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

Project 1 Final Interim Report

Contract Deliverable No. 14, Managed Medical Assistance Final Interim Report – Project 1 DY10: Components 1, 2, 5, and 7

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List of Acronyms

ADHD  Attention Deficit Hyperactivity Disorder
AMG   Amerigroup
BET   Better Health, Inc.
CAHPS  Consumer Assessment of Healthcare Providers and Systems
CCP   Community Care Plan
CDPS  Chronic Illness and Disability Payment System
CHA   Clear Health Alliance
CHF   Congestive Heart Failure
CMS   Centers for Medicare and Medicaid Services
CMSMA Statewide Medicaid Managed Care – Children’s Medical Services
CPSN  Capitated Provider Sponsored Network
COPD  Chronic Obstructive Pulmonary Disease
CVD   Cardiovascular Disease
CY    Calendar Year
DY    Demonstration Year
EBA   Enhanced Benefits Account
ED    Emergency Department
EQRO  External Quality Review Organization
FFS   Fee for Service
FRELD Frail Elder
GEE   Generalized Estimating Equations
HCBS  Home and Community-Based Services
HEDIS Healthcare Effectiveness Data and Information Set
HMO   Health Maintenance Organization
HMOMC Health Maintenance Organization Managed Care
HMOSC Health Maintenance Organization Specialized Care
HSAG  Health Services Advisory Group
HTCTS Health Track Complaints Tracking System
HUM   Humana Medical Plan
INT   Integral Quality Care
LDL   Low Density Lipoprotein
LTC   Long-term Care
MAG   Magellan Complete Care
MMA   Managed Medical Assistance
MMAC  Managed Medical Assistance Capitated
MMACC Managed Medical Assistance Child Welfare Capitated
MMASC Managed Medical Assistance Specialty Capitated
MOL   Molina Healthcare of Florida
MPASS MediPass
OTC   Over the Counter
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>PACE</td>
<td>Program for All Inclusive Care for Elderly</td>
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<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
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<tr>
<td>PHC</td>
<td>Positive Healthcare of Florida, Inc.</td>
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<td>PMPM</td>
<td>Per Member Per Month</td>
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<td>PIP</td>
<td>Performance Improvement Project</td>
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<td>PRE</td>
<td>Preferred Health</td>
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<td>PRS</td>
<td>Prestige Health Choice</td>
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<td>PSN</td>
<td>Provider Service Network</td>
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<td>PSNR</td>
<td>Provider Service Network - Reform</td>
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<td>PSNNR</td>
<td>Provider Service Network – Non-Reform</td>
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<td>RAHF</td>
<td>Medicaid Reform HMO - AHF</td>
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<td>REHMO</td>
<td>Medicaid Reform Health Maintenance Organization</td>
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<td>SFCCN</td>
<td>South Florida Community Care Network</td>
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<td>SFY</td>
<td>State Fiscal Year</td>
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<td>SHP</td>
<td>Simply Healthcare Plans</td>
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<td>SMI</td>
<td>Serious Mental Illness</td>
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<td>SMMC</td>
<td>Statewide Medicaid Managed Care</td>
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<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>STW</td>
<td>Staywell</td>
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<tr>
<td>SUN</td>
<td>Sunshine Health Plan</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance for Needy Families</td>
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<tr>
<td>URA</td>
<td>United Healthcare of Florida</td>
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<td>WNHD</td>
<td>Nursing Home Diversion Waiver</td>
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Executive Summary

This report presents the interim results of Project 1 of the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Evaluation for State Fiscal Year 2015-16 (SFY 2015-16), the second year of the SMMC program. Project 1 focuses on Components 1, 2, 5 and 7. Component 1 consists of quality, utilization, cost, accessibility and timeliness; Component 2 consists of expanded benefits; Component 5 looks at the impact of having separate MMA and Long-term care (LTC) plans; and Component 7 looks at Express Enrollment.

Data and Methods

This project used a mix of quantitative and qualitative methods. Quantitative data were provided by the Agency through a series of data requests from the evaluation team and included the eligibility, claims, and encounter data for Medicaid enrollees covering SFY 2011-12 and SFY 2012-13 (pre-MMA period), and SFY 2014-15 and SFY 2015-16 (MMA period) as well as various data reports provided to the Agency by the health plans. Quantitative methods consisted of both descriptive comparisons of use and costs of services (e.g., means and medians) as well as statistical models of use and costs designed to control for potential confounding effects to more precisely measure the effect of specific interest.

Qualitative work completed at this time includes developing survey tools and instruments.

Key Findings

Component 1 – Quality, Utilization, Cost, and Accessibility and Timeliness

Quality of Care

- Quality of care in MMA plans during the MMA period improved or remained the same for the majority of performance measures compared to quality of care in pre-MMA implementation plans. Out of the 32 performance measures, 69 percent (22 measures) improved, 3 percent (1 measure) remained the same, and 28 percent (9 measures) declined. While these results are positive overall, one measure, Medication Management for People with Asthma – 50 percent Medication Compliance, declined by 27 percentage points between the pre-MMA and MMA periods.

Utilization

- After adjusting for demographic characteristics and health status, reductions were seen in the mean number of all services – inpatient stays, outpatient visits, emergency department (ED) visits, and professional visits – between the pre-MMA and MMA periods, with mean adjusted per-Member per-Month (PMPM) services decreasing from 0.05 inpatient admissions PMPM to 0.03 inpatient admissions PMPM, 0.37 outpatient visits PMPM to 0.12 outpatient visits PMPM, 0.23 ED visits PMPM to 0.16 ED visits PMPM, and 2.16 professional visits PMPM to 1.61 professional visits PMPM.
Cost

- The cost analysis is taken from AHCA’s perspective, thus, costs were calculated based on monthly capitation payments to MMA plans.
- Reductions in mean expenditures were seen for all eligibility groups: Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and Dual Eligibles (DUAL). Mean adjusted PMPM expenditures decreased from $205 to $191 after MMA implementation for TANF enrollees, decreased from $1,420 to $983 for SSI enrollees, and decreased from $478 to $215 for dually eligible enrollees.
- 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.

Accessibility and Timeliness

- Statewide weighted means for selected performance measures related to access to care stayed the same or improved slightly between the pre-MMA and MMA periods, with 78 percent (21 measures) of the 27 accessibility measures showing improvement, 11 percent (3 measures) showing no change, and 11 percent (3 measures) showing decline between the pre-MMA and MMA periods.¹
- On average, wait times for visits were more likely to be longer than contract standards for urgent care visits, but were mostly met for routine care and well care visits.

Component 2 – Expanded Benefits

- 67.4 percent of the 3,781,049 MMA enrollees in DY10 were utilizing expanded benefits.
- 20.5 percent of 65,505,271 encounters in DY10 pertained to expanded benefits.
- MMA plans offered up to 20 Agency-approved expanded benefits in DY10.
- 8 of the 13 MMA plans offered at least 17 of the 20 expanded benefits.
- The average number of expanded benefits offered across all of the standard plans was 15, with the number of expanded benefits ranging from a low of 7 to a high of 20.
- 17.6 of expanded benefit encounters percent 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,

¹ Using data provided by the Agency, weighted means for each measure were calculated based on the eligible population for each plan. The means were then averaged across all plans for each time period. Percentages were calculated based on the difference in the 2011-2013 pre-MMA means and the unweighted arithmetic average of the CY 2015 and CY 2016 means. A mean increase from pre-MMA to the MMA period was counted as an improvement in the percentage calculations; a change of zero was counted as no change and a decrease in the means was counted as a worsening of the measure.
outpatient services, and dental services.

- Expanded benefits users had higher percentages of inpatient services and ED visits than non-users of expanded benefits:
  - 11.2 percent of expanded benefits users had inpatient admissions versus 4.2 percent of non-users.
  - 37 percent of expanded benefits users had ED visits compared to 20 percent of non-users.

**Component 5 - Comprehensive MMA-LTC Plan vs. Separate MMA and LTC Plans**

- During SFY 2015-16, 43.8 percent of unique Medicaid enrollees receiving both MMA and LTC services were enrolled in a single comprehensive Medicaid managed care plan for receipt of these services, while 56.2 percent were enrolled in separate Medicaid managed care plans for these services.

- Differences in Medicaid service utilization between enrollees in separate versus comprehensive plans varied across type of service in DY10.
  - Enrollees in comprehensive plans had lower adjusted mean service utilization for non-inpatient services compared to enrollees in separate plans for (1) hospital outpatient visits (-22.0 percent), (2) primary care physician visits (-11.2 percent), (3) specialty physician visits (-8.8 percent), (4) pharmacy claims (-16.7 percent), and (5) emergency department (ED) visits (-6.6 percent).
  - By contrast, enrollees in comprehensive plans had higher adjusted mean service utilization for (1) hospital inpatient admissions (+1.5 percent) and (2) hospital inpatient days (+15.5 percent).

- These DY10 differences between separate vs. comprehensive plans are quite similar to the DY9 differences.

**Component 7 – Express Enrollment**

- Express Enrollment, which provides immediate enrollment in a MMA plan upon determination of eligibility, was initiated in January 2016 for new enrollees who were mandated to participate in the MMA program. Because all enrollees participated in Express Enrollment, analyses examining time to access services during the relevant MMA period (January 1 – June 30 2016) compared enrollees who selected their plans to enrollees who did not make a selection and, therefore, were auto-enrolled into an MMA plan.

- 72.59 percent (N=98,778) of the 136,077 new enrollees with a valid date of service from January 1 through June 30 in DY10 were enrolled using auto-enrollment compared with 27.41 percent (N=37,299) enrolled by voluntary choice.

- During January 1 through June 30 in DY10, new enrollees accessed services approximately 33.36 days after enrollment on average.

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² Component 5 is focused solely on Medicaid utilization. Consequently, utilization for Medicaid enrollees receiving both MMA and LTC services who are also dually eligible for Medicare will only reflect the Medicaid portion of their total health care utilization.
This average was 37.09 days for those who were auto-enrolled.
This average was 23.49 days for those who made a voluntary choice for enrollment. The difference in these two averages is statistically significant.

- When comparing individuals who changed plans one or more times, those who changed plans had an earlier average time to service at 33.36 days compared with 33.37 days for those who did not change plans.

The average number of days for a new enrollee to access services from January 1 through June 30 2016 in DY10 under express enrollment, was 33.36 days, compared with 28.59 days, on average for DY7 prior to Express Enrollment.

### Introduction

This report presents the second-year results for Project 1 of the Florida Managed Medical Assistance (MMA) Evaluation. This second year of the MMA program evaluation covers Demonstration Year 10, July 1, 2015 through June 30, 2016, State Fiscal Year 2015-2016 (SFY 2015-16).

The MMA evaluation includes targeted evaluation questions that examine the following eight areas of focus (components), which have been organized into four separate projects:

- **Component 1.** The effect of managed care on access to care, quality and efficiency of care, and the cost of care (Project 1)
- **Component 2.** The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care (Project 1)
- **Component 3.** Participation in the Healthy Behaviors programs and its effect on participant behavior or health status (Project 1)
- **Component 4.** The impact of LIP funding on hospital charity care programs (Project 3)
- **Component 5.** The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care (Project 1)
- **Component 6.** The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals (Project 4)
- **Component 7.** The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner (Project 1)
- **Component 8.** The effect the Statewide Medicaid Prepaid Dental Health Program (PDHP) on accessibility, quality, utilization, and cost of dental health care services.\(^3\)

The remainder of this report provides (1) background on the MMA program and a brief summary of pertinent results from the first year of the MMA evaluation, (2) a listing of the components, evaluation questions, and hypotheses for Project 1, (3) a brief discussion of data and methods, (4) the results for each evaluation question from all four of Project 1’s components, and (5) conclusions and recommendations. Additional information and technical details on (1) overall structure of the MMA evaluation (components, evaluation questions, and hypotheses), (2) data sources, and (3) statistical methods and model results are provided in the appendices that

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\(^3\) Component 8 will be undertaken following the implementation of the PDHP when data become available.
Background

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

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

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

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

UF submitted a Final Comprehensive Evaluation Report for Demonstration Year 9 (DY9, i.e., SFY2014-15) to the Agency in December 2017, which included the following high level findings:

1. In the MMA period, there were sizable declines in service utilization compared to the pre-MMA period for the following:
   a. Inpatient stays
   b. Outpatient visits
   c. Emergency Department visits
   d. Professional (physician) visits

2. Out of a subset of 26 Healthcare Effectiveness Data and Information Set (HEDIS) measures, approximately 65 percent (17 measures) of the statewide weighted means improved and 27 percent (7 measures) stayed the same after implementation of MMA. Only 8 percent (2 measures) declined after implementation.

