RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

December 15, 2011

Mr. Mark Pahl
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Pahl:

The Agency for Health Care Administration is submitting the enclosed final evaluation report for Florida's 1115 Medicaid Reform Waiver as required by Special Term and Condition #89. The report covers evaluation activities and findings from July 1, 2006 through June 30, 2011. This report was prepared by the independent evaluation team at the University of Florida, led by R. Paul Duncan, Ph.D., who has served as the principal investigator for the evaluation.

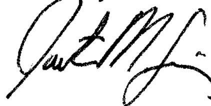
The final evaluation report includes a description of Florida Medicaid and the context in which the Demonstration was implemented as well as a description of the various components of the evaluation. The report presents evaluation findings regarding the participation of managed care organizations, enrollees' experiences with the Demonstration overall and with mental health services in particular, the fiscal impact of the Demonstration, and the Low Income Pool.
Key findings described in the evaluation report include:

- Consumers found that the Reform pilot improved access. The independent research team found statistically significant improvements from the benchmark year (pre-demonstration) to the Demonstration Years regarding ratings of "always" getting care right away, in terms of both urgent and routine care.
- Consumers found it easy to find a personal doctor. The independent researchers found significant increases between the year prior to the Demonstration and Demonstration Year 1 in the percentage of enrollees reporting that they have a personal doctor and that they did not have a problem finding a personal doctor with whom they were happy. The level achieved in Demonstration Year 1 was maintained in Years 2 and 3.
- Consumer satisfaction with their personal doctor went up significantly. The independent research team found a significant increase over time in the percentage of Demonstration enrollees reporting satisfaction with their personal doctor at the highest level.
- Consumers found improved communication with their personal doctor. The independent research team found statistically significant improvements between the year prior to the Demonstration and Demonstration Years 1, 2, and 3 in enrollees' ratings of communication with their personal doctor.

- The Demonstration allowed for consumer choice. The independent researchers found a clear majority of enrollees self-selected their health plans through the Choice Counseling program during the Demonstration.
- Demonstration health plans scored higher on quality measures, and improved their quality scores more rapidly. The independent research team found that health plans in the Demonstration areas achieved higher levels of performance than plans in non-demonstration areas for a number of HEDIS performance measures. From 2008 to 2009, demonstration plans also showed greater improvement in performance measures than non-demonstration plans.
- The Demonstration saved taxpayer money. The independent researchers found savings in per member per month (PMPM) expenditures for both SSI and TANF enrollees during the Demonstration. Savings remained even after the researchers controlled for age, gender, and race.
- The Demonstration rewarded Medicaid recipients for engaging in healthy behaviors. The independent research team found enrollees' awareness of and participation in the Enhanced Benefits Reward$ program increased from Year 1 to Year 2.

We appreciate your efforts in working with our staff on Florida's 1115 Medicaid Reform Waiver. Should you have any questions, please contact me at (850) 412-4007. We look forward to continuing to work with you.

Sincerely,



Justin M. Senior
Deputy Secretary for Medicaid

JMS/rml
Enclosure
cc: Jackie L. Glaze, CMS-RO
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Evaluating Florida's Medicaid Reform Demonstration Pilot:
2006 – 2011 Summary Report
December 2011

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The views expressed in this report are those of the authors. No official endorsement by the Agency for Health Care Administration is intended or should be inferred.

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SECTION I: EXECUTIVE SUMMARY

Florida's Section 1115 Medicaid research and demonstration project was initially planned as a five-year project extending from July 1, 2006, through June 30, 2011. The focus of the demonstration was to transition most Medicaid enrollees to a managed care form of medical care delivery. Research findings that can be discerned through the five-year period are summarized in this report, divided among major elements of the demonstration including managed care organizations (MCOs), the enrollees, the fiscal impact, the Low Income Pool, and mental health services.

