Hospital Inpatient Admissions	0.47	0.46	1.00%	0.42	0.41	1.53%	1.11	1.32	-15.9%	0.48	0.47	2.1%
Hospital Inpatient Days	4.26	3.81	11.81%	3.71	3.21	15.51%	6.57	7.10	-7.5%	3.34	3.09	8.1%
Hospital Outpatient Visits	1.18	1.44	-18.06%	1.16	1.48	-21.99%	2.93	3.18	-7.9%	1.83	1.76	4.0%
Physician Primary Visits	2.29	2.46	-6.91%	2.50	2.81	-11.18%	5.58	5.96	-6.4%	14.48	17.86	-18.9%
Physician Specialist Visits	5.67	5.79	-2.07%	5.62	6.16	-8.78%	12.75	13.09	-2.6%	9.93	6.88	44.3%
Pharmacy Claims	8.17	10.41	-21.52%	6.16	7.40	-16.72%	6.02	7.53	-20.1%	6.59	7.87	-16.3%
Emergency Dept. Visits	0.33	0.36	-8.33%	0.36	0.39	-6.56%	0.49	0.52	-5.8%	0.78	0.82	-4.9%

[a] Use rates by service category are not summed to yield a total use measure because the units of measurement vary across service categories. Percentage difference columns reflect the change in moving from separate plan use to comprehensive plan use.
[b] Service utilization is per actual enrollee-year. Expected service utilization is adjusted for age, race, sex, CDPS total risk score (case-mix), months enrolled, and separate vs. comprehensive plan type and is calculated as the product of the predicted probability of use > 0 and the expected use conditional on use > 0.

Project 1, Component 7 - Express Enrollment (RQs 7A-7B)

Project 1, Component 7 examines of access to services, including expanded benefits, after enrolling in a health plan.

Research Question 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?

Data and Methods

Express Enrollment, which provides immediate enrollment in a MMA plan upon determination of eligibility, was initiated in conjunction with implementation of the MMA program in May 2014 and provided to all new MMA enrollees. Given that all enrollees were part of the Express Enrollment plan, analyses examining time to access treatment during the MMA period compared enrollees who selected their plans to enrollees who did not make a selection and were auto-enrolled into an MMA plan.

RQs 7A and 7B were answered using the following data sources: enrollment, eligibility, plan change, and encounter data for DY10 (January-June 2016), DY11 (SFY 2016-17), DY12 (SFY 2017-18), DY13 (SFY 2018-19), and DY14 (SFY 2019-20). Note that Component 7 was not included in the DY9 (SFY 2014-15) report.

Results

Under Express Enrollment, the average number of days for a new enrollee to access services varied across demonstration years (see Table 29). The lowest average days to access service for new enrollees was 33.36 days in DY10, compared with the longest average time of 78.28 days in DY11. When comparing auto-enrollment with voluntary choice enrollment, the mean days to service varies by enrollment method. For each DY, those enrolled under voluntary choice had a shorter average time to first service than those auto-enrolled. The difference of length to service between enrollment types was significant (as determined by t-tests) in all DYs, with the exception of DY10. Additionally, when comparing individuals who changed plans one or more times, those who changed had an earlier average time to service (compared with those who did not change plans), in each DY with the exception of DY10. For DY10, no significant difference in average time to service was found between individuals who changed plans one or more times, and those who did not change plans.

Table 29. Mean Days to Service for New Enrollees DY10 through DY14, by Enrollment Method

	Auto-enrollment	Voluntary Choice	Total
DY10			
New Enrollees N (%)	98,778 (72.59)	37,299 (27.41)	136,077 (100)
Mean Days to Service (SD)	37.09 (23.38)	23.49 (20.64)	33.36 (23.46)
DY11			
New Enrollees N (%)	224,472 (80.85)	53,165 (19.15)	277,637 (100)
Mean Days to Service* (SD)	86.10 (89.00)	45.24 (68.32)	78.28 (86.93)
DY12			
New Enrollees N (%)	213,914 (82.39)	45,730 (17.61)	259,644 (100)
Mean Days to Service* (SD)	80.58 (86.02)	43.07 (72.56)	73.98 (85.02)
DY13			
New Enrollees N (%)	213,591 (91.08)	20,918 (8.92)	234,509 (100)
Mean Days to Service* (SD)	68.58 (77.76)	43.87 (63.26)	66.38 (76.90)
DY14			
New Enrollees N (%)	124,274 (94.70)	6,591 (5.30)	131,225 (100)
Mean Days to Service* (SD)	75.94 (83.25)	51.49 (72.0)	74.64 (83.25)

*t-tests indicate significant differences in means for those auto-enrolled with those who made a voluntary choice.
Note: DY10 only includes new enrollees from January-June 2016.

Research Question 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?

Data and Methods

As previously stated, because SFY 2013-14 was a transition year, the pre-Express Enrollment calculation of time to first service use examined data for SFY 2012-13 (DY7). Enrollees were included if their initial enrollment month was August 2012 or later and they had a valid first date of service. Time to first service use during the pre-MMA period were calculated for HMO enrollees using encounter data and for FFS recipients using claims data.

Results

The average number of days for a new enrollee to access services was 28.59 days, on average, for DY7 prior to Express Enrollment. Since the implementation of Express Enrollment, the DY with the shortest average time to access services was DY10, with an average of 33.36 days. When further examining DY10 by enrollment type however, the average days to service is lower for those enrolled using Voluntary Choice, at 23.49 days. The years following DY10 each had a longer average time to service, ranging from an average of 66.38 in DY13 to 86.93 in DY11.

Project 4, Component 6 - Dual-Eligible Enrollees (RQs 6A-6C)

Project 4, Component 6, which included Research Questions 6A-6C, evaluated the use of behavioral health and non-emergency transportation services by dual-eligible enrollees.

Research Question 6A

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

Data and Methods

For this question, descriptive statistics were used and, therefore, no hypothesis was tested.

Results

As shown in Figure 8, changes in dual-eligible MMA enrollment over the DY10-DY14 study period closely paralleled the changes in total MMA enrollment. Dual-eligibles as a percentage of total enrollment averaged 6.79 percent across the period, varying slightly from a low of 6.65 percent in DY9 to a high of 7.04 percent in DY11.