3. Per-member per-Month (PMPM) costs adjusted for age, race, gender, and Chronic Illness and Disability Payment System (CDPS) scores (case-mix) for MMA services are 32.9 percent lower for enrollees in comprehensive plans (serving both LTC and MMA enrollees) compared to PMPM costs for enrollees who are in separate LTC and MMA plans ($206 PMPM comprehensive vs. $306 PMPM separate).
While the Florida transition to statewide managed care in 2014 was not without challenges, the overall success in implementing such a broad transformation in the span of a few short months, while reducing PMPM costs and maintaining or improving quality measures, stands as a considerable accomplishment.

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.

Components, Evaluation Questions, and Hypotheses

This report addresses Project 1 (Components 1, 2, 5, and 7) of Florida’s SMMC MMA Program Evaluation for DY10 (SFY 2015-16). The remainder of this section lists the evaluation questions and hypotheses associated with each component of Project 1.

Component 1

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

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

Question 1A is answered descriptively using AHCA complaint, grievance, and appeal data and Health Track Complaints Tracking System (HTCTS) from the MMA period, and to the extent possible, Medicaid Fair Hearing data. Hence, no hypotheses are tested.

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

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

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

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

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

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

**1E.** What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?

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

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

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

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

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

## Component 2

The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care

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

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

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

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

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

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

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

This RQ will employ qualitative methods (no hypotheses).

**Component 5**

The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care and the cost of care

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?

RQs 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 evaluation questions.

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

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

**Component 7**

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

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

7B. Among new enrollees, what is the time to access services for enrollees who are enrolled
under Express Enrollment compared to enrollees who were enrolled prior to the implementation of Express Enrollment? These RQs will produce descriptive results comparing the time to service for enrollees (1) in general, (2) under auto-enrollment, and (3) who switch plans within 120 days. There are no hypotheses associated with these questions.

Data and Methods

Quantitative Methods

Quantitative data for this evaluation were provided by the Agency through a series of data requests from the evaluation team and included the eligibility, claims, and encounter data concerning Medicaid enrollees covering state fiscal years SFY 2011-12 and SFY 2012-13 (pre-MMA), and SFY 2014-15 and SFY 2015-16 (MMA) as well as various data reports provided to the Agency by the health plans. Analyses of per member per month costs involving FFS claims also includes data from SFY 2013-14. These data sources along with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) data sources are summarized in Appendix 2 in Volume 2 of this report. Overall, health plans examined in Project 1 were classified as “Pre-MMA” plans and “MMA” plans depending on whether the data were from or prior to SFY 2012-13 (the pre-MMA period) or from SFY 2014-15 or SFY 2015-16 (the MMA period).

During the MMA period, health plans were further subdivided into standard and specialty plans. There were no specialty plans broken out for the pre-MMA period.

The year immediately preceding the rollout of MMA (SFY 2013-14) is considered a transition year. Encounter data from this transition year were excluded from the utilization analyses in this report to ensure that 1) the transition from claims reporting during the pre-MMA period to encounter reporting during the MMA period had been completed; 2) appropriate data quality procedures had been implemented; and 3) changes observed between the pre-MMA and MMA periods did not include any transitory data anomalies resulting from MMA implementation.

While provider payments from the encounter data were excluded, capitation payments for SFY2013-14 were deemed accurate and were used in the comparisons of pre-MMA to MMA period costs.

Quantitative methods consisted of both descriptive comparisons of use and costs of services (e.g., means and medians) as well as statistical models of use and costs designed to control for potential confounding effects to more precisely measure the effect of specific interest.

The HEDIS health plan performance measures are maintained by the National Committee for Quality Assurance (NCQA). NCQA is a 501(c)(3) not-for-profit organization dedicated to improving health care quality that was founded in 1990. The NCQA currently measures health plans on 60 standards as part of the accreditation process.
Qualitative Methods

Data Collection
To address RQ 1E, in-depth interviews with quality care experts at each MMA plan will be conducted in June and July 2018. Plan contract managers will identify quality-of-care experts. Investigators will then send an introductory email to the quality-of-care experts, outlining the purpose of the study and a request for a 30 to 60 minute interview. The introductory email will also include a form-fillable PDF document with preliminary questions including a request to list and briefly describe the plans’ ongoing quality improvement and performance improvement projects. The in-depth interviews will occur with the quality of care experts identified at each plan, or appropriate delegated individuals.

The evaluation team developed a qualitative interview guide that has been approved by the Agency. In-depth interviews will focus primarily on understanding the strategies associated with high-performing projects as well as general barriers plans may have encountered as they sought to implement performance improvement projects.

Prior to the in-depth interviews, the evaluation team will review (1) each MMA plan’s updated Policy and Procedure document(s) provided by the Agency as it relates to quality of care and performance improvement and (2) the 2015-2016 Florida Annual Performance Improvement Project Validation Summary Report produced by the Health Services Advisory Group. These reviews will be used to generate additional questions and points of clarification that are unique to each plan and will be added to the interview guide prior to the telephone call.

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

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

Research Question 1A
What barriers do enrollees encounter when accessing primary care and preventive services?

This evaluation question is answered using descriptive analysis and therefore, no hypothesis is tested.
Methods

Evaluators used the plan-reported data extracted from the ‘Complaint, Grievance and Appeal Information Reports’ submitted to the Agency for July 2015-June 2016 as well as the Agency for Health Care Administration’s Health Track Complaints Tracking System (HTCTS) for SFY 2015-16 to analyze access-to-care complaints and issues reported by enrollees.

Results

Complaint, Grievance, and Appeal Data: Plan-reported complaints did not specify the particular type of access-to-care complaint registered by the enrollee. The analysis includes only records with a reported grievance date, such as the initial date that the grievance was recorded by each plan. Among those, 59.7 percent of total grievances were still pending at the end of the SFY 2015-16 analysis period and 40.3 percent were resolved as shown in Table 1. The 16,109 access-to-care grievances correspond to approximately 4.26 access-to-care grievances per 1,000 enrollees.

For records with a disposition status of pending, as stated in the instructions for completing the complaint, grievance, and appeals report provided to the plans by the Agency, “any grievance or appeal first reported as pending must be reported again when resolved.” Therefore, caution should be taken in interpreting the results because it is possible that a grievance from an enrollee could show up as pending across months and resolved in the same year. Moreover, any complaint, grievance, or appeal reported as pending as of the end of the fiscal year will be reported again when resolved either in the next fiscal year or later.

Table 1. Access-to-Care Grievances from Plan-Reported Data Table

<table>
<thead>
<tr>
<th>Disposition Status</th>
<th>Total SFY 2015-16</th>
<th>SFY 2015-16 Rate per 1,000 Enrollees&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending</td>
<td>9,625</td>
<td>59.7</td>
</tr>
<tr>
<td>Resolved</td>
<td>6,484</td>
<td>40.3</td>
</tr>
<tr>
<td>Total</td>
<td>16,109</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data extracted from plan reporting using the Complaint, Grievance and Appeal Information Reports from July 2015-June 2016.

<sup>b</sup> Rate based on 3,781,067 total FL SMMC enrollees identified from eligibility data as of July 1, 2016.

HTCTS Data: As shown in Table 2 below, there were 774 access-to-care complaints reported by enrollees to the Agency and entered in the HTCTS for the period July 2015-June 2016. Access complaints reported to the Agency through the HTCTS (n=774) fell into four broad categories: (1) Not Enough Providers of a Specific Type (42.2 percent), (2) No Provider of a Specific Type (39.1 percent), (3) Provider Too Far Away (14.9 percent) and (4) Appointments Not Timely (3.6 percent).
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?

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).

Performance Data:

Table 3 presents a comparison in the changes between the statewide weighted means for select HEDIS and Agency-defined performance measures for the pre-MMA period (CY 2011-2013) and the MMA period (CY 2015 and CY2016). While the measures do not directly capture barriers to access, access to care is reflected in the measures, since individuals with greater access to care will have higher utilization rates and hence higher performance measure rates.

Performance measures for 2014 are excluded because CY 2014 was a blend of the pre-MMA and MMA periods, making comparison to other years problematic.

Using data provided by the Agency, weighted means for each measure were calculated for each plan based on the eligible population. The means were then averaged across all plans for each time period shown in the table. Most measures stayed the same or improved slightly between the pre-MMA and MMA periods. More specifically, 78 percent (21 measures) of the 27 accessibility measures in Table 3 showed improvement between the pre-MMA and MMA periods, 11 percent (3 measures) of the measures showed no change, and 11 percent (3 measures) decreased between the pre-MMA and MMA periods.4

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4 These percentages were calculated based on the difference in the 2011-2013 pre-MMA means and the unweighted arithmetic average of the CY 2015 and CY 2016 means. A mean increase from pre-MMA to the MMA period was counted as an improvement in the percentage calculations, while a change of zero was counted as no change, and a decrease in the means was counted as a decrease in performance.
Table 3. Comparison of Changes in Statewide Means of Performance Measures, pre-MMA Plans (CYs 2011-2013) and All MMA Plans (CY 2015 and CY 2016)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>49%</td>
<td>53%</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services 20-44 years</td>
<td>67%</td>
<td>69%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services 45-64 years</td>
<td>82%</td>
<td>85%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services 65+ years</td>
<td>70%</td>
<td>77%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services Total</td>
<td>72%</td>
<td>75%</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Annual Dental Visits</td>
<td>Total</td>
<td>36%</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td></td>
<td>52%</td>
<td>61%</td>
<td>55%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td>56%</td>
<td>51%</td>
<td>56%</td>
</tr>
<tr>
<td>Childhood Immunization Status Combo 2</td>
<td></td>
<td>77%</td>
<td>77%</td>
<td>78%</td>
</tr>
<tr>
<td>Childhood Immunization Status Combo 3</td>
<td></td>
<td>72%</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners 12-24 months</td>
<td>95%</td>
<td>95%</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners 25 months – 6 years</td>
<td>88%</td>
<td>89%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners 7-11 years</td>
<td>86%</td>
<td>89%</td>
<td>89%</td>
<td></td>
</tr>
</tbody>
</table>
### Measure Components

<table>
<thead>
<tr>
<th>Measure</th>
<th>Component</th>
<th>Average of CY 2011-2013 Pre-MMA Plans</th>
<th>CY 2015 Statewide MMA Plans</th>
<th>CY 2016 Statewide MMA Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners</td>
<td>12-19 years</td>
<td>83%</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>16-20 years</td>
<td>57%</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>21-24 years</td>
<td>69%</td>
<td>69%</td>
<td>69%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>Total</td>
<td>62%</td>
<td>62%</td>
<td>63%</td>
</tr>
<tr>
<td>HIV-Related Outpatient Medical Visits</td>
<td>≥ 2 visits (182 days apart)</td>
<td>54%</td>
<td>28%</td>
<td>47%</td>
</tr>
<tr>
<td>Immunizations for Adolescents</td>
<td>Combination 1</td>
<td>58%</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td></td>
<td>59%</td>
<td>61%</td>
<td>66%</td>
</tr>
<tr>
<td>Timeliness of Prenatal Care</td>
<td></td>
<td>72%</td>
<td>83%</td>
<td>84%</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td></td>
<td>52%</td>
<td>59%</td>
<td>64%</td>
</tr>
<tr>
<td>Prenatal Care Frequency</td>
<td>≥ 81% of expected visits</td>
<td>60%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Transportation Availabilitya</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>0 visits</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>6+ visits</td>
<td>56%</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td></td>
<td>75%</td>
<td>75%</td>
<td>76%</td>
</tr>
</tbody>
</table>

† In accordance with HEDIS reporting requirements, measures for plans with denominators less than 30 were not included in the calculations of the weighted means. * Agency-defined measure. † Because 2014 is a hybrid/transition year, data for 2014 has been omitted from this table. ‡ This measure will not be reported after CY 2016 data.