First, the demonstration was implemented very quickly. Even considering that some preparatory steps could be taken during the period of anticipation, a true "go decision" could not be made until the special legislative session of December 2005. The mandated start date of July 1, 2006, was extremely ambitious by any standard. The Florida Agency for Health Care Administration (AHCA) was committed to meeting its legislated timeline. The use of a disciplined Project Management approach was a critical element in achieving the start time. Second, from the very beginning and throughout the pilot, AHCA organized key participants into teams that included staff from various AHCA bureaus, content experts, and trained, experienced project managers. Third, strong leadership at all levels played an integral role in the development and implementation of the demonstration. Effective internal communication and external communication were critical success factors in the development and implementation of the demonstration. Finally, the State's dedication of significant resources (including funding, vendors, human resources, information, and time) to the demonstration's development and implementation was critical to the initiative's success. On balance, it seems clear that AHCA did a commendable job of project implementation and management.

As is the case for all demonstrations, some implementation challenges emerged. In Florida's Medicaid demonstration, the most common of these involved communicating with numerous and diverse stakeholders, many of whom needed very different information. The demonstration evolved somewhat as its implementation matured, necessitating changes and communication about those changes. In some instances, changes made in response to some stakeholders created ambiguities or issues for other participants. MCO stakeholders expressed concerns that by the time they had figured out how to accomplish some specific task associated with the demonstration, the task might very well have changed. Follow-up communication was frequent and effective, but the issue of a "moving target" was frequently expressed in stakeholder interviews.

A second challenge was an issue of time and resource allocation given the controversial nature of some aspects of the demonstration. The philosophical, political, and policy conversations that began during the earliest stages of discussion regarding a waiver application continued through at least the first eighteen months of the demonstration itself. Part of the nation's civic culture has for many decades been predicated on a model that even relatively contentious political differences are set aside with the formal

passage of a law, as attention turns to program design and development. In the instance of Florida's Medicaid demonstration, the extension of these conversations into the implementation phase required an allocation of administrative (AHCA) effort and energy to ongoing descriptions and defense of the demonstration's basic tenets and objectives, rather than the enormous challenges of implementation.

THE DEMONSTRATION DID NOT FUNDAMENTALLY CHANGE MCO INTEREST IN MEDICAID—EXCEPT FOR PSNS

Early conversations about the planned demonstration included significant concerns that existing managed care organizations might simply choose not to participate in the demonstration and/or that new managed care organizations would not emerge to do so. From the onset and throughout the demonstration, plans indicated that a major reason for participating in the demonstration reflected their intention to remain in the Medicaid business. Most plans were participating in Medicaid prior to the demonstration, and they wanted to maintain their enrollee bases. Second, although plans were given some latitude in benefit design, most reported only minimal changes to their benefit structure from pre-demonstration plans. Additionally, plans made few changes to their provider networks, and issues with contracting that existed pre-demonstration remain.

The idea behind provider service networks (PSNs) is to create a group of providers that will provide care and be accountable for a defined population, in this case Medicaid enrollees. The concept allows for shared savings upon the achievement of certain quality standards and cost reductions (Duncan, Lemak, et al., 2008). This is similar to the arrangement under Florida's Minority Physician Network Program, a waiver that demonstrated the potential for improved quality and cost savings (Lemak, et al., 2004). By 2011, four PSNs were participating in the demonstration including one focused on children. On several dimensions, the PSNs participating in the 2006 – 2011 demonstration show considerable promise as managed care organizations familiar with and effective in the delivery of healthcare services to Medicaid enrollees.

MARKET DYNAMICS WERE SIGNIFICANT

Demonstration years three through four included significant changes in organizational participation. The departure of the dominant health maintenance organization (HMO), WellCare, and its two plans (HealthEase and Staywell) from all of the demonstration counties led to dramatic increases in enrollment for several other managed care organizations (MCOs). Specifically, the two hospital-affiliated PSNs (South Florida Community Care Network and First Coast Advantage) more than doubled their enrollment and one health plan (Total Health Choice) saw a four-fold increase in membership during a two-month period in 2009.

For many plans, the growth in enrollment resulting from Wellcare's departure from the market meant increasing network capacity and more emphasis on physician relationships. Most of the plans reported that they were successful in this process.