Figure 8. Total MMA and Dual-Eligible Enrollments

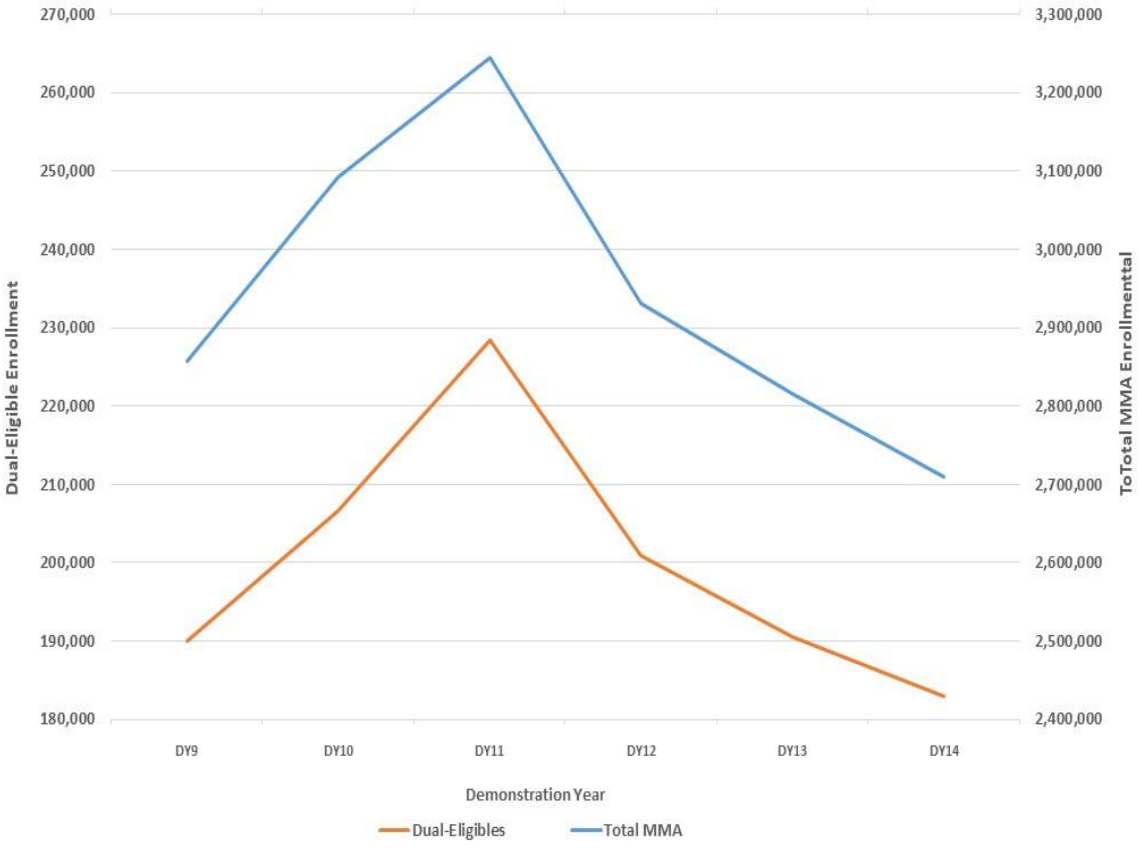


Table 30 below presents the annualized percentage changes in users, encounters, and amounts paid for BH and NET services for dual-eligibles and non dual-eligibles over the DY10-DY14 study period. Overall, the total number of users, encounters, and amounts paid for BH and NET services increased over the study period. The sole exception was the dollars amount for NET services for non dual-eligibles, which declined at an annualized rate of -9.71 percent over the study period. This is especially surprising given an annualized increase of 2.42 percent in NET encounters over the same period.

Table 30. Annualized Percent Changes - Users, Encounters, and Amounts Paid for Behavioral Health and Non-Emergency Transportation Services, Dual-Eligible and Non Dual-Eligibles, DY10- DY14

Enrollee Category	Medicaid BH and NET Users	Behavioral Health Encounters	Behavioral Health Amounts Paid	Non-Emergency Transportation Encounters	Non-Emergency Transportation Amounts Paid
Non-Dual-Eligibles	1.69%	2.57%	6.36%	2.42%	-9.71%
Dual-Eligibles	3.93%	0.60%	3.01%	7.47%	0.83%

To better understand the drivers of the aggregate amounts in

Table 30, Table 31 shows how dollars per user is determined by the dollars per encounter (i.e., the average amount paid by the MMA plan for each service encounter) multiplied by the number of service encounters per user (i.e., the average annual number of usages of the service among those who used the service). For example, the -9.71 percent annualized decline in dollars paid for NET services for non dual-eligible enrollees over the study period (Table 30) is driven by an -11.74 percent annualized decline in dollars per NET encounter (i.e., the amount that MMA plans pay for a NET encounter) (Table 31).

Table 31. Annualized Percent Changes in Dollars Per User, Dollars Per Encounter, and Encounters Per User for Behavioral Health and Non-Emergency Transportation Services, Dual-Eligibles and Non-Dual-Eligibles, DY10-DY14

Enrollee Category	Behavioral Health Dollars Per User	Behavioral Health Dollars Per Encounter	Behavioral Health Encounters Per User	Non-Emergency Transport Dollars Per User	Non-Emergency Transport Dollars Per Encounter	Non-Emergency Transport Encounters Per User
Non Dual-Eligibles	4.59%	3.64%	0.87%	-11.17%	-11.74%	0.73%
Dual-Eligibles	-0.91%	2.43%	-3.19%	-3.00%	-6.24%	3.42%

Other noteworthy results from Table 31 include:

- The amounts paid for NET services per user for dual-eligibles also declined over the DY10-DY14 study period, but at a more modest annualized rate of -3.00 percent. This decline, however, was composed of (1) an annualized decrease in amounts paid per NET encounter (-6.24 percent per annum) and (2) a partially offsetting annualized

increase in NET encounters per user (3.42 percent per annum).

- For BH services, dual-eligibles showed relative stability in BH dollar amounts paid per user with only a -0.91 percent annualized decline. This decline was driven by a -3.19 percent annualized decline in BH encounters per user significantly offset by a 2.43 percent annualized increase in BH amounts paid per encounter.
- By contrast, non dual-eligibles had an annualized increase in BH amounts paid per user of 4.59 percent over the DY10-DY14 period. This was driven primarily by a 3.64 percent annualized increase in BH dollars per encounter combined with a smaller 0.87 percent annualized increase in BH encounters per user over the study period.

Research 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?

Data and Methods

Qualitative results were obtained combining survey data and key informant interviews. Details about each method and participant involvement are discussed below.

Qualitative Interviews with MMA Health Plans (RQ 6B). The evaluation team conducted qualitative interviews with experts in care coordination at the MMA plans. Interview sessions followed a semi-structured format using an in-depth interview guide approved by the Agency. Sessions were audio recorded and interviews transcribed for thematic analysis. The evaluation team created a comprehensive codebook with themes related to behavioral health and non-emergency transportation services provided to dual-eligible enrollees which was finally used to identify patterns in responses and detect exemplary quotes. During DY13-14 the evaluation team did not conduct qualitative interviews but collected care coordination experts' perspectives via email sending a multimodal survey questionnaire in pdf format. Once completed, care coordination experts sent the survey back to the evaluation team. Data was analyzed using SPSS and MAXQDA for thematic analysis. Respondents were contacted for a follow-up interview if clarifications were needed and their answers were included in the final report.