**CAHPS Data:** Table 4 and Table 5 show changes in the accessibility of services before and after MMA implementation using CAHPS adult and child measures of patient experience. Because of changes over time in CAHPS measure reporting and in administration of the surveys, CAHPS results collected across the pre-MMA and MMA periods are not comparable,
and direct comparisons should not be made. Higher scores during the MMA period may represent changes in how the measures were aggregated and reported.

**CAHPS Adult Data:** As shown in Table 4, 54 percent of adult enrollees reported that it was always easy to get care quickly and 28 percent rated the number of doctors they had to choose from as excellent during CY 2013 and CY 2014.

**Table 4. Statewide Means of CAHPS Measures, Pre-MMA Plans (CYs 2013-2014)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>CAHPS Version 4 &amp; 5 Adult Medicaid Questions for 2013 and 2014 (pre-MMA)</th>
<th>Simple Average of 2013 and 2014 Pre-MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>Percentage of respondents reporting it is always easy to get needed care (vs. usually, sometimes or never)</td>
<td>53%&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>Percentage of respondents reporting it is always easy to get care quickly (vs. usually, sometimes or never)</td>
<td>54%</td>
</tr>
<tr>
<td>Rate the Number of Doctors</td>
<td>Percentage of respondents rating the number of doctors to choose from as excellent (vs. very good, good, fair, or poor)</td>
<td>28%</td>
</tr>
<tr>
<td>Health Plan Information and Customer Service</td>
<td>Percentage of respondents reporting they usually or always get the help/information needed from their plan’s customer service staff (vs. sometimes or never)</td>
<td>*&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>* Not reported.<br>a Tables 4 and 5 report different time periods because reporting methods changed between 2013-2014 and 2015. Scores in Tables 4 and 5 should not be compared.<br>b 2014 scores only.</sup>

As shown in Table 5, in 2016, 88 percent of adult enrollees reported usually or always getting help/information from their plan’s customer service staff and 82 percent reported it was usually or always easy to get care quickly (Table 5). Rate the Number of Doctors was not reported in the 2016 survey. All 2016 accessibility of services measures were within two percentage points of 2015 measures.

**Table 5. Statewide Means of CAHPS Measures, All MMA Plans (CY 2015 and CY 2016)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>CAHPS Version 5 Adult Medicaid Questions (MMA)</th>
<th>2015 MMA</th>
<th>2016 MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>Percentage of respondents reporting it is usually or always easy to get needed care (vs. sometimes or never)</td>
<td>82%</td>
<td>80%</td>
</tr>
</tbody>
</table>
**CAHPS Child Data:** Table 6 and Table 7 show changes in the accessibility of services before and after MMA implementation using CAHPS child measures for patient experiences. In the pre-MMA period, 73 percent of respondents reported they usually or always got the help/information needed from the customer service staff of their child’s health plan, and 66 percent of respondents reported it was always easy to get care quickly for their child.

**Table 6. Statewide means of CAHPS Measures, Pre-MMA Plans (CYs 2013-2014)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>CAHPS Version 5 Adult Medicaid Questions (MMA)</th>
<th>2015 MMA</th>
<th>2016 MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Care Quickly</td>
<td>Percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)</td>
<td>83%</td>
<td>82%</td>
</tr>
<tr>
<td>Rate the Number of Doctors</td>
<td>Percentage of respondents rating the number of doctor’s to choose from as excellent or very good (vs. good, fair, or poor)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Health Plan Information and Customer Service</td>
<td>Percentage of respondents reporting they usually or always get the help/information needed from their plan’s customer service staff (vs. sometimes or never)</td>
<td>87%</td>
<td>88%</td>
</tr>
</tbody>
</table>

* Not reported.

---

<table>
<thead>
<tr>
<th>Measure</th>
<th>CAHPS Version 4 &amp; 5 Child Medicaid Questions for 2013 and 2014 (pre-MMA)</th>
<th>Simple Average 2013 to 2014 (Pre-MMA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>Percentage of respondents reporting it is always easy to get needed care (vs. usually, sometimes or never)</td>
<td>60%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>Percentage of respondents reporting it is always easy to get care quickly (vs. usually, sometimes or never)</td>
<td>66%</td>
</tr>
<tr>
<td>Rate the Number of Doctors</td>
<td>Percentage of respondents rating the number of doctors to choose from as excellent (vs. very good, good, fair, or poor)</td>
<td>36%</td>
</tr>
<tr>
<td>Health Plan Information and Customer Service</td>
<td>Percentage of respondents reporting they usually or always get the help/information needed from their plan’s customer service staff (vs. sometimes or never)</td>
<td>73%a</td>
</tr>
</tbody>
</table>

*a 2014 scores reported only.*
In 2016, 87 percent of respondents reported they usually or always got the help/information needed from their plan’s customer service staff and 89 percent of respondents reported it was always easy to get care quickly (Table 7). Eighty-three percent of respondents reported it is usually or always easy to get needed care. All 2016 accessibility of services measure results were within one percentage point of results for 2015.

Table 7. Statewide Means of CAHPS, All MMA plans (CY 2015 and CY 2016)

<table>
<thead>
<tr>
<th>Measure</th>
<th>CAHPS Version 5 Child Medicaid Questions for 2015 (MMA)</th>
<th>2015 MMA</th>
<th>2016 MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Needed Care</td>
<td>Percentage of respondents reporting it is usually or always easy to get needed care (vs. sometimes or never)</td>
<td>82%</td>
<td>83%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>Percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Rate the Number of Doctors</td>
<td>Percentage of respondents rating the number of doctor's to choose from as excellent or very good (vs. good, fair, or poor)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Health Plan Information and Customer Service</td>
<td>Percentage of respondents reporting they usually or always get the help/information needed from their plan's customer service staff (vs. sometimes or never)</td>
<td>86%</td>
<td>88%</td>
</tr>
</tbody>
</table>

* Not reported.

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 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 recipients in the MMA period compared to the pre-MMA period. 2) There will be no difference in enrollee use of services provided by 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.

Service utilization was captured using claims and encounter data and placed into the following categories for the study period: inpatient visits, outpatient visits, emergency department (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 shows 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. 0.04 inpatient visits PMPM is equivalent to 0.48 inpatient visits per member per year).

Univariate Analyses

In order to calculate Medicaid program service utilization, claims and encounters were obtained for all Medicaid enrollees for SFY 2011-12, SFY 2012-13, SFY 2014-15, and SFY 2015-16. Claims and encounters for all individuals in a qualifying eligibility category 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 services used by a person in a month (a member-month). Average PMPM services were calculated by pre-MMA (SFY 2011-12 and SFY 2012-13) and MMA (SFY 2014-15 and SFY 2015-16) periods. The analysis was based on data referring to all Medicaid enrollees who met the inclusion and exclusion criteria. Hence, the subjects included here represent the complete population of eligible enrollees germane to this analytic question, as distinct from a random sample.

Multivariate Analyses

Multivariate interrupted time-series analyses were conducted to better understand the pattern of changes in service utilization, as well as to control for any differences in the distribution of age, race, gender, or risk scores between the pre-MMA and MMA enrollees. As with the univariate analysis, the multivariate analysis examined whether trends in PMPM service utilization significantly differed between the pre-MMA and MMA time periods. The statistical model was estimated using negative binomial regressions that account for correlation of observations over time. For physician and specialist visits, a logistic regression model was conducted, with the outcome indicator being whether the person used that service each month (yes/no). Because services 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 48 observations for the analyses (representing monthly observations across SFY 2011-12, SFY 2012-13, SFY 2014-15, and SFY 2015-16).

RQ1C Part 1: Utilization of Services pre-MMA and post-MMA

Univariate Results

The univariate (unadjusted) results are shown below in Table 8. When comparing mean and median PMPM service utilization between the pre-MMA and MMA periods, reductions were seen in the mean number of all services – inpatient visits, outpatient visits, ED visits and professional visits. Mean utilization of inpatient visits for an enrollee in a month decreased from 0.04 per month to 0.03 inpatient visits per month, from 0.36 outpatient visits per month to 0.14 outpatient visits per month, from 0.23 ED visit per month to 0.14 ED visits per month, and from

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5 Professional services consist of primary care fee-for-service (FFS), specialty care FFS, other professional FFS, subcapitated professional services, and professional service settlements.

6 This analysis was completed using the XTNBREG procedure in Stata

7 This analysis was completed using the XTLOGIT procedure in Stata.
2.40 professional visits per month to 1.60 professional visits per month. During the MMA period, the mean numbers of physician visits and specialist visits were 0.52 PMPM and 0.79 PMPM, respectively.

**Table 8. Unadjusted Service Utilization PMPM Before (SFY 2011-12 and SFY 2012-13) and After (SFY 2014-15 and SFY 2015-16) MMA Implementation**

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-MMA (N = 29,168,486)</th>
<th>MMA (N = 29,992,175)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.04</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.36</td>
<td>0</td>
</tr>
<tr>
<td>ED</td>
<td>0.23</td>
<td>0</td>
</tr>
<tr>
<td>Professional</td>
<td>2.40</td>
<td>1</td>
</tr>
<tr>
<td>Physician (MMA only)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialist (MMA only)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Multivariate Results**

Depicted in Table 9 is the adjusted PMPM service utilization from the multivariate analyses. The multivariate results are adjusted for differences in demographic characteristics and health status between pre-MMA and MMA. For inpatient, outpatient, ED, and professional visits, results are presented as adjusted service counts. For physician and specialist visits, results are presented as adjusted probabilities of having any visit in a month in accordance with the evaluation team's two-part statistical models. The incidence rate ratios (or coefficients) of the variables of interest estimated in the multivariate analyses are presented in Appendix 3 of Volume 2 of this report.

When comparing adjusted mean and median PMPM service utilization between the pre-MMA and MMA periods (Table 9) results were similar to the unadjusted results, with reductions seen in the mean number of all services – inpatient, outpatient, ED, and professional. Mean adjusted PMPM services decreased after MMA implementation from 0.05 inpatient visits PMPM to 0.03 inpatient visits PMPM, 0.37 outpatient visits PMPM to 0.03 outpatient visits PMPM, 0.23 ED visits PMPM to 0.16 ED visits PMPM, and 2.16 professional visits PMPM to 1.61 professional visits PMPM. During the MMA period, the adjusted mean number of physician visits PMPM was 0.36 visits, while the number of specialist visits was 0.31 visits PMPM.
Table 9. Adjusted Service Utilization PMPM Before (SFY 2011-12 and SFY 2012-13) and After (SFY 2014-15 and SFY 2015-16) MMA Implementation

<table>
<thead>
<tr>
<th></th>
<th>Pre-MMA</th>
<th>MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 29,168,486)</td>
<td>(N = 29,992,175)</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.37</td>
<td>0.32</td>
</tr>
<tr>
<td>ED</td>
<td>0.23</td>
<td>0.22</td>
</tr>
<tr>
<td>Professional</td>
<td>2.16</td>
<td>2.04</td>
</tr>
<tr>
<td>Physician (MMA only)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialist (MMA only)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>


Univariate Results

Per-member per-month utilization rates among enrollees with HIV/AIDS and serious mental illness (SMI) enrolled in standard MMA plans compared to those enrolled in the HIV/AIDS and SMI specialty MMA plans (part 2 of Component 1C) are shown in Tables 10, 11, 14, and 15. In addition, per-member per-month utilization among enrollees eligible for the Children’s Medical Services Network (CMSN) and Sunshine Child Welfare (CW) specialty plans but who are enrolled in standard MMA plans compared to those enrolled in specialty MMA plans are depicted in Tables 12, 13, 16, and 17.