In contrast to dramatic enrollment increases in some plans, several others maintained a freeze on enrollment in the demonstration counties, essentially preventing any future growth for themselves in the pilot areas. Payment rates perceived as low and the high administrative costs specific to the demonstration were cited as the primary reasons for such freezes. Plans found rates in the demonstration to be particularly problematic, but they have no desire to leave Florida Medicaid overall (Lemak, Landry, Billello, Bell, & Van Wert, 2010).

MANAGED CARE BROUGHT INNOVATIVE TOOLS AND INCREASED ACCOUNTABILITY

Under the demonstration, substantial responsibility for managing providers shifted from AHCA to the MCOs. Several MCOs put in place a variety of tools to educate and communicate with contracted providers. Early evidence finds that some plans are also using innovative ways to work with and communicate with providers. There are also indications that all types of Medicaid providers have a greater degree of accountability for practice patterns in the demonstration counties because they are now being more carefully managed.

AHCA instituted new quality improvement plan reporting requirements with the demonstration. These requirements go further than any previously existing in MediPass and further than previous requirements for Medicaid HMOs. For example, Florida's Medicaid HMOs are now required to gather and submit encounter data.

The demonstration plans report that their Medicaid provider networks remained largely the same as their pre-demonstration networks. Additionally, AHCA has conducted an analysis of provider networks and has concluded that access has not been reduced as a result of the demonstration (Florida Agency for Health Care Administration, 2011b). Access to specific types of specialty care continues to be a challenge throughout our nation's healthcare system. The demonstration, in and of itself, has neither mitigated nor exacerbated this fundamental issue, although some suggest that access to specialists has improved in the demonstration due to partnerships with local hospital districts, and contracts with specialty providers on a case by case basis. Surveys of enrollees showed no statistically significant difference in beneficiary ratings of specialty care access.

ENROLLEE EXPERIENCES

Enrollee experiences with the demonstration were assessed primarily through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys that were fielded both prior to and throughout the duration of the demonstration. Survey findings indicate relatively few changes in enrollee satisfaction over the period of the demonstration. The few changes that were observed occurred among enrollees in Broward and Duval counties and included both positive and negative shifts in enrollee ratings and reports of their health care. Satisfaction with health care declined in the year following implementation, and then remained stable for the subsequent three years. Satisfaction with health plans declined across the four survey years. Over the demonstration period, higher proportions of enrollees reported that they were better able to connect with a personal doctor, and interactions with the personal doctor were more positively assessed. The proportions of enrollees providing positive reports of their communication with providers, and reporting that they were able to get care right away were higher during the demonstration compared to the benchmark measure taken prior to the demonstration.

For most ratings, the observed differences between PSN and HMO enrollees were not statistically significant. In the satisfaction indicators where statistically significant changes are observed, the differences (either positive or negative) are small. Enrollees who switched health plans expressed lower satisfaction ratings.

In the context of selecting an MCO, enrollees reported some frustration with (a) being required to choose, and (b) the level of detailed knowledge required to make a good choice. But they were willing and able to make a selection and to utilize the Choice Counseling processes made available to assist in their choice. Satisfaction measures clearly indicated enrollee frustration with the market volatility that led to changes in the participation of various managed care organizations and sometimes required that they switch plans.

The Enhanced Benefit Reward$ (EBR) program was an innovative element in the demonstration, intended to incentivize enrollees to take an active role in their health and health care by engaging in certain healthcare behaviors. Enrollees who engaged in an approved list of health care or health behaviors would receive a credit which could be redeemed at a Medicaid-participating pharmacy. Program effectiveness was measured by participation (both earning and expending credits) and by the extent to which enrollees are aware of the opportunity.