The results for research question 6B for DYs 10, 11 and 13-14 were similar, showing consistent challenges to coordinating behavioral health (BH) and non-emergency transportation (NET) services related to social determinants of health (e.g., stigma associated with mental health, issues of network adequacy in rural areas) and poor contact information of dual eligible members. Reviewing encounters emerged as particularly difficult for behavioral health service provision because two separate systems were used, one for medical and the other for BH. For the provision of NET services, health plans played a crucial role in implementing coordination strategies and ensuring that their vendors provided timely, safe and high-quality transportation services to dual-eligible members. However, plans experienced challenges in providing NET services if the Medicare provider information was unknown. Coordinating BH care and NET service for dual-eligibles was identified as challenging when access to multiple encounter systems was needed, or when Medicare data was not available to MMA plans, and/or Medicare case managers and providers were not available or were reluctant to cooperate.

Results

For DY10 and DY11, qualitative interviews with MMA plan experts revealed several possible best practices for coordinating BH services for dual-eligible members such as:

- Adopting a comprehensive case management strategy that integrates traditional case management approaches with utilization management, performance measures, member education, member and family engagement, and linkage to community resources.
- Enhancing the collaboration with hospital case managers for discharge planning, establishing behavioral health homes at community mental health centers, and working with Medicare plans to share information on members.
- Obtaining access to systems such as the Homeless Management Information System (HMIS) to facilitate member location.

Similar practices were indicated to improve access and quality of NET services suggesting, for example, the adoption of technological innovations to coordinate NET services in real-time.

For DYs 13-14 the key informant survey revealed that unique challenges emerged during the COVID-19 state of emergency. During the pandemic, limited access to members' physical health information represented the main barrier to effective and timely care coordination for members using behavioral health services. In addition, COVID-19 limited the in-person services that behavioral health and primary care providers could offer to members, and drove the same providers to implement telehealth services, although those services were not accessible to everyone. Reduced in-person visits impacted delivery of care for the most vulnerable and high-risk members, especially among those who had to start services with a new provider or did not have the technological means to participate in telehealth appointments. Plans and BHOs implemented outreach activities (by phone and mail) together with educational initiatives designed to address these problems. The expansion of telehealth definitely represented a crucial goal for the further development of plan programs. COVID-19 definitely impacted the health care system and introduced new modalities of care coordination that the health plans and BHOs will continue to utilize and develop for their dual-eligible members.

Research Question 6C

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

Data and Methods

The evaluation team developed a structured telephone survey to be administered to dual-eligible members in MMA standard and MMA specialty plans, addressing experiences and satisfaction with coordination of behavioral health and non-emergency transportation services. Telephone survey data was analyzed using SPSS and statistics were provided to report satisfaction and experience rates of dual-eligible enrollees.

Results

Survey data was consistent throughout DYs 10, 11, 13-14 and showed that dual-eligible members overall had positive experiences and satisfaction with the BH and NET services through MMA standard plans and MMA specialty plans. Some areas for improvement included ensuring that needed BH services are fully covered by health plans (which may involve better coordination with Medicare plans) and improving the timeliness of NET services in picking up enrollees after their scheduled appointments.

While the survey results throughout demonstration years were similar, a significant area of difference between DY10 and DYs 11 and 13-14 was the precipitous drop in sample productivity for the specialty plan members who received both BH and NET services. For DY10, 13 records were needed to get a completed survey from these members while in DY11, 21 records were needed, and in DY13-DY14, about 20 calls were needed to get a completed survey. Because the general trend with telephone surveys decreased in response rates over time, the number of completed surveys obtainable per year from this population will continue to decrease, thereby resulting in larger margins of error and potentially increased non-response bias associated with the answers to this research question. To address this issue, it may be necessary to increase the resources allocated to the survey data collection or pursue alternative data collection strategies (e.g., web-based surveys and/or focus groups) to counter this trend in declining sample productivity in the future.

G. Conclusions

In general, the results of the MMA evaluation to date show that the demonstration was effective in achieving five of the six goals[34] established at the beginning of the demonstration: In particular, the findings of this evaluation suggest the following with regard to the MMA demonstration's six goals:

Goal 1: Improving outcomes through … maintaining fiscal responsibility… for Medicaid beneficiaries …[35]

Evidence from this evaluation indicates that the MMA demonstration improved outcomes for Medicaid beneficiaries while maintaining fiscal responsibility:

- With respect to outcomes, a total of 10 health plan performance measures and sub-measures included in the MMA evaluation dealt with the effectiveness of care in improving outcomes for cardiovascular health, diabetes, and behavioral health conditions. Comparing those measures over the 2011-2013 pre-MMA period to the 2015-2019 MMA period showed that 9 of the 10 effectiveness measure means were higher in the MMA period than in the pre-MMA period, indicating higher quality of care during the MMA period. The average percentage difference across all 10 measures between the MMA and pre-MMA periods was +7.10 percent.
- With respect to fiscal responsibility, Medicaid cost per member per month was substantially lower during the MMA period compared to the pre-MMA period.[36]

Goal 2: Improving program performance … on nationally recognized quality measures (such as … HEDIS scores). … A key objective of improved program performance is to increase patient satisfaction.[37]

A substantial majority of health plan performance measures (76 percent) increased under MMA compared to the pre-MMA period. More specifically,

- From DY9 to DY14, 22 of the 29 MMA health plan performance measures (approximately 76 percent) improved, 5 measures (17 percent) remained the same, and

[34] The state's goals for the MMA demonstration include goals and various hypothesized pathways whereby these goals could be realized. For purposes of evaluating the attainment of goals, this section concentrates on the goals themselves rather than delving into the pathways. In other words, this section concentrates on the ends rather than the hypothesized means whereby those ends were achieved.

[35] Full text of Goal 1: Improving outcomes through care coordination, patient engagement in their own healthcare, 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.

[36] Medicaid cost per member per month was measured by (1) Agency capitation payment rates under MMA compared to (2) Agency payments to providers under the previous fee-for-service system.