When comparing standard MMA plans to specialty MMA plans among enrollees with HIV/AIDS, as shown in Table 10 below, mean service utilization was greater in standard plans compared to specialty plans for outpatient visits (0.32 visits PMPM versus 0.12 visits PMPM), ED visits (0.18 visits PMPM versus 0.14 visits PMPM), professional visits (2.60 visits PMPM versus 2.13 visits PMPM), physician visits (0.51 visits PMPM versus 0.28 visits PMPM), and specialist visits (1.67 visits PMPM versus 1.37 visits PMPM). Mean service utilization was greater in specialty plans compared to standard plans for inpatient visits (0.06 visits PMPM versus 0.05 visits PMPM). Additional research is needed to draw conclusions as to service utilization of enrollees with HIV in standard versus specialty MMA plans.

<table>
<thead>
<tr>
<th></th>
<th>Standard (N = 133,302)</th>
<th>Specialty (N = 134,302)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.05</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.32</td>
<td>0</td>
</tr>
<tr>
<td>ED</td>
<td>0.18</td>
<td>0</td>
</tr>
<tr>
<td>Professional</td>
<td>2.60</td>
<td>1</td>
</tr>
<tr>
<td>Physician</td>
<td>0.51</td>
<td>0</td>
</tr>
<tr>
<td>Specialist</td>
<td>1.67</td>
<td>0</td>
</tr>
</tbody>
</table>

When comparing standard MMA plans to specialty MMA plans among enrollees with SMI in Table 11, mean service utilization was greater in standard plans compared to specialty plans for outpatient visits (0.19 visits PMPM versus 0.07 visits PMPM), professional visits (1.94 visits PMPM versus 1.83 visits PMPM), and physician visits (0.46 visits PMPM versus 0.37 visits PMPM). Mean service utilization was greater in specialty plans compared to standard plans for inpatient visits (0.09 visits PMPM versus 0.04 visits PMPM), ED visits (0.21 visits PMPM versus 0.16 visits PMPM), and specialist visits (1.32 visits PMPM versus 1.17 visits PMPM). Additional research is needed to draw conclusions as to service utilization of enrollees with SMI in standard versus specialty MMA plans.


<table>
<thead>
<tr>
<th></th>
<th>Standard (N = 3,181,774)</th>
<th>Specialty (N = 577,872)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.04</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.19</td>
<td>0</td>
</tr>
<tr>
<td>ED</td>
<td>0.16</td>
<td>0</td>
</tr>
<tr>
<td>Professional</td>
<td>1.94</td>
<td>1</td>
</tr>
<tr>
<td>Physician</td>
<td>0.46</td>
<td>0</td>
</tr>
<tr>
<td>Specialist</td>
<td>1.17</td>
<td>0</td>
</tr>
</tbody>
</table>
When comparing standard MMA plans to specialty MMA plans among CMSN-eligible enrollees, as shown in Table 12, mean service utilization was greater in standard plans compared to specialty plans for inpatient visits (0.02 visits PMPM versus 0.01 visits PMPM), outpatient visits (0.21 visits PMPM versus 0.20 visits PMPM), ED visits (0.10 visits PMPM versus 0.05 visits PMPM), professional visits (1.85 visits PMPM versus 1.81 visits PMPM), and physician visits (0.47 visits PMPM versus 0.12 visits PMPM). Mean service utilization was greater in specialty plans compared to standard plans for specialist visits (1.25 visits PMPM versus 0.91 visits PMPM). Additional research is needed to draw conclusions as to service utilization of CMSN-eligible enrollees in standard versus specialty MMA plans.


<table>
<thead>
<tr>
<th></th>
<th>Standard (N = 178,051)</th>
<th>Specialty (N = 326,138)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.02</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.21</td>
<td>0</td>
</tr>
<tr>
<td>ED</td>
<td>0.10</td>
<td>0</td>
</tr>
<tr>
<td>Professional</td>
<td>1.85</td>
<td>1</td>
</tr>
<tr>
<td>Physician</td>
<td>0.47</td>
<td>0</td>
</tr>
<tr>
<td>Specialist</td>
<td>0.91</td>
<td>0</td>
</tr>
</tbody>
</table>

For comparisons of standard MMA plans to specialty MMA plans among CW enrollees, as shown in Table 13, mean service utilization was greater in standard plans compared to specialty plans for outpatient visits (0.08 visits PMPM versus 0.06 visits PMPM), ED visits (0.11 visits PMPM versus 0.10 visits PMPM), professional visits (1.21 visits PMPM versus 1.17 visits PMPM), and physician visits (0.50 visits PMPM versus 0.35 visits PMPM). Mean service utilization was greater in specialty plans compared to standard plans for specialist visits (0.49 visits PMPM versus 0.48 visits PMPM). Inpatient visits were relatively equal between plans at 0.01 visits PMPM. Additional research is needed to draw conclusions as to service utilization of CW enrollees in standard versus specialty MMA plans.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard (N = 544,200)</th>
<th>Specialty (N = 342,931)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.01</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.08</td>
<td>0</td>
</tr>
<tr>
<td>ED</td>
<td>0.11</td>
<td>0</td>
</tr>
<tr>
<td>Professional</td>
<td>1.21</td>
<td>1</td>
</tr>
<tr>
<td>Physician</td>
<td>0.50</td>
<td>0</td>
</tr>
<tr>
<td>Specialist</td>
<td>0.48</td>
<td>0</td>
</tr>
</tbody>
</table>

### Multivariate Results

Depicted in Tables 14-17 are the adjusted PMPM service utilization from the multivariate analyses for HIV/AIDS, SMI, CSMN, and CW enrollees respectively in standard versus specialty plans. For inpatient, outpatient, ED, and professional visits, results are presented as adjusted service counts. For physician and specialist visits, results are presented as adjusted probabilities of having any visit in a month in accordance with the two-part statistical models. The incidence rate ratios (or coefficients) of the variables of interest estimated in the multivariate analyses are presented in Appendix 3 in Volume 2 of this report.

When comparing adjusted mean and median PMPM service utilization between the standard and specialty MMA plans for enrollees with HIV (Table 14), results were similar to the unadjusted results, with mean adjusted PMPM service utilization greater in standard versus specialty plans for outpatient visits (0.28 visits PMPM versus 11 visits PMPM), ED visits (0.18 visits PMPM versus 0.14 visits PMPM), professional visits (2.51 visits PMPM versus 2.09 visits PMPM), physician visits (0.28 visits PMPM versus 0.16 visits PMPM), and specialist visits (0.42 visits PMPM versus 0.36 visits PMPM) services. Inpatient visits were roughly equal between standard and specialty visits, at 0.06 visits PMPM.


<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard (N = 133,302)</th>
<th>Specialty (N = 134,302)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.28</td>
<td>0.27</td>
</tr>
</tbody>
</table>
Adjusted mean and median PMPM service utilization comparisons between the standard and specialty MMA plans for enrollees with SMI (Table 15) demonstrate results were similar to the unadjusted results. Mean adjusted PMPM services were greater in standard plans compared to specialty plans for outpatient visits (0.18 visits PMPM versus 0.07 visits PMPM), professional visits (1.91 visits PMPM versus 1.86 visits PMPM), and physician visits (0.28 visits PMPM versus 0.20 visits PMPM) services. Mean service utilization was greater in specialty plans compared to standard plans for inpatient visits (0.09 visits PMPM versus 0.04 visits PMPM), ED visits (0.23 visits PMPM versus 0.17 visits PMPM), and specialist visits (0.40 visits PMPM versus 0.37 visits PMPM) services.


<table>
<thead>
<tr>
<th>Service</th>
<th>Standard (N = 3,181,774)</th>
<th>Specialty (N = 577,872)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.18</td>
<td>0.19</td>
</tr>
<tr>
<td>ED</td>
<td>0.17</td>
<td>0.17</td>
</tr>
<tr>
<td>Professional</td>
<td>1.91</td>
<td>1.97</td>
</tr>
<tr>
<td>Physician</td>
<td>0.28</td>
<td>0.28</td>
</tr>
<tr>
<td>Specialist</td>
<td>0.37</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Adjusted mean and median PMPM service utilization comparisons between the standard and specialty MMA plans for CMSN-eligible enrollees (Table 16) demonstrate results were similar to the unadjusted results. Mean adjusted service utilization was greater in standard plans compared to specialty plans for inpatient visits (0.02 visits PMPM versus 0.01 visits PMPM), outpatient visits (0.19 visits PMPM versus 0.16 visits PMPM), ED visits (0.10 visits PMPM versus 0.05 visits PMPM), professional visits (1.77 visits PMPM versus 1.62 visits PMPM), and physician visits (0.34 visits PMPM versus 0.11 visits PMPM). Mean service utilization was greater in specialty plans compared to standard plans for specialist visits (0.34 visits PMPM versus 0.31 visits PMPM).

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard (N = 178,051)</th>
<th>Specialty (N = 326,138)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.02</td>
<td>0.01</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.19</td>
<td>0.16</td>
</tr>
<tr>
<td>ED</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Professional</td>
<td>1.77</td>
<td>1.56</td>
</tr>
<tr>
<td>Physician</td>
<td>0.34</td>
<td>0.32</td>
</tr>
<tr>
<td>Specialist</td>
<td>0.31</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Adjusted mean and median PMPM service utilization comparisons between the standard and specialty MMA plans for CW enrollees (Table 17) demonstrate results were similar to the unadjusted results with the exception of specialist visits. Mean service utilization was greater in standard plans compared to specialty plans for outpatient visits (0.07 visits PMPM versus 0.05 visits PMPM), ED visits (0.12 visits PMPM versus 0.10 visits PMPM), professional visits (1.20 visits PMPM versus 1.15 visits PMPM), physician visits (0.37 visits PMPM versus 0.22 visits PMPM), and specialist visits (0.22 visits PMPM versus 0.21 visits PMPM). Inpatient visits were relatively equal between plans at 0.01 visits PMPM.


<table>
<thead>
<tr>
<th>Service Type</th>
<th>Standard (N = 544,200)</th>
<th>Specialty (N = 342,931)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Outpatient</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>ED</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>Professional</td>
<td>1.20</td>
<td>1.00</td>
</tr>
<tr>
<td>Physician</td>
<td>0.37</td>
<td>0.33</td>
</tr>
<tr>
<td>Specialist</td>
<td>0.22</td>
<td>0.23</td>
</tr>
</tbody>
</table>
Research Question 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.

To determine changes in the quality of care among health plans in the pre-MMA period and the MMA period, Table 18 displays the weighted mean scores for certain performance measures. Using data provided by the Agency, weighted means for each measure were calculated for each year based on the eligible population. The means were then averaged across all plans for each time period shown in the table. Based on the average of the three years in the pre-MMA period, quality of care improved or remained the same for the majority of the performance measures compared to quality of care in the pre-MMA period. Out of the 32 performance measures in Table 18, roughly 69 percent (22 measures) improved, 3 percent (1 measure) remained the same, and 28 percent (9 measures) declined. On average, the measures that had the greatest increases from the pre-MMA period to the MMA period were Chlamydia Screening in Women, 16-20 and 21-24 years, Adult BMI Assessments, HIV-Related Outpatient Medical Visits, Annual Dental Visits, and Comprehensive Diabetes Care – Nephropathy. The largest decrease from pre-MMA to MMA was for Medication Management for People with Asthma- 50 percent Medication Compliance.8

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8 These percentages were calculated based on the difference in the unweighted average of the 2011-2013 pre-MMA means and the unweighted arithmetic average of the 2015 and 2016 means in the table. If the mean increased from pre-MMA to the MMA period, this increase was counted as an improvement in the percentage calculations. Similarly, a change of zero was taken as no change and a decrease in the means was counted as a decrease in performance. Percentage differences were rounded to the nearest whole number percentage (i.e., -2%, -1%, 0%, +1%, +2%, etc.).
Table 18. Comparing MMA Program Weighted Means to Pre-MMA Program Weighted Means †

