pennsylvania
DEPARTMENT OF HUMAN SERVICES

Evaluation Design

Brief Background

On January 28, 2022, the Pennsylvania Department of Human Services (DHS), obtained approval from the Center for Medicare & Medicaid Services (CMS) to amend the "Pennsylvania Medicaid Coverage for Former Foster Care Youth from a Different State and Substance Use Disorder" section 1115(a) demonstration (Project Number 11-W-00308/3). This amendment provides expenditure authority to test a Managed Care Risk Mitigation COVID-19 PHE demonstration. This amendment tests whether, in the context of the current COVID-19 PHE, an exemption from the regulatory prohibition in 42 CFR § 438.6(b)(1) promotes the objectives of Medicaid. The expenditure authority is expected to support DHS with making appropriate, equitable payments during the PHE to help maintain beneficiary access to care and allows DHS to enter into or modify a risk mitigation arrangement with a Medicaid managed care plan after the applicable rating period has begun.

The demonstration amendment is expected to allow DHS to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by the COVID-19 PHE. This authority is effective regardless of whether the state substantially complied with the regulation by, for example, submitting unsigned contracts and rate certification documents for CMS review either before or after the effective date of the new regulation but before the start of the rating period. The approval letter for from CMS identifies the following federal goals in authorizing the amendment:

- Assessing whether providing this authority results in either increased or decreased payments to plans, given the significant fluctuations in utilization that may occur during a pandemic.
- Assessing whether and how payments under the retroactive risk mitigation arrangements, which must be developed in accordance with all other applicable requirements in 42 CFR § 438, including §§ 438.4 and 438.5, and generally accepted actuarial principles and practices, are sufficient to cover costs under the managed care contract.
- Whether or not implementation of risk mitigation after the start of the rating period, which may not truly address the uncertainty inherent in setting capitation rates prospectively, compares to not allowing retroactive risk sharing during a PHE, which may lead to substantially inaccurate or inequitable payments given the severe disruption in utilization.

DHS applied for a COVID-19 section 1115 Demonstration Waiver to seek expenditure authorities to allow the continuity of the Adult Community Autism Program (ACAP) operated through a managed care contract. The Adult Community Autism Program, also known as ACAP, is one of two programs in Pennsylvania specifically designed to help adults with autism spectrum disorder participate in their communities in the way that they want to, based upon their identified needs. The demonstration provided expenditure authority for the state to add or modify a risk sharing arrangement after the start of the rating period to maintain capacity during the emergency and only applies to the following contracts and rating periods:

RATING PERIOD BEGIN	RATING PERIOD END	PROGRAM	RISK MITIGATION ARRANGEMENT
07/01/2019	06/30/2020	Adult Community Autism	Profit Experience Rebate
07/01/2020	06/30/2021	Adult Community Autism	Profit Experience Rebate
07/01/2021	06/30/2022	Adult Community Autism	Profit Experience Rebate

Evaluation Questions

The evaluation of the PHE Demonstration will test whether and how the expenditure authority impacted the ACAP managed care expenditures. The evaluation hypotheses and questions are presented in Table 1 below.

Table 1: PHE Demonstration Evaluation Objectives and Corresponding Evaluation Hypotheses

Evaluation Objective	*Evaluation Questions*
Furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of beneficiaries receiving HCBS Services by mitigating the potential negative impacts of the COVID-19 PHE.	1. Did DHS utilize this authority to increase or decrease payments under the contract due to fluctuations in utilization or enrollment due to the COVID-19 PHE?
	2. Did the retroactive nature of the risk adjustment authority result in the sufficient funding under the contract?
	3. Did spending patterns for DHS change under the contract due to the ability to implement retroactive risk sharing?
Support DHS efforts to make appropriate and equitable payments during the COVID-19 PHE to better maintain beneficiary access to care that would have otherwise been challenging due to the prohibitions at 42 CFR 438.6(b)(1).	4. Did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans? 5. What conflicts with the objectives of Medicaid did the application of section 438.6(b)(1) during the PHE create and did the exemption alleviate these problems?

Evaluation Methodology

Per CMS guidance, DHS will track capitation expenditures for contract years affected, including initial capitation costs, any additional costs due to program changes and the impact on the calculation of the medical loss ratio (MLR). In addition, key utilization of services covered by the managed care contract rendered prior to and during the COVID-19 pandemic will be gathered and analyzed. Any observable trends, and differences in trends will be explored.