[37] Full text of Goal 2: 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.

three measures (10 percent) declined compared to the pre-period. Six measures had improvements greater than 10 percent from the pre-MMA period to the MMA period:

- Chlamydia Screening in Women 21-24 years (42%)
- Adult BMI Assessments (19%)
- Chlamydia Screening in Women 16-20 years (16%)
- Total Annual Dental Visits (13%)
- Comprehensive Diabetes Care-Nephrology (12%)
- Well-Child Visits in the First 15 Months of Life - 6+ visits (11%)
-

- Enrollee satisfaction as reflected in the enrollee's overall rating of their health plan in CAHPS increased for both adults and children between the pre-MMA period (2013 and 2014[38]) and the MMA period (2015-2019). More specifically,
  - The percentage of adult enrollees rating their health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased from 48.5 percent in the pre-MMA period (2013-2014) to 61.7 percent in the MMA period (2015-2019).
  - Similarly, the percentage of child enrollees rating their health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased from 58.0 percent in the pre-MMA period (2013-2014) to 67.3 percent in the MMA period (2015-2019).

Goal 3: 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.

- Comparing the HEDIS accessibility measures between the pre-MMA period and the post-MMA period (CY2015-2019), 21 of the 23 (91%) measures improved and two measures (9%) remained the same. None of the measures declined. The measures with the largest improvements (defined as greater than or equal to ten percent) were:
  - Adults' Access to Preventive/Ambulatory Health Services 65+ Years (15%)
  - Immunizations for Adolescents – Combination 1 (14%)
  - Timeliness of Pre-Natal Care (13%)
  - Timeliness of Post-Partum Care (13%)
  - Well-Child Visits in the First 15 Months of Life (11%)
- In addition, CAHPS measures concerning getting needed care and getting care quickly increased in the MMA period relative to the pre-MMA period for both adults

[38] CY 2014 was treated as a transition year in this evaluation but is included in the pre-MMA period for this particular comparison.

and children. Satisfaction with the number of doctors to choose from was also substantially higher (as shown in Table 4 and
- Table 5 in this report) in the MMA period compared to the pre-MMA period.

Goal 4: Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals, FQHCs and RHCs that are furnished through charity care programs that adhere to the HFMA principles.

- The LIP program provided between $576M and up to $2B in funds to safety net providers in DY9 through DY14. Over the course of the demonstration, the majority of providers that received LIP funds to offset charity care costs were hospitals; however, FQHCs, and MSPPs also received funding in DY12 to DY14. Despite such substantial funding, it is not possible within the scope of this evaluation to infer any type of causal relationship between LIP funding and access to care.
- Moreover, because the types of providers, funding amounts, and number of reporting providers that received LIP funding varied from year to year it is not possible to make comparisons or identify meaningful trends based on the data provided.

Goal 5: 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.

- New enrollee medical debt as of Medicaid enrollment increased by $12 PMPM for new enrollees overall[39] following the retroactive enrollment policy change compared to prior to the policy change.
- When limiting the analysis to only those new enrollees who accrued some new medical debt, the mean increase in medical debt upon enrollment was substantially larger at $85 PMPM.[40]
- No change was detected in total non-medical debt accrued in the 12 months prior to new Medicaid enrollment for those who enrolled following the policy change compared to those who enrolled prior to the policy change.
- No changes in provider uncompensated care costs or financial margins were found between the year prior to the policy change compared to the first year following the policy change.

Goal 6: 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.

[39] This includes new enrollees who had zero medical debt.
[40] Two caveats concerning these findings should be kept in mind. First, these increases are *mean* increases. The actual changes in medical debt vary widely around these overall means. Consequently, a small percentage of Medicaid enrollees are likely to incur increases in medical debt substantially in excess of these means of $12 PMPM and $85 PMPM.

- The MMA evaluation results showed improved health outcomes and reduced health care costs following the introduction of MMA, suggesting that Goal 6 was fully attained.

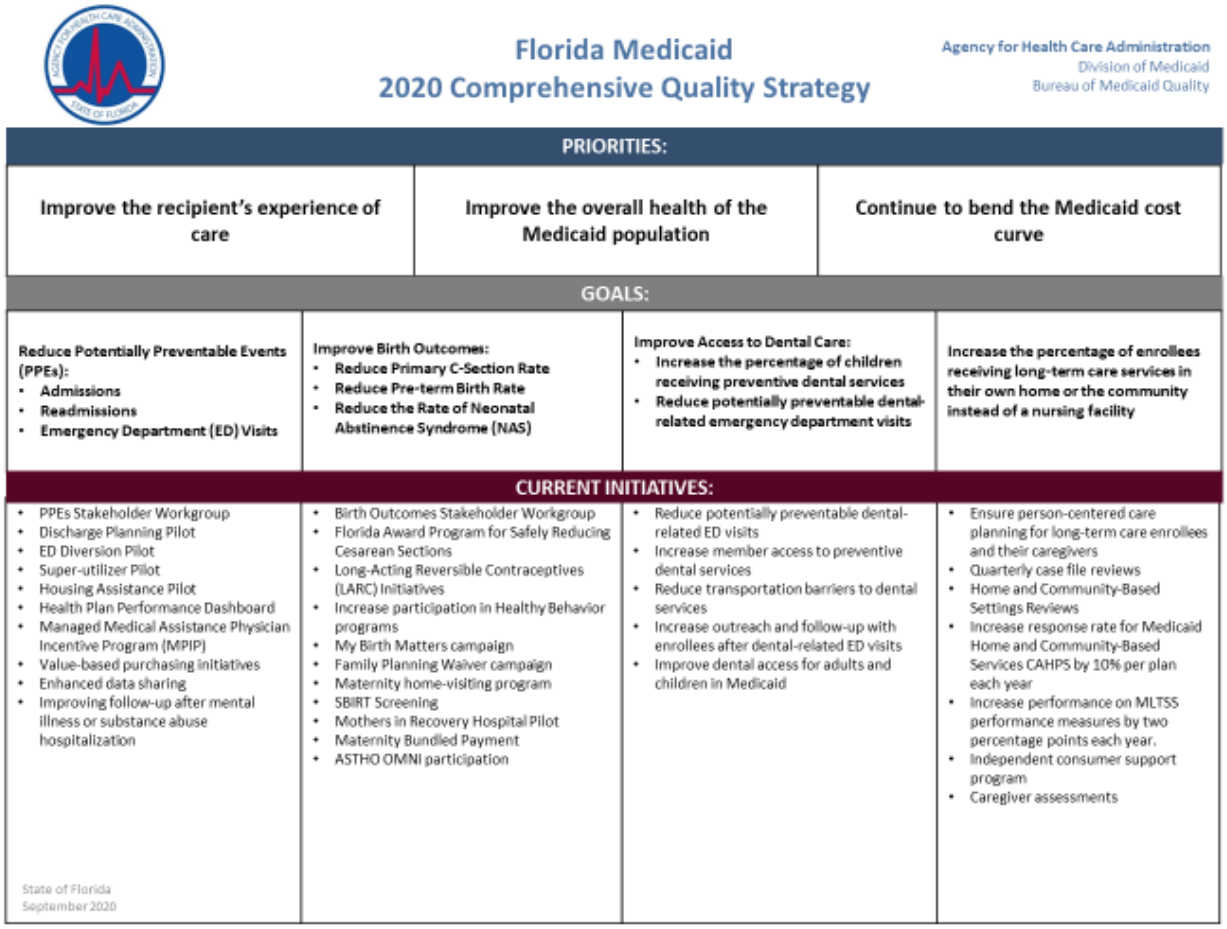
Goal 5 concerning retroactive enrollment is the only goal of the MMA demonstration that was not fully achieved. In particular, the evaluation team found no evidence of improved continuity of coverage, uptake of preventive services, or increased enrollment immediately after becoming eligible. Part of the reason this goal was not achieved may have involved the failure to communicate the policy change effectively to a sufficiently broad audience. However, the evaluation team questions whether better public dissemination of the policy change alone would alter Medicaid enrollees' behavior regarding enrollment continuity and the uptake of preventive care. In particular, motivating enrollees to consider the need for timely Medicaid enrollment and the implications of Medicaid non-renewal for future access to care may involve far more than an effective public information campaign. It may require a change in the way in which individuals prioritize preventive health care as a way of remaining healthy and avoiding future acute illnesses.