<table>
<thead>
<tr>
<th>Measure</th>
<th>Component</th>
<th>Pre-MMA</th>
<th>MMA</th>
<th>MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td></td>
<td>57%</td>
<td>72%</td>
<td>82%</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>Acute</td>
<td>52%</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>Continuation</td>
<td>35%</td>
<td>37%</td>
<td>38%</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td></td>
<td>48%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Annual Dental Visits</td>
<td>Total</td>
<td>29%</td>
<td>39%</td>
<td>40%</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>Combo 2</td>
<td>78%</td>
<td>78%</td>
<td>76%</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>Combo 3</td>
<td>72%</td>
<td>72%</td>
<td>71%</td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners</td>
<td>12-24 mos</td>
<td>95%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners</td>
<td>25 mos–6 yrs</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners</td>
<td>7-11 years</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Children and Adolescents’ Access to Primary Care Practitioners</td>
<td>12-19 years</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Measure</td>
<td>Component</td>
<td>Pre-MMA</td>
<td>MMA</td>
<td>MMA</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------</td>
<td>---------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>16-20 years</td>
<td>41%</td>
<td>48%</td>
<td>49%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>21-24 years</td>
<td>28%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>Total</td>
<td>61%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>HIV-Related Outpatient Medical Visits</td>
<td>≥ 2 visits (182 days apart)</td>
<td>23%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>Immunizations for Adolescents</td>
<td>Combination 1</td>
<td>68%</td>
<td>68%</td>
<td>68%</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
<td>--</td>
<td>60%</td>
<td>58%</td>
<td>60%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>0 visits</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>6+ visits</td>
<td>57%</td>
<td>56%</td>
<td>54%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care -</td>
<td>HbA1c Good Control (&lt;8.0%)</td>
<td>46%</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care -</td>
<td>HbA1c Poor Control (&gt;9.0%) (lower indicates better performance)</td>
<td>46%</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care</td>
<td>Eye Exam</td>
<td>46%</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Measure</td>
<td>Component</td>
<td>Pre-MMA</td>
<td>MMA</td>
<td>MMA</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Nephropathy</td>
<td></td>
<td>79%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1C Testing</td>
<td></td>
<td>78%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td></td>
<td>52%</td>
<td>51%</td>
<td>53%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td>7 day</td>
<td>35%</td>
<td>34%</td>
<td>27%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td>30 day</td>
<td>54%</td>
<td>51%</td>
<td>45%</td>
</tr>
<tr>
<td>Follow-up Care for Children Prescribed ADHD Medication</td>
<td>Continuation &amp; Maintenance Phase</td>
<td>56%</td>
<td>52%</td>
<td>62%</td>
</tr>
<tr>
<td>Highly Active Anti-Retroviral Treatment*</td>
<td></td>
<td>62%</td>
<td>63%</td>
<td>72%</td>
</tr>
<tr>
<td>Mental Health Readmission Rate*</td>
<td></td>
<td>25%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>Medication Management for People with Asthma-50% Medication Compliance</td>
<td>Total</td>
<td>82%</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td></td>
<td>76%</td>
<td>74%</td>
<td>75%</td>
</tr>
</tbody>
</table>

† In accordance with HEDIS reporting requirements, measures for plans with denominators less than 30 were not included in the calculations of the weighted means. * Agency-defined measure. † Because 2014 is a hybrid/transition year, data for 2014 is not included in this table. ‡ This measure will not be reported after CY 2016.
For the second part of RQ 1D (examining quality of care in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan who are enrolled in standard plans versus enrollees in specialty plans), individual level HEDIS data is required. Since individual level HEDIS data was not available for DY10, no results are available.

CAHPS Methods

The basic analytic strategy for RQ 1D involved calculating and comparing descriptive statistics and tests of significance for standard measures and composites of the CAHPS survey, comparing the MMA program as a whole to pre-MMA (Reform and 1915 (b) waiver) plans. The chosen CAHPS standard measures and composites consisted of overall ratings related to satisfaction with health care, health plan, shared decision-making, personal doctor, and specialists. Because CAHPS data were aggregated and not stratified by enrollees with and without specialty plan conditions, it was not possible to assess quality of care for enrollees with specialty conditions who were enrolled in standard plans. Because of changes over time in CAHPS survey administration and measure reporting, CAHPS results collected across the pre-MMA and MMA periods are not comparable, and direct comparisons should not be made.

Results

As shown in Table 19, 47 percent of adult enrollees in 2013 and 50 percent of adult enrollees in 2014 gave an overall rating of 9 or 10 out of 10 for their health plan. Among parents, 57 percent in 2013 and 59 percent in 2014 gave an overall rating of 9 or 10 out of 10 for their child’s health plan.

Table 19. Adult and Child CAHPS Data, Enrollee Satisfaction with Health Plan, Pre-MMA (2013-2014)

<table>
<thead>
<tr>
<th>CAHPS Measure</th>
<th>Adult Data</th>
<th>Child Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>Overall Rating of Health Plan [percentage of respondents rating their plan a 9 or 10 on a scale of 0 (worst) – 10 (best).]</td>
<td>47%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*Because of changes over time in CAHPS measure reporting and in administration of the surveys, CAHPS results collected across the pre-MMA and MMA periods are not comparable, and direct comparisons should not be made.

Table 20 shows overall ratings for CAHPS standard measures and composites from adult enrollees and parents of children enrolled in a health plan in 2015 and 2016, after implementation of the MMA program. In 2016, 73 percent of adult enrollees gave an overall rating of 8, 9 or 10 for their health plan; 75 percent gave an overall rating of 8, 9 or 10 for their health care; 77 percent reported that there was shared decision-making between the provider and respondent; 82 percent gave an overall rating of 8, 9 or 10 for their personal doctor; and 82 percent gave an overall rating of 8, 9 or 10 for their specialists. All 2016 quality of care measures were within three percentage points of 2015 measures.

Among parents surveyed in 2016, 83 percent gave an overall rating of 8, 9 or 10 for their child’s health plan; 86 percent gave an overall rating of 8, 9 or 10 for their child’s health care; 72 percent reported that there was shared decision-making between the provider and the
respondent; 90 percent gave an overall rating of 8, 9 or 10 for their child’s personal doctor; and 86 percent gave an overall rating of 8, 9 or 10 for their child’s specialists. All 2016 quality of care measures were within three percentage points of 2015 measures.

Table 20. Adult and Child CAHPS Data, MMA Program (CYs 2015 and 2016)

<table>
<thead>
<tr>
<th>CAHPS Measure</th>
<th>Adult Data</th>
<th>Adult Data</th>
<th>Child Data</th>
<th>Child Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating of Health Plan [percentage of respondents rating their plan an 8, 9 or 10 on a scale of 0 (worst) – 10 (best).]</td>
<td>74%</td>
<td>73%</td>
<td>81%</td>
<td>84%</td>
</tr>
<tr>
<td>Overall Rating of Health Care [percentage of respondents rating their health care an 8, 9 or 10 on a scale of 0 (worst)- 10 (best)]</td>
<td>76%</td>
<td>75%</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>Shared Decision-Making [percentage of respondents reporting there is shared decision-making between the provider and respondent (Yes vs. No)]</td>
<td>77%</td>
<td>77%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Overall Rating of Personal Doctor [percentage of respondents rating their doctor an 8, 9, or 10 on a scale of 0 (worst)- 10 (best)]</td>
<td>85%</td>
<td>82%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Overall Rating of Specialists [percentage of respondents rating their specialist an 8, 9, or 10 on a scale of 0 (worst)-10 (best)]</td>
<td>85%</td>
<td>82%</td>
<td>83%</td>
<td>86%</td>
</tr>
</tbody>
</table>

*Because of changes over time in CAHPS measure reporting and in administration of the surveys, CAHPS results collected across the pre-MMA and MMA periods are not comparable, and direct comparisons should not be made.

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?

This research question will be addressed using qualitative methods and therefore, there is no hypothesis.

Key results for RQ 1E will be added once the in-depth interviews with MMA plan quality experts are completed between June and July 2018. In order to provide preliminary information, descriptive analyses were performed based on a review of MMA Performance Improvement Projects (PIPs) as found in the 2015-2016 Florida Annual Performance Improvement Project Validation Summary Report produced by Health Services Advisory Group (HSAG).
Review of 2015-2016 Florida Annual Performance Improvement Project Validation Summary Report

The 2015-2016 Florida Annual Performance Improvement Project Validation Summary Report produced by Health Services Advisory Group (HSAG) presents the status and results for the performance improvement projects (PIPs) that were submitted for validation to the Agency. In collaboration with the Agency, HSAG developed a PIP Validation Tool to assess the PIPs across the following sets of activities.

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

During the 2015-2016 review, HSAG assessed the PIPs based on the first 8 activities only, since none of the projects had progressed to the outcomes stage. HSAG rated each activity for each PIP as ‘met’, ‘partially met’, ‘not met’, ‘not applicable’, or ‘not assessed’.

Mandated Performance Improvement Activities

The two State-mandated PIP topics for the MMA plans are: Improving Timeliness of Prenatal Care, Well-Child Visits During the First 15 Months of Life, and Preventive Dental Services for Children.

**Improving Timeliness of Prenatal Care, Well-Child Visits During the First 15 Months of Life.** HSAG assessed 13 standard MMA plans for this topic. All PIPs that were assessed were received ‘mets’ for activities I through V for this PIP. However, some plans did not receive ‘met’ ratings for activities VI, VII, and VIII. Eighty-five percent of the plans received a ‘met’ for activity VI, 69 percent received a ‘met’ for activity VII, and 89 percent received a ‘met’ for activity VIII. Fifty-four percent of the PIPs received a met in all 8 of the activities that were assessed during the 2015-2016 review.

**Preventive Dental Services for Children.** HSAG assessed 16 PIPs for this topic. All of the PIPs received a met for activities I and II. Ninety-four percent of the PIPs received a ‘met’ for activity III, 88 percent received a ‘met’ for activity IV, 90 percent received a ‘met’ for activity VI, 69 percent of plans received a ‘met’ for activity VII, and 84 percent received a met for activity VIII. Activity V was not assessed for this PIP. Twenty-five percent of the dental PIP received ‘mets’ in all 7 components reviewed for this PIP.

The HSAG report also provided baseline performance indicators for the mandated projects. Table 21 identifies the highest and lowest baseline performers for each mandated PIP category.
Table 21. High and Low Baseline Indicator Results, 2015-2016

<table>
<thead>
<tr>
<th>Category</th>
<th>High-Performer</th>
<th>Low- Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Mandated Projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Timeliness of Prenatal Care</td>
<td>Prestige Health Choice (87.0%)</td>
<td>Simply Health Care Plans (71.9%)</td>
</tr>
<tr>
<td>Well-Child visits in the First 15 Months of Life</td>
<td>Amerigroup (64.6%)</td>
<td>Integral (32.9%)</td>
</tr>
<tr>
<td>Preventive Dental Services for Children</td>
<td>Children’s Medical Services Network (28.9%)</td>
<td>Clear Health Alliance (5.6%)</td>
</tr>
</tbody>
</table>

Non-clinical and Clinical Performance Improvement Activities

**Non-clinical:** Plans must also implement a non-clinical performance improvement activity. HSAG assessed 25 non-clinical PIPs implemented in both the standard MMA plans and the MMA specialty plans.

Overall, among the MMA standard plans 100 percent of the non-clinical PIPs received a ‘met’ for criteria III, IV, and V. Ninety-six percent and 92 percent of the PIPs received ‘met’ scores on activities I and II, respectively. Seventy-two percent of the PIPs scored a ‘met’ on activity VII and 80 percent received a ‘met’ on activity VIII. In sum, 69 percent of the PIPs in the standard plans received a ‘met’ across all 8 activities.

Among the specialty MMA plans, 40 percent of the PIPs received a ‘met’ for their non-clinical projects in all 8 activities. One hundred percent of the non-clinical PIPs for the specialty plans received a ‘met’ for activities I through IV. Seventy-three percent received ‘mets’ for activity V and 92 percent received ‘mets’ for activity VI. Fifty-three percent and 78 percent of the specialty plans received ‘mets’ for activities VII and VIII for their non-clinical PIPs, respectively.