It is important to note that the ACAP program has historically included smaller enrollment (generally between 160 – 190 enrollees annually) as the program targets adults with autism and this may make evaluation difficult as credibility adjustments have historically been applied in ACAP. Enrollment and utilization trends will be compared both during the PHE period and prior to the PHE period. Additionally, expenditure trends, MLR results, and mid-year program adjustments (if any) will be reviewed to ascertain the impact of COVID-19 on rate setting and risk mitigation under the contract.

Table 2 explores potential data sources and potential analyses that may support the evaluation of each proposed hypothesis.

Evaluation Hypothesis	Potential Data Source	Potential Analysis	Approach
Did DHS utilize this authority to increase or decrease payments under the contract due to fluctuations in utilization or enrollment due to the COVID-19 PHE?	Encounter and claims data submitted by MCOs to DHS; financial reporting from MCOs, document review.	Evaluate impact of flexibility; evaluate utilization of contract services beneficiaries during PHE compared to historic baseline. Compare to historic spending throughout contract periods during the PHE compacted to historic baseline.	Quantitative Analysis
Did the retroactive nature of the risk adjustment authority result in the sufficient funding under the contract?	Encounter and claims data submitted by MCOs to DHS; financial reporting from MCOs, document review.	Compare historic spending throughout contract period during the PHE compacted to historic baseline.	Qualitative Analysis
Did spending patterns for DHS change under the contract due to the ability to implement retroactive risk sharing?	Encounter and claims data submitted by MCOs to DHS; financial reporting from MCOs, document review.	Compare historic spending throughout contract period during the PHE compacted to historic baseline.	Qualitative Analysis
Did the retroactive risk sharing result in more accurate payments to the managed care plan?	Encounter and claims data submitted by MCOs to DHS; financial reporting from MCOs, document review.	Compare historic spending throughout contract period during the PHE compacted to historic baseline.	Qualitative Analysis
What conflicts with the objectives of Medicaid did the application of section 438.6(b)(1) during the PHE create and did the exemption	Staff Interviews	Descriptions of actions taken by DHS to address challenges. Description of how successful the actions were the actions to address the challenges.	Qualitative Analysis

alleviate these problems?			

Methodological Limitations

While the PHE Demonstration offers various flexibilities, the implementation of the authorities sought may vary; it is possible that implementation may not result in program changes that vary in actual impact on the nature of risk mitigation. For example, while the existing risk mitigation tool was not approved prior to the start of the contract period as required by CMS, the terms of the risk mitigation tool may not change during the PHE contracting period or vary in nature from the pre- PHE contracting period.

Additionally, enrollment is historically small in the ACAP program, and the analysis may not result in statistically credible results. Due to the small enrollment levels, ACAP has historically not met CMS' standard for partial credibility in the MLR calculation. The COVID-19 pandemic may have an unprecedented and unpredictable impact that supersedes the mitigating flexibilities implemented by the PHE Demonstration; external factors (e.g. imposition of state lock downs, community-level fear, and decreased access to services, etc.) may confound the outcomes of the evaluation. Other changes within Medicaid in response to the COVID-19 pandemic (e.g. encouragement/ increased use of telehealth services, substantial increase in enrollment) may also impact care delivery; these factors may, in turn, affect the outcomes of the evaluation.

Evaluator and Evaluation Report

This evaluation will be conducted internally by DHS staff. Data will be gathered as part of standard DHS operations and will draw upon the findings from the cost/utilization assessment to describe the extent to which the administrative and program costs related to this demonstration were effective at achieving the objectives of the demonstration. The Final Report will be organized based on the structure outlined in CMS' section 1115 demonstration evaluation guidance "Preparing the Evaluation Report." Per CMS guidance, the focus of the Final Report will be on describing the challenges presented by the COVID-19 public health emergency to the Medicaid program, how the flexibilities of this demonstration assisted in meeting these challenges, and any lessons that may be taken for responding to a similar public health emergency in the future. The Final Report will be a stand-alone evaluation (not part of the larger 1115 demonstration evaluation report) due to the specific, time-limited nature of the authority provided and submitted no later than one year following the end of the PHE Demonstration authority. Per 42 CFR § 431.428, the Final Report will capture all the requirements stipulated for an annual report. If the demonstration lasts longer than one year, the annual report information for each demonstration year will be included in the Final Report and will adhere to the stipulations of 42 CFR § 431.428. In addition, as required by CMS, the state will host a post-award public forum either in person or by webinar to gather comments and feedback using the appropriate modality(ies), or if needed, request an extension of the deadline to meet this deliverable.