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

Overall Medicaid Context and Long-Range Planning

The MMA Program and the LTC Program are the two components of Florida's Statewide Medicaid Managed Care (SMMC) Demonstration, and are integral components of Florida Medicaid's 2020 Comprehensive Quality Strategy as depicted in the following figure:

Figure 9. Florida Medicaid 2020 Comprehensive Quality Strategy



Source: *Comprehensive Quality Strategy 2020 Update*, Florida Agency for Health Care Administration, https://ahca.myflorida.com/medicaid/policy_and_quality/quality/docs/Comprehensive_Quality_Strategy_Report.pdf, accessed March 3, 2022.

In particular, evidence summarized in this report shows that the MMA demonstration has contributed materially to all three of the major priorities of the Florida Medicaid 2020 Comprehensive Quality Strategy as shown in Table 32.

Table 32. MMA Contributions to Florida's Medicaid 2020 Comprehensive Quality Strategy Priorities

Comprehensive Quality Strategy Priority Area	MMA Impacts Relevant to Priority Area
Improve the recipient's experience of care	Enrollee satisfaction as reflected in the enrollees' overall rating of their health plans in CAHPS increased for both adults and children between the pre-MMA period (2013 and 2014) and the MMA period (2015-2019).[41] More specifically, • The percentage of adult enrollees rating their health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased on average from 48.5 percent in the pre-MMA period (2013-2014) to 61.7 percent in the MMA period (2015-2019). • Similarly, the percentage of parents rating their child's health plan a 9 or 10 on a scale of 0 (worst) to 10 (best) increased from 58.0 percent in the pre-MMA period (2013-2014) to 67.3 percent in the MMA period (2015-2019). CAHPS measures concerning getting needed care and getting care quickly[42] also increased in the MMA period relative to the pre-MMA period for both adults and children. Satisfaction with the number of doctors to choose from was also much higher in the MMA period.
Improve the overall health of the Medicaid population	A total of 10 health plan performance measures and sub-measures included in the MMA evaluation (see Figure 1 in the Executive Summary) addressed the effectiveness of care in improving outcomes for cardiovascular health, diabetes and behavioral health conditions. Comparing these measures over the 2011-2013 pre-MMA period to the 2015-2019 MMA period showed that 9 of the 10 effectiveness measure means were higher in the MMA period than in the pre-MMA period, indicating higher quality of care during the MMA period. The

[41] CY 2014 was treated as a transition year in this evaluation, but is included in the pre-MMA period for this particular comparison. In general, the pre-MMA comparison periods will vary somewhat depending on the CAHPS measures under scrutiny for reasons discussed earlier in this report.

[42] See Table 4 and Table 5 in this report. CAHPS changed the way they aggregated their survey results between the pre-MMA and MMA periods, precluding the comparison of pre-MMA and MMA CAHPS results using these aggregations. For purpose of this summative report, the evaluation team used disaggregated CAHPS survey answer distributions to produce consistent re-aggregations of CAHPS results so that valid comparisons could be made.

	average percentage difference across all 10 measures between the MMA and pre-MMA periods was +7.10 percent.
Continue to bend the Medicaid cost curve	When comparing statistically-adjusted mean and median PMPM expenditures between the pre-MMA and MMA periods, substantial reductions in mean expenditures were seen for all eligibility groups. Mean adjusted PMPM expenditures decreased from $428 to $241 after MMA implementation for TANF enrollees, decreased from $1,448 to $1,230 for SSI enrollees, and decreased from $542 to $222 for dually eligible enrollees. See Table 9 above.

The MMA demonstration also complements other federal waiver initiatives supporting these strategic priorities and goals. In particular, two of the eight state initiatives supporting Florida's Medicaid 2020 Comprehensive Quality Strategy (the Health Behaviors Program and the Housing Assistance Pilot Program) are integral components of the MMA demonstration.

Table 33 lists the other ongoing federal waiver demonstrations in Florida and their various functions. These other waiver programs generally have provisions that add to the effectiveness of the MMA demonstration. For example, the Family Planning Waiver extends family planning and related services to women at high-risk of unwanted pregnancies who have lost their Medicaid coverage, thereby adding to the positive impacts of the MMA program on access to care. Also, the Long-term Care Waiver extends managed care principles of consumer choice and capitated payment to an important long-term care population in much the same way the MMA program extends such principles to Medicaid enrollees more broadly. Finally, the Home and Community-Based Service Waiver extends managed care's emphasis on alternatives to institutional care to those who require nursing facility level of care in much the same way that the MMA program emphasizes ambulatory preventive services as a way of reducing the need for hospitalizations for conditions that can be managed effectively through ambulatory care services.

Table 33. Interactions Between the MMA Demonstration and Other Federal Demonstrations and Initiatives in Florida

Waiver	Waiver Functions
Section 1115 Family Planning Waiver (Federal)	The family planning waiver provides family planning and family planning-related services to all women of child bearing ages (14-55) losing Medicaid coverage, who have a family income at or below 185 percent of the federal poverty level and who are not otherwise eligible for Medicaid, Children's Health Insurance Program, or other health insurance coverage providing family planning services. Coverage is available for up to two years after loss of Medicaid eligibility.