Knowledge and awareness of the EBR program among enrollees, the number of enrollees participating, the dollar value of credits earned and the dollar value of credits expended all increased throughout the demonstration period. Self-reported program participation varied, with non-English speaking enrollees and those who reported themselves to be in poorer health were less likely to report participation; those who

reported having a close connection to their primary care provider were more likely to be aware of and engaged in the program. Concerns were expressed that the program rewarded too many behaviors; that many behaviors were activities that enrollees would undertake regardless of incentive, and that credits were largely earned because the MCOs were diligent in reporting. The program was modified over the course of the demonstration to address these concerns, with input from an advisory committee.

The demonstration provided enrollees with a means of "opting out" of Medicaid and instead using the funds that would have been allocated to their Medicaid as the employee share of private, employer-sponsored health insurance. This element of the demonstration was pursued by only a very small number of enrollees, fewer than 100 individuals throughout the five-year period of observation, the majority of whom were disenrolled from the Opt-Out program due to loss of job or loss of Medicaid eligibility.

FISCAL IMPACT

Over the first four fiscal years of the demonstration (the period for which key data are available), the State of Florida has spent less money on the medical care of enrollees in the demonstration on a per member per month (PMPM) basis than it would have spent on comparable enrollees in those same counties had there been no demonstration. This does not mean that total expenditures by the State were lower; it represents a lower amount of increase in expenditures than would have been expected over the first four years of the demonstration absent reform. The observed relative reduction in expenditures is greater for Supplemental Social Security Income (SSI) enrollees ($263 PMPM) than for those enrollees whose eligibility for Medicaid derives from their Temporary Assistance for Needy Families (TANF) eligibility ($35 PMPM). The differences in expenditures are greater for enrollees whose Medicaid managed care participation is in a PSN than for those whose managed care organization is an HMO. It is important to note that to date no analyses have been conducted to estimate or better understand the source of these differences.

THE LOW INCOME POOL

The primary objectives associated with the Low Income Pool (LIP) were to (a) maintain the state's commitment to providing resources that assist safety-net hospitals in the achievement of their traditional commitment to providing needed care to the Medicaid, underinsured, and uninsured populations; and (b) extend the distribution of resources for that same purpose to a larger number of hospitals and to non-hospital providers of care.

By setting the LIP at $1.0 billion per year throughout the demonstration, the first objective was accomplished in the aggregate. Total funding under the LIP program increased in comparison to the program in place before the Medicaid demonstration (the Special Medicaid Payments (SMP) program). Moreover, LIP funding went to more

hospitals than before the Medicaid demonstration, and non-hospital providers also began receiving funding under the LIP program. Hospitals receiving LIP funding served an average of approximately 30 Medicaid, underinsured, and uninsured individuals for every $1,000 of LIP payments, while non-hospital providers receiving LIP funding served an average of approximately 120 Medicaid, underinsured, and uninsured individuals for every $1,000 of LIP payments.

Given a fixed pool, the per patient amounts distributed to any single organization must decline as the number of organizations receiving funds increases, and that pattern was observed over the period of the demonstration. It might be argued that a decline in the per patient amounts allocated to the traditional safety-net hospitals represents a failure to maintain the prior levels of commitment; but if the general issue is whether or not Florida balanced the inherent inconsistencies of objectives (a) and (b) above, it seems clear that the LIP program achieved its objectives.

IMPACT ON MENTAL HEALTH SERVICES

It is well documented that Medicaid enrollees are especially vulnerable. They are poor by definition. They often have severe disabilities or chronic health conditions and live highly stressed lives in the most difficult of circumstances—and none more than those who are living with mental and behavioral health issues. Thus the impact of a managed care initiative on this particular population segment was considered to merit special consideration. The evaluation studied enrollee satisfaction with services received in the demonstration, and pursued an analysis of legal resources to determine whether the demonstration had an impact on two of the most salient consequences of insufficient mental health care—the frequency of Baker Act examinations and arrest rates

Adults with severe mental illness and youth with severe emotional disturbance in the demonstration counties fared as well on the two indicators (Baker Act examinations and arrest rates) after the implementation of the demonstration as before. Specifically, the implementation of the demonstration was not associated with significant changes in the frequency of Baker Act examinations or the frequency of juvenile justice encounters for either adults or youth. However, for adults, there was a significant reduction in Baker Act examinations and arrests with the implementation of the PMHP program that was not observed with the demonstration.