For their non-clinical project, several plans chose to focus on improving member satisfaction. The performance indicator for several plans was the percent of enrollees who responded 8, 9, or 10 to the CAHPS 5.0 survey item ‘Overall Rating of Health Plan’. According to the HSAG report, some plans reported this indicator for all enrollees and some plans chose to report respondents to the Adult and Child Surveys differently. Table 22 lists the baseline measure of the proportion of enrollees providing an 8, 9, or 10 for respondents to the CAHPS 5.0 survey. Among the plans with adult only measures, the proportion of respondents giving the overall health plan rating a score of 8 or more ranged between 83 percent and 88 percent. Among the plans with the child only scores, the proportion providing an 8 or higher rating ranged from 73 percent% to 88 percent. Finally, among the plans who provided measures for all enrollees, the proportion of respondents with an 8 or more ranged from 70 percent to 77 percent.
Table 22. Improving Member Satisfaction: Percentage of Enrollees Rating their Health Plan an 8, 9 or 10 (Adult CAHPS 5.0), CYs 2015-2016

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>2015-2016-MMA Plans (Standard and Specialty)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Enrollees</td>
<td>Child</td>
<td>Adult</td>
</tr>
<tr>
<td>Amerigroup</td>
<td>76.8%</td>
<td>Child and adult scores not reported separately</td>
<td></td>
</tr>
<tr>
<td>Better Health</td>
<td>Not reported</td>
<td>75.3%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Coventry</td>
<td>73.3%</td>
<td>Child and adult scores not reported separately</td>
<td></td>
</tr>
<tr>
<td>Prestige</td>
<td>69.3%</td>
<td>Child and adult scores not reported separately</td>
<td></td>
</tr>
<tr>
<td>Simply Health Plan</td>
<td>Not reported</td>
<td>88.0%</td>
<td>86.7%</td>
</tr>
<tr>
<td>Sunshine</td>
<td>Not reported</td>
<td>73.2%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Clear Health Alliance</td>
<td>76.7%</td>
<td>Child and adult scores not reported separately</td>
<td></td>
</tr>
</tbody>
</table>

Note: Magellan Complete Care reported a satisfaction score of 9 or above and therefore was not included.

Other non-clinical PIPs include electronic health records and meaningful use (Humana), provider satisfaction (Molina), continuity of care and care coordination (Preferred), and call answer timeliness (Staywell, Children’s Medical Services, United).

Clinical: In addition to the mandated projects and the non-clinical projects, plans must implement a PIP related to one of the following clinical topics: a population health related activity within a specific geographic region needing improvement (e.g. diabetes or asthma); the integration of primary care and behavioral health; or a project focusing on the reduction of preventable admissions. Nine plans have PIPs that focus on population health. Three plans focus on asthma (Amerigroup, Molina, and Preferred) and seven plans have PIPs that target diabetes. Six plans target preventing readmissions for mental health or physical health conditions. Two plans had programs aimed at integrating primary care and behavioral health.

Forty-four percent of the PIP clinical projects received ‘mets’ across all plan types. Forty-six percent of the PIPs in the standard MMA plans had an overall ‘met’, while 42 percent of the PIPs in the specialty plans had an overall ‘met’ for their clinical projects. Among the standard MMA plans, there were both ‘not-mets’ or ‘partially mets’ across all criteria for the clinical projects. Among the specialty plans, all PIPs were scored a ‘met’ for Activity I. However, for the remaining activities, there were ‘not mets’ or ‘partially mets’ for some clinical projects in specialty plans.
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?

Hypothesis: 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).

Methods

Descriptive statistics for the Getting Care Quickly CAHPS survey measure was used, comparing the MMA program as a whole to Reform and 1915 (b) waiver plans. To address questions related to timeliness of services, evaluators analyzed overall ratings related to Getting Care Quickly. Because of changes over time in CAHPS survey administration and measure reporting, CAHPS results collected across the pre-MMA and MMA periods are not comparable, and direct comparisons should not be made.

Results

CAHPS Data: As shown in Table 23, 53 percent of adult enrollees in 2013 and 55 percent of adult enrollees in 2014 reported that it is always easy to get care quickly. The percentage of parents who reported that it is always easy to get care quickly for their child was 62 percent in 2013 and 70 percent in 2014.

Table 23. Adult and Child CAHPS Data, Timeliness of Services, Pre-MMA (2013-2014)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Adult Data</th>
<th>Child Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>53%</td>
<td>55%</td>
</tr>
</tbody>
</table>

In 2016, 81 percent of adult enrollees reported that it is usually or always easy to get care quickly and 89 percent of parents reported that it is usually or always easy to get care quickly for their child, as shown in Table 24.
Table 24. Adult and child CAHPS data, timeliness of services, MMA (2015 and 2016)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Adult Data</th>
<th>Child Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Care Quickly [percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)]</td>
<td>83%</td>
<td>81%</td>
</tr>
</tbody>
</table>

Timely Access PCP Wait Times Report and Contract Standards: Timely access PCP wait times are reported by plan as to whether or not the contractual standard was met. Agency contracts with MMA plans require the plans to provide access to urgent care within one day of the request, access to routine sick care within one week of the request, and access to well-care visits within one month of the request. Table 25 reports the percentage of PCPs that did not meet the contractual requirement for each visit type. On average, wait times were more likely to be longer than contract standards for urgent care visits, but, in general, were mostly met for all types of care visits.

Table 25. Percentage of PCPs Not Meeting Contractual Wait-Time Requirements by MMA Plan, SFY 2015-16

<table>
<thead>
<tr>
<th>Plan</th>
<th>Number of PCPs</th>
<th>Urgent Care Not Met</th>
<th>Routine Care Not Met</th>
<th>Well Care Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>228</td>
<td>9.2%</td>
<td>2.2%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Better Health, Inc.</td>
<td>280</td>
<td>2.5%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Clear Health Alliance</td>
<td>433</td>
<td>1.4%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Coventry Health Care of Florida</td>
<td>216</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Freedom Health</td>
<td>1,074</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Humana Medical Plan, Inc.</td>
<td>546</td>
<td>15.2%</td>
<td>1.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Magellan Complete Care</td>
<td>86</td>
<td>3.5%</td>
<td>10.5%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Molina Healthcare of Florida</td>
<td>374</td>
<td>0.8%</td>
<td>0.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Community Care Plan</td>
<td>236</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Positive Healthcare Florida</td>
<td>80</td>
<td>30.0%</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Prestige Health Choice</td>
<td>2,697</td>
<td>0.4%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
HEDIS and Agency Data: Table 26 shows HEDIS and Agency-defined performance measures related to timeliness of services (Prenatal Care, Postpartum Care, and Transportation Timeliness). Weighted mean scores for Florida Medicaid health plans were lower than Medicaid national means during the pre-MMA period. In the MMA period, the Medicaid HMO national means for prenatal care were slightly lower than the state mean. For timeliness of postpartum care, in 2015, the national mean was slightly higher than the state mean and in 2016 the averages were the same at 64 percent. State scores increased in 2016 compared to state scores in 2015.

Table 26. Comparing Florida Medicaid Weighted Means to Medicaid HMO National Means for HEDIS and Agency Measures related to Timeliness of Services†

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care</td>
<td>73%</td>
<td>83%</td>
<td>72%</td>
<td>83%</td>
<td>71%</td>
<td>82%</td>
<td>83%</td>
<td>80% b</td>
<td>84%</td>
<td>82% b</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td>52%</td>
<td>64%</td>
<td>52%</td>
<td>63%</td>
<td>51%</td>
<td>61%</td>
<td>59%</td>
<td>61% b</td>
<td>64%</td>
<td>64% b</td>
</tr>
<tr>
<td>Transportation</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>71%</td>
<td>----</td>
<td>83%</td>
<td>---- a</td>
</tr>
<tr>
<td>Timeliness</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>---- a</td>
</tr>
</tbody>
</table>

† In accordance with HEDIS reporting requirements, measures for plans with denominators less than 30 were not included in the calculations of the weighted means.

a Empty cells reflect unavailable data. b Medicaid HMO average

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)?

Hypothesis: 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).

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 2015-16. 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 by fiscal year (SFY 2011-12 through SFY 2015-16) as well as by pre-MMA (SFY 2011-12 through SFY 2013-14) and MMA (SFY 2014-15 through SFY 2015-16) periods. These results were calculated by eligibility group (TANF, SSI, dual-eligible) and pre-MMA expenditures were also compared to expenditures in standard MMA plans and specialty MMA plans. The analysis was based on data that incorporated all Medicaid enrollees who met the inclusion and exclusion criteria. Hence, the subjects included here represent the complete population of eligible enrollees germane to this analytic question, as distinct from a random sample.

**Multivariate Analyses**

A two-part 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-MMA and MMA enrollees. As with the univariate analysis, the multivariate analysis examined whether these trends significantly differed between the pre-MMA and MMA time periods for all MMA plans combined as well as when restricted to standard MMA plans or specialty MMA plans during the MMA time period. 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 60 observations to the analyses.

**Univariate Results**

The univariate (unadjusted) results are shown below in Table 27 through Table 29. While there was no overall trend in Table 27 in per-member per-month (PMPM) expenditures by fiscal year among enrollees with TANF or SSI eligibility, mean PMPM expenditures decreased over time for enrollees who were dually eligible for Medicare, with the largest annual decrease occurring between SFY 2013-14 and SFY 2014-15 ($922 vs. $375). PMPM expenditures increased between the first and second year of the MMA program (FY2014-15 to FY2015-16) among enrollees with TANF and SSI eligibility. When per member per month expenditures is ranked from lowest to highest, the 50th percentile is still a very low number. Prior to MMA when beneficiaries were using fee-for-service, most beneficiaries used little if no services in any given month. In addition, medians that are much smaller than the means are common when dealing with right-skewed utilization distributions.
When comparing mean and median PMPM expenditures between the pre-MMA and MMA periods (Table 28), reductions were seen for all eligibility groups. Mean PMPM expenditures after MMA implementation decreased from $390 to $237 for TANF enrollees, from $2,040 to $1,243 for SSI enrollees, and from $991 to $318 for dual-eligible enrollees.

Table 29. Unadjusted Per-Member Per-Month Expenditures in Standard MMA Plans and Specialty MMA Plans, SFY 2014-15 and SFY 2015-16

<table>
<thead>
<tr>
<th></th>
<th>Standard MMA</th>
<th>Specialty MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>TANF</td>
<td>$234</td>
<td>$471</td>
</tr>
<tr>
<td>SSI</td>
<td>$1,250</td>
<td>$1,140</td>
</tr>
<tr>
<td>DUAL</td>
<td>$318</td>
<td>$254</td>
</tr>
</tbody>
</table>

It should be noted that these are unadjusted PMPM expenditures that do not account for differences in demographic characteristics and health status between time periods and types of MMA plans. Additionally, all PMPM expenditures are included in the unadjusted analysis, so mean expenditures may be influenced by outliers (PMPM expenditures that are very high).
Multivariate Analyses

The adjusted PMPM expenditures from the multivariate analyses are presented in Table 30 and Table 31. The multivariate results use a two-part model that (1) assesses the likelihood of having any expenditures and then (2) assesses total expenditures, given that some expenditures are incurred. All multivariate analyses are adjusted for differences in demographic characteristics and health status as measured by total Chronic Illness and Disability Payment System\(^9\) (CDPS) risk score between time periods and types of MMA plans, and the second part of the analysis uses the natural log of expenditures to diminish the influence of outliers. The full results for all multivariate regression models are presented in Appendix 3 of Volume 2.

When comparing adjusted mean and median PMPM expenditures between the pre-MMA and MMA periods (Table 30), reductions in mean expenditures were seen for all eligibility groups. Mean adjusted PMPM expenditures decreased from $205 to $191 after MMA implementation for TANF enrollees, decreased from $1,420 to $983 for SSI enrollees, and decreased from $478 to $215 for dually eligible enrollees.