Florida 1915(b)(4) Waiver Non-Emergency Transportation Waiver (Federal)	This waiver provides non-emergency transportation services to eligible Medicaid recipients.
Florida Concurrent Section 1915(b) and 1915(c) Long-term Care Waiver (Federal)	The Long-Term Care program provides long-term care services and supports to eligible disabled individuals age 18-64 and elderly individuals age 65 or older, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. Program recipients receive their services through competitively selected managed care organizations.
Home and Community-Based Service 1915(c) Waivers (Federal)	Home and Community-Based Services Waivers programs are the federally approved Medicaid programs authorized by Title XIX of the Social Security Act, Section 1915(c) that provide services in the home or other community settings for person who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility.
1915(c) Florida Familial Dysautonomia Waiver (FD) (State)	The purpose of the Medicaid Familial Dysautonomia (FD) Waiver is to provide home and community-based supports and services to eligible persons with Familial Dysautonomia living in their own homes or family homes. The FD Waiver is designed to promote, maintain and restore the health of eligible recipients with Familial Dysautonomia and to minimize the effects of illness and disabilities through the provision of needed supports and services in order to delay or prevent hospital placement or institutionalization.
1915(c) Florida Developmental Disabilities (DD) Individual Budgeting Waiver (iBudget) (State)	The purpose of the Medicaid iBudget Waiver is to provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting, utilize an individual budgeting approach, and provide enhanced opportunities for self-determination. The iBudget Waiver is designed to promote and maintain the health of eligible individuals with developmental disabilities, to provide medically necessary supports and services to delay or prevent institutionalization, and to foster the principles and appreciation of self-determination.
1915(c) Florida Model Waiver (State)	The purpose of the Medicaid Model Waiver is to provide services to eligible children 20 years of age or younger who are medically complex/medically fragile or diagnosed with degenerative spinocerebellar disease. The Model Waiver is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while living at home in their community.

Source: "Federal Waivers", Florida Agency for Health Care Administration, https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/index.shtml, accessed March 3, 2022.

Interpretations and Policy Implications at the State and Federal Levels

The MMA evaluation results largely speak for themselves in terms of quality, cost, and access.

Improving quality while reducing costs and maintaining or improving access suggests that the MMA Demonstration was successful. Similarly, achieving five out of the six goals of the MMA Demonstration does not require nuanced interpretations as with more equivocal results. The MMA Demonstration should continue, and the state should strive to build upon an impressive start.

A recent updated review of 32 peer-reviewed studies of Medicaid managed care published between 2011 and 2019 found evidence of "state-specific cost savings and instances of increased access or quality with implementation or redesign of Medicaid managed-care programs."[43] This review is considerably different from the earlier, more pessimistic assessment of Medicaid managed care effects on access, cost, and quality that spawned this update.[44] Within this context, the performance of the MMA demonstration is consistent with the more recent published literature on the performance of other states' Medicaid managed care programs on costs, access, and quality.

Relatively little published work has been done on PDHP programs in other states.[45] With only one-year of preliminary evidence on Florida's PDHP program, comparisons must await future results of Florida's PDHP program and additional results from Virginia and other states implementing PDHPs.

Evidence on supportive housing programs in other states is similarly sparse, but a 2021 study by Hollander, et al.[46] was consistent with the first-year results from Florida's Supportive Housing Pilot Program. Florida found statistically significant reductions in ED use and avoidable hospitalizations in the first-year of its Supportive Housing Pilot Program. Hollander, et al. found statistically significant reductions in both overall hospital inpatient use and ED use among enrollees in Pennsylvania's Permanent Supportive Housing intervention.

I. Lessons Learned and Recommendations

The MMA evaluation has yielded numerous lessons about how a demonstration such as MMA should be implemented and evaluated.

1. **Issue:** The MMA demonstration was implemented statewide over a single three-month period. This implementation strategy precluded the ability to identify a valid comparison group for the evaluation, and greatly limited the ability to make causal inferences about the impact of the demonstration.

[43] Franco Montoya D, Chehal PK, Adams EK. Medicaid Managed Care's Effects on Costs,Access, and Quality: An Update. *Annu Rev Public Health* [Internet]. 2020 Apr 1 [cited 2021 Nov 16];41:537–49. Available from: https://pubmed.ncbi.nlm.nih.gov/32237985/.
[44] Sparer M. *Medicaid Managed Care: Costs, Access and Quality of Care - RWJF* [Internet]. 2012 Sep [cited 2022 Mar 2]. Available from: https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html.
[45] The only published work identified examining Medicaid PDHP programs was a 2021 study of Virginia Medicaid's three year-old Dental Support Organizations (DSOs) published in the *Journal of the American Dental Assocation*. This work found a "significant increase in provider participation and growth of DSO-affiliated provider." Brickhouse TH, Dahman BA, Peters BWR, Liu H, Kumar AM. The impact of dental Medicaid reform on dental care provider activity and market penetration of dental support organizations. J Am Dent Assoc [Internet]. 2021 Oct 1 [cited 2022 Mar 1];152(10):822–31. Available from: https://pubmed.ncbi.nlm.nih.gov/34454708/.
[46] Hollander MAG, Cole ES, Donohue JM, Roberts ET. Changes in Medicaid Utilization and Spending Associated with Homeless Adults' Entry into Permanent Supportive Housing. J Gen Intern Med [Internet]. 2021 Aug 1 [cited 2022 Mar 1];36(8):2353–60. Available from: https://pubmed.ncbi.nlm.nih.gov/33515190/.

Recommendation: To improve the focus of future evaluation efforts, we recommend that the evaluation design for future demonstrations be fully integrated into the demonstration design process itself. This would (1) allow the demonstration design team to alert the evaluation design team when demonstration design and implementation processes may constrain the design and conduct of the evaluation and (2) allow the evaluation team to highlight to the demonstration team how particular choices about the design and implementation of the demonstration can have major effects on the usefulness of the evaluation results. Such early and continuing interaction will help ensure that the evaluation will yield the most relevant and useful information for the Agency, while ensuring that the results are as valid and reliable as possible.

2. **Issue:** Attempting to answer over fifty evaluation questions in-depth using state-of-the-art causal inference techniques is prohibitively expensive.

   Recommendation: Reduce the number of evaluation questions to focus specifically on those questions dealing with the fundamental impacts of the demonstration on key variables such as outcomes, quality of care, access to care, and utilization. In particular, we recommend limiting the number of purely descriptive evaluation questions concerning routine program performance statistics such as enrollments, participation rates, enrollee choices, and program completion rates. Such information is very important for managing new initiatives such as MMA, but can be provided more frequently and at lower cost through well-designed routine management reports rather than through the demonstration evaluation.