Survey data indicated few and modest differences in enrollee/caregiver satisfaction with mental health services comparing enrollees in the demonstration to enrollees in a control county. Some differences were observed when comparing demonstration HMOs and PSNs, but there was not a consistent pattern indicating greater effectiveness in either organizational type.

SECTION II: INTRODUCTION TO MEDICAID AND CONTEXT FOR THE DEMONSTRATION IN FLORIDA

In keeping with the nation's federalist approach to management of government programs and services, the Medicaid program involves collaboration between the states and the federal government. Because Medicaid is essential to so many key stakeholders, states have limited managerial discretion in some aspects of program design and operation. A set of minimum program characteristics apply to all states and these must be achieved and maintained to establish and retain federal funding. States are free to design, develop, and implement program elements that exceed the minima; therefore, states have greater flexibility in managing those additional elements of their programs. However, any proposed initiatives that might impact the degree to which the core requirements are achieved may be implemented by a state only if there is a formal waiver of federal rules. Such a waiver is accomplished by means of a negotiation between the proposing state and the federal Centers for Medicaid and Medicare Services (CMS). CMS must authorize a "Research and Demonstration Project," in which a state can test the viability and utility of a proposed initiative.

In 2005, the State of Florida sought such a waiver and received federal approval to implement a set of reforms to its Medicaid program. This report provides core findings of a 5-year research study to assess the impact of the changes Florida implemented. The report includes five major sections.

The first section is an Executive Summary (above).

The second section includes an introduction and description of Medicaid at the national level and the context in which Florida's Medicaid program operated when the Medicaid research and demonstration project (hereafter, the demonstration) was contemplated, designed, and implemented.

In the third section, a brief description of the demonstration is provided. The section includes summaries of key elements such as the overarching vision, policy processes, steps undertaken in the demonstration's development, and the demonstration's fundamental form as implemented.

In the fourth section, the demonstration is assessed and subdivided to reflect areas of fundamental interest. These interest areas were largely determined by the demonstration's objectives and the program described in the Section 1115 Waiver Application, as well as the approved waiver (including its special terms and conditions). Thus, major portions of this section are devoted to the following:

- The participating MCOs,
- The enrollees, including the Enhanced Benefits Reward$ program and enrollee satisfaction,
- Fiscal impact,

- The Low Income Pool, and
- Impact on mental health services.

In the fifth section, key findings and conclusions are discussed, along with lessons gleaned from the demonstration at this stage of its operation.

Florida's approach to changing selected attributes of its Medicaid program generated considerable interest and no small amount of controversy from the onset of the most preliminary conversations and throughout the actual demonstration. Assessments and commentary on the program and its impact have been numerous. These extend over a wide range of formality and have resulted in reports that range from academic papers/presentations to mass media reports, editorial expressions of opinion, advocacy positions, webinars, and other communications. Some findings and information gleaned from other evaluations are included in this report and are referenced accordingly.

MEDICAID

Since 1965, Medicaid has financed healthcare services for disadvantaged Americans. The program operates in all 50 states as well as the District of Columbia, American Samoa, Guam, Marianas, Puerto Rico, and the United States Virgin Islands. Medicaid pays hospitals, physicians, and other medical care providers for medical care needed by people who meet eligibility requirements, are uninsured, and otherwise unable to pay for their care. In addition, Medicaid shares responsibility with Medicare for financing medical care for people who are eligible for both Medicare and Medicaid.

At present, Medicaid serves more than 50 million enrollees throughout the nation (Henry J. Kaiser Family Foundation, 2011). Medicaid covers 45% of all Americans with incomes below the federal poverty level ($22,025 for a family of four in 2008). Since Medicaid enrollees' needs are extensive, Medicaid benefits are diverse and include health services typically provided by private sector insurance covering physician office visits, related diagnostic tests, treatments, hospital stays, medical equipment, and prescription drugs. Additional services may also be provided, such as dental, vision, transportation, translation, and long-term care for elders who meet an income eligibility threshold (Kaiser Commission on Medicaid and the Uninsured, 2010; Klees, Wolfe, & Curtis, 2010).