Table 30. Adjusted Per-Member Per-Month Expenditures Before and After MMA Implementation

<table>
<thead>
<tr>
<th></th>
<th>Pre-MMA (SFY 2011-12 through SFY 2013-14)</th>
<th>MMA (SFY 2014-15 through SFY 2015-16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>TANF</td>
<td>$205</td>
<td>$186</td>
</tr>
<tr>
<td>SSI</td>
<td>$1,420</td>
<td>$1,627</td>
</tr>
<tr>
<td>DUAL</td>
<td>$478</td>
<td>$356</td>
</tr>
</tbody>
</table>

When comparing standard MMA plans to specialty MMA plans (Table 31), 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 31. Adjusted Per-Member Per-Month Expenditures for Standard MMA Plans and Specialty MMA Plans, SFY 2014-15 and SFY 2015-16

<table>
<thead>
<tr>
<th></th>
<th>Standard MMA</th>
<th>Specialty MMA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>TANF</td>
<td>$188</td>
<td>$164</td>
</tr>
<tr>
<td>SSI</td>
<td>$987</td>
<td>$1,109</td>
</tr>
<tr>
<td>DUAL</td>
<td>$217</td>
<td>$142</td>
</tr>
</tbody>
</table>

\(^9\) CDPS stands for Comprehensive Illness and Disability Payment System, a widely used case-mix adjustment system for capitation rate-setting among Medicaid programs across the United States, including Florida. The total risk score is a measure of the enrollee’s burden of illness based on diagnostic and pharmacy data contained in Medicaid encounter data. See Kronick, R., Gilmer, T., Dreyfus, T., & Lee, L. (2000). Improving health-based payment for Medicaid beneficiaries: CDPS. *Health Care Finance Rev*, 21(3), 29-64.
Component 2. The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or 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?

This question provides context and therefore has no hypothesis.

Expanded Benefits

Because no MMA plans offered customized benefits, this evaluation component focuses on expanded benefits offered by MMA plans. In DY10 (SFY 2015-16), as shown in Table 32 and Table 33, there were 13 standard MMA plans and six specialty MMA plans with varying regions of operation.

Table 32. MMA Standard Plans and Regions of Operation

<table>
<thead>
<tr>
<th>MMA Standard Plan Name</th>
<th>Regions of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup Florida (AMG)</td>
<td>5, 6, 7, 11</td>
</tr>
<tr>
<td>Better Health (BET)</td>
<td>6, 10</td>
</tr>
<tr>
<td>Coventry Health Care of Florida (COV)</td>
<td>11</td>
</tr>
<tr>
<td>Humana Medical Plan (HUM)</td>
<td>1, 6, 9, 10, 11</td>
</tr>
<tr>
<td>Integral Health Plan d/b/a Integral Quality Care (INT)</td>
<td>1, 6, 8</td>
</tr>
<tr>
<td>Molina Healthcare of Florida (MOL)</td>
<td>1, 4, 6, 7, 8, 9, 11</td>
</tr>
<tr>
<td>Preferred (PRE)</td>
<td>11</td>
</tr>
<tr>
<td>Prestige Health Choice (PRS)</td>
<td>2, 3, 5, 6, 7, 8, 9, 11</td>
</tr>
<tr>
<td>South Florida Community Care Network (SFCCN) d/b/a Community Care Plan (CCP) (Name Change Effective 7/15/2016)</td>
<td>10</td>
</tr>
<tr>
<td>Simply (SHP)</td>
<td>11</td>
</tr>
<tr>
<td>Staywell (STW)</td>
<td>2, 3, 4, 5, 6, 7, 8, 11</td>
</tr>
<tr>
<td>Sunshine Health Plan (SUN)</td>
<td>3, 4, 5, 6, 7, 8, 9, 10, 11</td>
</tr>
<tr>
<td>United Healthcare (URA)</td>
<td>3, 4, 7, 11</td>
</tr>
</tbody>
</table>

Note: The Preferred plan contract ended October 15, 2015; and the Integral plan contract ended October 31, 2015.
Table 33. MMA Specialty Plans and Regions of Operation

<table>
<thead>
<tr>
<th>MMA Specialty Plan Name</th>
<th>Regions of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Health Alliance - HIV/AIDS</td>
<td>1,2,3,5,6,7,8,9,10,11</td>
</tr>
<tr>
<td>Children’s Medical Services (CMS) - Services for children from birth to age 21 with special health care needs</td>
<td>1 through 11</td>
</tr>
<tr>
<td>Freedom Health- (Dual Eligibles Only) Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) or Cardiovascular Disease (CVD)</td>
<td>3,5,6,7,8,9,10,11</td>
</tr>
<tr>
<td>Magellan Complete Care - Serious Mental Illness</td>
<td>2,4,5,6,7,9,10,11</td>
</tr>
<tr>
<td>Positive Healthcare of Florida (PHC), Inc. - HIV/AIDS</td>
<td>10,11</td>
</tr>
<tr>
<td>Sunshine Health Plan Child Welfare Specialty Plan - Children under age 21 in the custody of the state of Florida</td>
<td>1 through 11</td>
</tr>
</tbody>
</table>

In DY10, each plan offered up to 20 Agency-approved expanded benefits. The expanded benefits offered by the plans included:

1. Adult dental services
2. Adult hearing services
3. Adult vision services
4. Art therapy
5. Equine therapy
6. Home health care (non-pregnant adults)
7. Influenza vaccine
8. Medically related lodging & food
9. Newborn circumcisions
10. Nutritional counseling
11. Outpatient hospital services
12. Over-the-counter drugs/supplies
13. Pet therapy
14. Physician home visits
15. Pneumonia vaccines
16. Post-discharge meals
17. Prenatal/perinatal visits
18. Primary care visits for non-pregnant adults
19. Shingles vaccine
20. Waived co-payments

**Standard Plans**

A total of 20 different Agency-approved expanded benefits were offered by the 13 standard plans in DY 10. Table 34 shows that 8 of the 13 plans offered 17 or more of the 20 expanded benefits. The fewest expanded benefits offered by a plan was seven. One plan offered all 20 expanded benefits. The average number of expanded benefits offered across all of the standard plans was 15.
Table 34. Expanded Benefits Offered by MMA Standard Plans

<table>
<thead>
<tr>
<th>Service</th>
<th>AMG</th>
<th>BET</th>
<th>COV</th>
<th>HUM</th>
<th>INT</th>
<th>MOL</th>
<th>PRE</th>
<th>PRS</th>
<th>CCP</th>
<th>SHP</th>
<th>STW</th>
<th>SUN</th>
<th>URA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult Hearing Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult Vision Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Art Therapy</td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Equine Therapy</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Home Health (non-preg. adults)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medically Related Lodging and Food</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Newborn Circumcisions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>OTC Meds and Supplies</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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</tbody>
</table>
**Contract MED18**  
**Evaluation of Florida’s Managed Medical Assistance (MMA) Program Demonstration**

<table>
<thead>
<tr>
<th></th>
<th>AMG</th>
<th>BET</th>
<th>COV</th>
<th>HUM</th>
<th>INT</th>
<th>MOL</th>
<th>PRE</th>
<th>PRS</th>
<th>CCP</th>
<th>SHP</th>
<th>STW</th>
<th>SUN</th>
<th>URA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pet Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physician Home Visits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
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<td>X</td>
<td>X</td>
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<td></td>
<td></td>
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<td>Prenatal/Perinatal Visits</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Primary Care Visits for Non-Pregnant Adults</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Shingles Vaccine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Waived Co-Payment</td>
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<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Expanded Benefits</td>
<td>18</td>
<td>17</td>
<td>8</td>
<td>17</td>
<td>18</td>
<td>12</td>
<td>16</td>
<td>6</td>
<td>17</td>
<td>20</td>
<td>18</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>
The expanded benefits differed somewhat across the standard and specialty plans (Table 35). Equine therapy and pet therapy were offered by the standard plans only. Only the specialty plans offered home and community-based services and intensive outpatient services as expanded benefits.

**Table 35. Expanded Benefits Offered by MMA Specialty Plans**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult Influenza Vaccine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult Pneumonia Vaccine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>Adult Shingles Vaccine</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Art Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home and Community-Based Services</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Home Health Care non-pregnant adult</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Intensive Outpatient Services</td>
<td></td>
<td></td>
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<td></td>
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<td>X</td>
</tr>
<tr>
<td>Medically Related Lodging &amp; Food</td>
<td>X</td>
<td></td>
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<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Newborn Circumcisions</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Extra Outpatient Services</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Over-The Counter Drugs/Supplies Aid</td>
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<td>X</td>
</tr>
<tr>
<td>Physician Home Visits</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>---------------------------------------------------</td>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Post-Discharge Meals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Extra Prenatal/Perinatal Visits</td>
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<tr>
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<td>X</td>
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<tr>
<td>Vision Services</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Waived Co-payments</td>
<td>X&lt;sup&gt;a&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Total Number of Expanded Benefits</td>
<td>0</td>
<td>18</td>
<td>0</td>
<td>14</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>

Notes: Children and pregnant women are eligible for all medically necessary services.  
<sup>a</sup>Copay required for dental services;  
<sup>b</sup>Sunshine Child Welfare Plan offers the same expanded benefits as their standard plan;  
<sup>c</sup>Freedom and Children's Medical Services Network (CMSN) do not offer expanded benefits.

Specialty health plans tailor the type of expanded benefits to particular populations such as children or individuals with HIV or AIDS by offering the services that would provide the most value to those groups. Other examples of tailored benefits for specific populations include intensive outpatient services for patients with serious mental illness and art therapy services for enrollees in the child welfare specialty plan.

**Research Question 2B**

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

This question provides context and has no hypothesis.

Of the 3,781,049 enrollees in DY10, 67.4 percent utilized expanded benefits (Table 36). An expanded benefit may include any of the following: 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, dental, and over-the-counter drugs/supplies.

**Table 36. MMA Expanded Benefits by Enrollees, SFY 2015-16**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollees Using Expanded Benefits</td>
<td>2,549,354</td>
<td>67.4</td>
</tr>
<tr>
<td>Total Enrollees</td>
<td>3,781,049</td>
<td>100</td>
</tr>
</tbody>
</table>

Of the 65,505,271 health care services enrollees received in DY10, 20.5 percent pertained to
expanded benefits (Table 37). Of those expanded benefits, 17.6 percent 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. Approximately one percent pertained to outpatient services that corresponded to revenue codes, such as arthrography, CAT scans, physical therapy, occupational therapy, speech therapy, etc. Lastly, 1.7 percent of the expanded benefits corresponded to NDC codes, which refer to pharmaceutical services and over-the-counter drugs/supplies. The detailed product list can be found at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/PUBLIC MISC FILES/Expanded Benefit Product List.xls.

Table 37. MMA Expanded Benefits by Category, SFY 2015-16

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Benefits (All Categories)</td>
<td>13,433,769</td>
<td>20.5</td>
</tr>
<tr>
<td>Services*</td>
<td>11,521,796</td>
<td>17.6</td>
</tr>
<tr>
<td>OP Services</td>
<td>802,221</td>
<td>1.2</td>
</tr>
<tr>
<td>Pharmacy &amp; OTC Drugs</td>
<td>1,109,752</td>
<td>1.7</td>
</tr>
<tr>
<td>Total Encounters</td>
<td>65,505,271</td>
<td>100</td>
</tr>
</tbody>
</table>

*Includes primary care, physician home visits.

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?

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

Contrary to the hypothesis, enrollees who used expanded benefits had higher percentages of inpatient and ED visits than expanded benefit non-users (Table 38). That is, 11.2 percent of expanded benefits users reported inpatient visits versus 4.2 percent of expanded benefit non-users. Approximately 37 percent of expanded benefit users reported ED visits, compared to 20 percent of expanded benefit non-users.

Table 38. MMA Inpatient and ED Visits by Enrollees who Used Expanded Benefits vs. Enrollees who Did Not Use Expanded Benefits, SFY 2015-16

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expanded Benefits Users</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>286,536</td>
<td>11.2</td>
</tr>
<tr>
<td>ED Visits</td>
<td>955,165</td>
<td>37.4</td>
</tr>
<tr>
<td><strong>Expanded Benefits Non-Users</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>51,256</td>
<td>4.2</td>
</tr>
<tr>
<td>ED Visits</td>
<td>252,294</td>
<td>20.4</td>
</tr>
<tr>
<td><strong>Total Enrollees</strong></td>
<td>3,781,049</td>
<td>100</td>
</tr>
</tbody>
</table>
Component 5. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care and the cost of care.

Component 5 addresses three RQs focused on the differences in enrollment and utilization between Medicaid enrollees eligible for both MMA services and LTC services and those who receive such services (a) through two separate health plans (one plan for MMA services and one plan for LTC services) or (b) through a single comprehensive plan that delivers both types of services.