3. **Issue:** Consult with the evaluation team prior to altering existing information flows when implementing a new demonstration. While new demonstrations can eliminate the need for certain data elements and thereby streamline operations, maintaining existing data collection efforts even temporarily can greatly aid in conducting the evaluation. An excellent example is provided by the retroactive enrollment application process for new enrollees. When the retroactive enrollment policy change was implemented, the collection of data for verifying retroactive enrollment eligibility was immediately limited to pregnant women and children only. This had the unintended consequence of making it impossible to identify those relatively few new enrollees who would have qualified for retroactive enrollment in the absence of the policy change. This greatly hampered examining the impact of the policy change on the financial burden of new enrollees.

   Recommendation: Consult with the evaluation team prior to the planning of new components to ensure that critical baseline data are not lost or discontinued. In particular, even a brief delay in implementing changes to existing data collection processes can be invaluable in the evaluation of a new demonstration. Alternatively, small workarounds can preserve essential information for the evaluation while allowing changes in information flows to proceed largely as planned.

4. **Issue:** Tracking the evolution of the demonstration's impact in the first few years following implementation necessitates replicating analyses using newly acquired data to identify changes in the demonstration's impact. Consequently, there is some necessary

and appropriate repetition of analyses using new data in order to track changes in the demonstration's effects. However, it is also important to recognize that the emphasis on particular questions may need to evolve based on past findings and the availability of new data. This requires flexibility in the evaluation design so that resources can be shifted from topics where substantial evidence has been acquired to newer questions and topics whose relative importance has increased based on the evolution and progress of the demonstration.

Recommendation: Develop an adaptive evaluation plan where the focus of the evaluation can shift annually as evidence on the demonstration's effects accumulate and new data become available.

5. **Issue:** Health plan reports submitted to the Agency were often incomplete and/or contained data of questionable validity. This limited the usefulness of the data for purposes of answering the evaluation questions.

   Recommendation: Ensure that health plans consistently submit their data and reports in the formats as specified in the Agency guidance.

J. Appendices

Appendix I. MMA Evaluation Design

MMA Evaluation Design approved by the CMS is included in Volume II of this report.

Appendix II. Year-to-Year Changes in MMA Evaluation Topics and Questions

The MMA evaluation has expanded in scope over the six years covered in this report. In particular, new evaluations have been added focused on the Prepaid Dental Health Program (PDHP), the retroactive enrollment policy change, and supportive housing pilot. Most of the original core question topics explored in the first year of the evaluation, however, have remained largely unchanged although there were minor changes in the wording of particular questions.

Beyond the new evaluations for PDHP, retroactive enrollment, and supportive housing, the elimination of the Fraud and Abuse domain/component following DY9 was the only major change in the MMA evaluation. The consensus among the Agency and the evaluation team was that there was little to be learned in analyzing the Fraud and Abuse questions once they were initially explored in DY9. The Fraud and Abuse domain/component consisted of the following questions:

4A. *What are the program integrity related measures employed by the MMA managed care plans related to: deterring fraud and abuse by network and non-network providers; deterring fraud and abuse by recipients; detecting fraud and abuse by network and non-network providers; and detecting fraud and abuse by recipients?*

4B. *How often do managed care plan compliance officers/teams interact with providers in the plan networks? What types of contact and interactions do the compliance officers/teams have with providers? How do plans document and track their efforts to deter fraud and abuse?*

4C. *How does State collect and track Medicaid fraud and abuse data reported by the MMA plans? How does the State coordinate and/or assist the MMA plans with fraud and abuse efforts?*

4D. *How do health plan compliance officers/teams measure the effectiveness of the health plan policies and procedures related to program integrity?*

Additional substantive changes included (1) the sunsetting of the joint eligibles component after DY11, (2) the dropping of the Health-Promoting Incentive Programs questions following DY9 because of the overlap with the new Healthy Behaviors Program.

The table and footnotes below summarize the year-to-year changes in the topic content of the MMA Demonstration over the DY9-DY14 period.

Table 34. Changes in MMA Evaluation Topics DY9-DY14

Topic	DY9	DY10	DY11	DY12	DY13/DY14[47]
Access, Utilization, Quality, Timeliness, and Cost					
Access Barrier Types	1A	1A	1A	1A	1A
Pre-Post Overall Accessibility Changes	1B	1B	1B	1B	1B
Pre-Post Overall and Specialty vs. Standard Accessibility Changes, Plan vs. Pop.[48]	1C, 1D, 1E	Consoli-dated into 1B	Consoli-dated into 1B	Consoli-dated into 1B	Consolidated into 1B
Pre-Post Overall and Specialty vs. Standard Utilization Changes, Plan vs. Pop.	1F	1C	1C	1C	1C
Pre-Post Overall and Specialty vs. Standard Quality Changes, Plan vs. Pop.	1G	1D	1D	1D	1D
Quality of Care Improvement Strategies and Their Effectiveness, Standard vs. Specialty	1H	1E	1E	1E	1E
Pre-Post Overall and Specialty vs. Standard Timeliness Changes, Plan vs. Pop.	1I	1F	1F	1F	1F
Pre-Post Overall and Specialty vs. Standard Cost Changes, Plan vs. Pop.	1J	1G	1G	1G	1G
Expanded Benefits					

[47] Because of delays in the start of the MMA evaluation, the MMA evaluation started out one year behind the most recently available MMA encounter and eligibility data. To bring the MMA evaluation up to date with currently available data, DY13 and DY14 were evaluated as separate evaluation years during a single calendar year. The results for DY13 and DY14 were published in a single set of reports using the designation "DY13/14" to signify that two evaluation years were covered in single set of reports.

[48] Research Questions 1B-1E (RQ 1B-1E) in DY9 all dealt with similar dimensions of health care accessibility under MMA. Because of the similarity of the questions, RQ 1B-1E from DY9 were consolidated under RQ 1B for DY10-DY13/14.

Topic	DY9	DY10	DY11	DY12	DY13/DY14[47]
Types, Tailoring, and Use of EB[49]	2A	2A, 2B (Use separated out into 2B)	2A, 2B (Use separated out into 2B)	2A, 2B (Use separated out into 2B)	2A, 2B (Use separated out into 2B)
Enrollee Satisfaction and Types of EB	2B	Postponed until DY11	2D	2D	2D
Enrollee Accessibility and Types of EB	2C	Dropped	Dropped	Dropped	Dropped
Service Use for EB Users vs. Non-Users[50]	--	--	2C	2C	2C
Joint Eligibles (MMA and LTC)[51]					
Separate Plan Enrollments	10A	5A	5A	Sunset	Sunset
Comprehensive Plan Enrollments	10B	5B	5B		
Utilization and Cost Diffs. Separate vs. Comprehensive	10C	5C	5C		
Strategies and Effectiveness for Care Coordination[52]	10D	Dropped	Dropped		
Healthy Behaviors					
Healthy Behaviors Programs Offered	3A	3A	3A	3A	3A
Healthy Behaviors Incentives and Rewards	3B	3B	3B	3B	3B
Healthy Behaviors Participation, Enrollment, and Completion	3C	3C	3C	3C	3C
Healthy Behaviors Sociodemographics	3D	3D	3D	3D	3D

[49] Because use was qualitatively different from types and tailoring of EB services, it was listed as a separate question following DY9.
[50] Because service use for EB users and non-users was deemed an important topic, it was added in DY11 as a new RQ2C in place of the original version of RQ 2C dealing with accessibility.
[51] The joint eligibles topic was sunset following DY11.
[52] The Agency and the evaluation team decided to drop the data collection on strategies and effectiveness for care coordination after DY9 since replicating the DY9 data collection was unlikely to uncover new information.

Topic	DY9	DY10	DY11	DY12	DY13/DY14[47]
Service Utilization by Participants vs. Non-Participants	3E	3E	3E	3E	3E
Health-Promoting Incentive Programs[53]					
EBAP Enrollment vs. Healthy Behaviors Enrollment	12A	Dropped	Dropped	Dropped	Dropped
Healthy Behaviors Programs not in EBAP	12B				
Use of HB Incentives vs. Prior EBAP Incentives	12C				
Use of Services in EBAP vs. Participation in HB	12D				
Fraud and Abuse[54]					
Program Integrity Measures	4A	Dropped	Dropped	Dropped	Dropped
Compliance-Provider Interactions	4B				
State Fraud and Abuse Data Collection and Tracking	4C				
Health Plan Compliance Measures of Program Integrity	4D				
Amount of Overlap Between LTC and MMA Programs	11A				
Low-Income Pool[55]					
LIP Program Changes Year-Over-Year	5A	Dropped	Dropped	Dropped	Dropped
Uninsured/Underinsured Service Receipt Through LIP	5B	4B	4B	4B	4B

[53] Questions about the EBAP were only collected in DY9 because of their overlap with the Health Behaviors Program.
[54] Based on the DY9 results, questions related to fraud and abuse were discontinued since no new information was anticipated from subsequent data collection.
[55] Topics concerning the LIP program evolved over the course of the evaluation to concentrate on the key questions on types and amounts of services and accessibility for UCC patients in place of descriptive information about LIP tiers.

Topic	DY9	DY10	DY11	DY12	DY13/DY14[47]
Changes in Accessibility for Pops. Funded by LIP	6A	4A	4A, 4C	4A, 4C	4A, 4C
Number of LIP-funded Programs to Reduce Disparities	6B	Dropped	Dropped	Dropped	Dropped
Goals of Tier-One Milestone Programs	7A	Dropped	Dropped	Dropped	Dropped
Success of Tier-One Programs in Access and Quality	7B	Dropped	Dropped	Dropped	Dropped

Appendix III. Research Question 9C

Data Merge Methods:

UF, the lead institution in MMA evaluation, is entered into a contract with Trans Union LLC (TU) to license depersonalized information from TransUnion's database of consumer credit information ("TU Data") on medical and total debt burdens for new Medicaid enrollees in Florida. These data will be used to evaluate the impact of the February 2019 change in retroactive enrollment policy that limited retroactive enrollment to pregnant women and children. In particular, medical and total non-medical debt data was analyzed both descriptively and in a series of multivariable regression models to determine if Florida's new retroactive enrollment policy impacted new enrollee financial burden.

To accomplish this work, UF will sent TU via secure FTP server a finder file containing each new enrollee's name, address, social security number (SSN), and month and year of Medicaid enrollment along with a randomly-assigned anonymous ID number. A total of 24 monthly cohorts of new enrollees were transmitted for the 12 months immediately prior the February 2019 policy change and the 12 months immediately following the February 2019 policy change. TransUnion used this information to match each new enrollee's name, address, and SSN to TransUnion Data on medical and total debt for that enrollee in the months surrounding their month of Medicaid enrollment.

To ensure privacy and data security, a UF honest broker served as liaison between the UF MMA evaluation team and TU. This UF honest broker was in charge of adding the randomly-assigned anonymous ID number to the finder file prior to transmittal to TU. The UF honest broker is a member of the Department of Health Outcomes and Biomedical Informatics (HOBI) data team, but had and has no responsibilities under or connection to the UF MMA evaluation team.

Once TU merged the finder file with TU's debt data, TU then stripped off all Personally Identifiable Information (PII) (i.e., name, address, and SSN) to ensure strict confidentiality before transmitting the randomly assigned ID and medical and total debt data back to the UF honest broker via secure FTP. TU did not use the original finder file for any purpose other than fulfilling its contractual obligation of providing to UF the requested TU Data. TransUnion will destroy the finder file once UF notifies them that the analyses are complete. The transmitted TU Data was placed in the UF ResShield environment, UF's FISMA-compliant secure computing environment, in a folder accessible only by the UF honest broker.

The UF honest broker then merged the TU data with a file containing key Medicaid enrollee covariates (e.g., age, sex, race/ethnicity, and case-mix index) furnished by the MMA evaluation team. Prior to the merge, the honest broker used the original finder file to assign the random ID from the finder file to the Medicaid covariate file. This allowed the honest broker to merge the

TU Data with the Medicaid covariate file using the random ID alone. Once the merge was accomplished, the honest broker documented the success of the merge (percentage matched correctly, percentage found in one but not both datasets, etc.), and destroyed the original finder file containing the name, address, SSN, and random ID. After accounting for the fact that children under the age of 16 do not have credit reports, the percentage of successful matches was approximately 96%, indicating a robust merge methodology. The UF honest broker then sent the merged TU-Medicaid analytic file to the secure MMA analytic folder used by MMA evaluators. The evaluation team then conducted the required analyses using this merged TU-Medicaid analytic file.

State Assistance Groups Eligibility Inclusion/Exclusion Status

Table 35. State Assistance Groups Included and Excluded in Analysis

State Assistance Category Code	State Assistance Category Description	Eligible for Inclusion in Analysis (Yes/No)
1	SSI	Yes
2	Elderly Disabled	Yes
3	SOBRA Children	No
4	TANFF	Yes
5	Unemployed Parents PMA	Yes
6	Medically Needy	Yes
8	Refugee Assistance Program	Yes
9	QMB or SLMB or WD	Yes
10	SOBRA Pregnant Women	No
11	SOBRA Children Over Poverty Level	No
12	SOBRA Preg Women Over Poverty Level	No
14	Family Planning	No
15	MediKids Under 150% Poverty	No

16	MediKids Over 150% Pov and 133% age 1	No
17	Medicaid Expansion From SOBRA age <1	No
18	Unknown	No
19	MediKids for Chip Transition	No