Analyses for Project 1, Component 5 relied upon simple descriptive statistics on enrollment and a series of statistical analyses comparing the health care use differences between enrollees who received MMA and LTC services through separate plans and enrollees who received such services through a single comprehensive plan. More detail on the statistical analyses and the model results are available in Appendix 3 of Volume 2 of this report.

Research Question 5A

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

There is no hypothesis for this question.

As of June 2016, the Statewide Medicaid Enrollment Report\(^\text{10}\) indicates that 3,190,232 individuals were enrolled in the Florida SMMC program, and that 91,718 of these individuals were receiving both LTC and MMA services. Analyses of Medicaid encounter data showed that 99,192 unique individuals received both LTC and MMA services simultaneously during at least one month of SFY 2015-16. Of these 99,192 unique individuals, 55,712 unique Medicaid enrollees, or 56.2 percent, were enrolled in separate Medicaid managed care plans for MMA and LTC services.

Research Question 5B

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

There is no hypothesis for this question.

During SFY 2015-16, 43,480 unique Medicaid enrollees were enrolled in a comprehensive Medicaid managed care program for receipt of both MMA and LTC services simultaneously. This represented 43.8 percent of the 99,192 unique Medicaid enrollees enrolled in both MMA and LTC services.

\(^\text{10}\) http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml
Figure 1 shows that while overall enrollment among enrollees eligible for both MMA and LTC services rose by 11.1 percent from 89,289 to 99,192, that growth was driven entirely by growth in separate plan enrollments of 22.7 percent, from 45,401 to 55,712. Enrollment in comprehensive plans, by contrast, dropped by 0.9 percent from 43,488 to 43,480 between DY9 and DY10.
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?

**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.

Figure 2 and Table 39 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 and DY10.

Differences in service utilization between separate versus comprehensive plans vary across type of service. For MMA services in DY10, enrollees in comprehensive plans have lower adjusted mean service utilization for non-inpatient (i.e., ambulatory) care than enrollees in separate plans: (1) hospital outpatient visits (1.16 vs. 1.48, -21.99 percent), (2) primary care physician visits (2.5 vs. 2.81, -11.18 percent), (3) specialty physician visits (5.62 vs. 6.16, -8.78 percent), (4) pharmacy claims (6.16 vs. 7.4, -16.72 percent), and (5) emergency department (ED) visits (0.36 vs. 0.39, -6.56 percent). By contrast, enrollees in comprehensive plans had higher adjusted mean service utilization for (1) hospital inpatient admissions (0.42 vs. 0.41, +1.53 percent) and (2) hospital inpatient days (3.71 vs. 3.21, +15.51 percent). These DY10 differences between separate vs. comprehensive plans are quite similar to the DY9 differences. While the exact magnitudes vary somewhat from DY9 to DY10, the overall pattern remains the same. Hospital inpatient admissions and patient-days were higher in comprehensive plans and non-hospital ambulatory care was lower in comprehensive plans in both DY9 and DY10.
Figure 2. Adjusted MMA service use for separate vs. comprehensive plans, DY9 (SFY 2014-15) & DY10 (SFY 2015-16)
Table 39. DY9 (SFY 2014-15) and DY 10 (SFY 2015-16) Unadjusted and adjusted mean service use for separate vs. comprehensive plans

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.

<table>
<thead>
<tr>
<th>Use Category</th>
<th>Comp</th>
<th>Separate</th>
<th>% Diff</th>
<th>Comp</th>
<th>Separate</th>
<th>% Diff</th>
<th>Comp</th>
<th>Separate</th>
<th>% Diff</th>
<th>Comp</th>
<th>Separate</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Inpatient Admissions</strong></td>
<td>0.47</td>
<td>0.45</td>
<td>3.50%</td>
<td>0.43</td>
<td>0.41</td>
<td>4.8%</td>
<td>0.47</td>
<td>0.46</td>
<td>1.00%</td>
<td>0.42</td>
<td>0.41</td>
<td>1.53%</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Days</strong></td>
<td>4.74</td>
<td>3.32</td>
<td>42.77%</td>
<td>4.23</td>
<td>2.78</td>
<td>52.1%</td>
<td>4.26</td>
<td>3.81</td>
<td>11.81%</td>
<td>3.71</td>
<td>3.21</td>
<td>15.51%</td>
</tr>
<tr>
<td><strong>Hospital Outpatient Visits</strong></td>
<td>0.82</td>
<td>1.51</td>
<td>-45.70%</td>
<td>0.75</td>
<td>1.59</td>
<td>-52.7%</td>
<td>1.18</td>
<td>1.44</td>
<td>-18.06%</td>
<td>1.16</td>
<td>1.48</td>
<td>-21.99%</td>
</tr>
<tr>
<td><strong>Physician Primary Visits</strong></td>
<td>2.08</td>
<td>2.63</td>
<td>-20.91%</td>
<td>2.07</td>
<td>2.97</td>
<td>-30.3%</td>
<td>2.29</td>
<td>2.46</td>
<td>-6.91%</td>
<td>2.50</td>
<td>2.81</td>
<td>-11.18%</td>
</tr>
<tr>
<td><strong>Physician Specialist Visits</strong></td>
<td>5.28</td>
<td>5.62</td>
<td>-6.05%</td>
<td>4.98</td>
<td>6.58</td>
<td>-24.3%</td>
<td>5.67</td>
<td>5.79</td>
<td>-2.07%</td>
<td>5.62</td>
<td>6.16</td>
<td>-8.78%</td>
</tr>
<tr>
<td><strong>Pharmacy Claims</strong></td>
<td>4.61</td>
<td>9.56</td>
<td>-51.78%</td>
<td>3.76</td>
<td>9.02</td>
<td>-58.3%</td>
<td>8.17</td>
<td>10.41</td>
<td>-21.52%</td>
<td>6.16</td>
<td>7.40</td>
<td>-16.72%</td>
</tr>
<tr>
<td><strong>Emergency Dept. Visits</strong></td>
<td>0.3</td>
<td>0.38</td>
<td>-21.05%</td>
<td>0.32</td>
<td>0.40</td>
<td>-19.3%</td>
<td>0.33</td>
<td>0.36</td>
<td>-8.33%</td>
<td>0.36</td>
<td>0.39</td>
<td>-6.56%</td>
</tr>
</tbody>
</table>

*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. See Appendix 3 for statistical details.

*The percentage change shown may differ from that calculated using the values in the table because of rounding.
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 a 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, Medicare encounter data is needed to see the full picture of acute care utilization in order to gauge appropriateness. Encounter data for Medicare Advantage enrollees are not available since CMS does not release Medicare Advantage encounter data to researchers.

In summary, the differences in utilization observed in DY10 are similar in relative magnitude to the differences in utilization observed in DY9.

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

**Research 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?*

There is no hypothesis for this question.

Express Enrollment, which provides immediate enrollment in a MMA plan upon determination of eligibility, was initiated in January 2016 for new enrollees who were mandated to participate in the MMA program. 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 from SFY 2015-16. More specifically, only new enrollees from January-June 2016 were evaluated. Additionally, only new enrollees with a valid date of service were included for a final sample size of 136,077 individual enrollees (Table 40). Of these enrollees, 72.59 percent (N=98,778) were enrolled under Express Enrollment using auto-enrollment, compared with 27.41 percent (N=37,299) who were enrolled by voluntary choice. On average, new enrollees access services approximately 33.36 days after enrollment, though the number of days varies by enrollment method. The average number of days for a new enrollee to access services under express enrollment was 37.09 days for those who were auto-enrolled, versus 23.49 days for those who made a voluntary choice for enrollment in DY10 (January-June 2016). Results from a t-test indicate that this difference is significant. Additionally, when comparing individuals who changed plans one or more times (Table 41), those who changed had no significant difference in time to service at 33.37 days, compared with 33.36 days for those who did not change plans.
Table 40. Mean Days to Service for New Enrollees DY10 (January-June 2016), by Enrollment Method

<table>
<thead>
<tr>
<th>Enrollment Method</th>
<th>New Enrollees N (%)</th>
<th>Mean Days to Service</th>
<th>Median Days</th>
<th>Range Days</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-enrollment</td>
<td>98,778 (72.59)</td>
<td>37.09</td>
<td>34</td>
<td>0-179</td>
<td>23.38</td>
</tr>
<tr>
<td>Voluntary Choice</td>
<td>37,299 (27.41)</td>
<td>23.49</td>
<td>18</td>
<td>0-90</td>
<td>20.64</td>
</tr>
<tr>
<td>Total</td>
<td>136,077 (100)</td>
<td>33.36</td>
<td>28</td>
<td>0-179</td>
<td>23.46</td>
</tr>
</tbody>
</table>

Note: A t-test indicates a statistically significant difference in means for those auto-enrolled with those who made a voluntary choice (t=-98.79; p<0.001).

Table 41. Mean Days to Service for New Enrollees DY10 (January-June 2016), by Plan Change Status

<table>
<thead>
<tr>
<th>Plan change within 120 days</th>
<th>New Enrollees N (%)</th>
<th>Mean Days to Service</th>
<th>Median Days</th>
<th>Range Days</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>111,432 (81.89)</td>
<td>33.36</td>
<td>28</td>
<td>0-179</td>
<td>23.56</td>
</tr>
<tr>
<td>1+ Plan Changes</td>
<td>24,645 (18.11)</td>
<td>33.37</td>
<td>31</td>
<td>0-90</td>
<td>22.98</td>
</tr>
<tr>
<td>Total</td>
<td>136,077 (100)</td>
<td>33.36</td>
<td>28</td>
<td>0-179</td>
<td>23.46</td>
</tr>
</tbody>
</table>

Note: A t-test fails to find a statistically significant difference in means for those who changed plans compared to those who did not change plans (t=0.02; p=0.9818).

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?

There is no hypothesis associated with this question.

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). For SFY 2012-13, there were 317,556 new enrollees included in the sample, as shown in Table 42. 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. The average number of days for a new enrollee to access services in DY10, under express enrollment, was 33.36 days, compared with 28.59 days, on average for DY7 prior to Express Enrollment.
<table>
<thead>
<tr>
<th>New Enrollees (N)</th>
<th>Mean Days to Service</th>
<th>Median Days</th>
<th>Range Days</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>317,556</td>
<td>28.59</td>
<td>23</td>
<td>0-333</td>
<td>25.25</td>
</tr>
</tbody>
</table>
Conclusion and Recommendations

This report has presented the results of Project 1 of the MMA program evaluation for the second year of MMA program implementation (DY10, SFY 2015-16). The results reported here for DY10 are generally consistent with the results for DY9. Medicaid costs per member per month are lower in the MMA period compared to pre-MMA period while the improvements in the quality of care shown in DY9 have been sustained with relatively little year-to-year change.

In last year’s Project 1 report, it was noted that the results presented here should be considered preliminary since new programs often take more than one year to show their complete impact on important dimensions of program performance. This evaluation will incorporate SFY 2015-16 and SFY 2016-17 data as they become available. These expanded analyses should provide a more complete picture of the impact of the MMA program.

The broad similarity of the DY10 evaluation results to the DY9 results is somewhat surprising since new program implementations can show considerable year-to-year variability in their first few years of existence. The DY11 evaluation results should shed light on whether the MMA program’s performance stability over its first two years persists or whether the program’s performance will start to evolve as MMA evolves into a more mature and established program.

One result from Project 1 deserves further scrutiny. One HEDIS measure, Medication Management for People with Asthma – 50 percent Medication Compliance, declined by 27 percentage points between the pre-MMA and MMA periods. We recommend that (1) NCQA documentation be checked to ensure that the definition of this measure has remained the same over the time period examined (2011-2016). Often, subtle changes in measure definitions can produce substantial changes in measure scores that render multi-year comparisons inaccurate. If the measure values are comparable across years, the root cause of such a decline should be identified so that interventions can be designed to improve performance on this measure.

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1 Agency for Health Care Administration, “Evaluation of Florida’s Managed Medical Assistance (MMA) Program Demonstration: Project 1 Final Interim Report, Demonstration Year 9, Domains 1, 2 and 10,” May 2017, p. 69