Medicaid is an expensive program, primarily because health care is expensive. National Medicaid expenditures now exceed $300 billion annually and continue to increase at about the same rate of growth noted in other parts of the healthcare system (Holahan, Clemans-Cope, Lawton, & Rousseau, 2011). The third largest program in the federal budget after Social Security and Medicare, Medicaid accounts for 8% of federal spending (Kaiser Commission on Medicaid and the Uninsured, 2011). Despite a substantial federal share (generally close to half the total costs), state expenditures for the program can be very high and are always among the top two or three largest single

components of state budgets—typically, 16% of the entire state's budget (Kaiser Commission on Medicaid and the Uninsured, 2011). Thus, Medicaid has become the single most difficult budget issue facing many state governments. As a result, most state budget conversations begin and end with the line item associated with their Medicaid program. Beyond magnitude, states are concerned with the countercyclical nature of Medicaid expenditures. The number of enrollees increases in difficult economic periods when unemployment rises and incomes fall (Holahan, et al., 2011). It is estimated that Medicaid enrollment increases by 1 million for every percent increase in the unemployment rate (Holahan & Garrett, 2009). These are precisely the times in which states are likely to experience declining tax revenues, which reduce their capacity to meet the increased needs.

It is almost impossible to overstate the importance of Medicaid to its enrollees, the states/territories, and many providers of care. The budgetary significance of the program, especially to state/territory governments, has been noted. For many hospitals, clinics, doctors, medical equipment suppliers, and other providers of care, Medicaid is an essential source of payment. For example, Medicaid composes 33% of public hospitals' revenues and is the largest source of third party payment for health centers (Kaiser Commission on Medicaid and the Uninsured, 2010). Clearly, the program is absolutely critical to enrollees. It provides a level of financial access to immediate healthcare services for millions of people, including some of the most vulnerable among us, who simply have no other means with which to pay for care.

CONTEXT OF MEDICAID IN FLORIDA

Medicaid exists in our nation as a result of Title XIX of the Social Security Act, the 1964 federal law creating the national program and the administrative/structural framework governing Medicaid's financing and state/federal managerial collaboration. Florida passed legislation to create the State's program during 1969, with a start date of January 1, 1970.

By the year 2005, Florida's Medicaid program had grown to include 17 eligibility categories, 47 different services, 20 federal waiver initiatives, 91 service vendors, and 70,000 enrolled providers (Bush, 2005a). The program covered 27% of the State's children; 51% of infant deliveries; 63% of nursing home days; 885,000 adults (parents, aged, and disabled); and 52% of individuals with AIDS (Arnold, 2004). Florida's Medicaid program served 2.2 million enrollees in 2004, and expenditures were about $14 billion annually. There were 11 HMOs in 33 counties, with over 750,000 enrollees and three pilot projects in 25 counties with over 100,000 enrollees (Arnold, 2004). Between 1998 and 2004, Florida's Medicaid program costs increased by 88%. It was estimated that if the then current Medicaid growth rate continued at 13%, the program would consume more than 50% of Florida's state budget in 2015 (Bush, 2005b).

In effect, Florida's Medicaid program was not a single program but a complex set of programs, each with its own set of management challenges, but all residing within the purview of a single state-level agency. Florida's Medicaid program provided critically important support for many of the State's most vulnerable citizens and the healthcare organizations serving their needs. Continuation of these two major objectives was essential and thus the basis on which Governor Bush's administration made its initial decision to pursue a reform agenda.

Florida's Medicaid program was not without issues. Problems, perceived by a wide variety of stakeholders, included concerns about low levels of provider participation (particularly among specialty care physicians), quality of care, payment rates, bureaucracy, fraud, and waste. And within both the executive and legislative branches of Florida's state government, there were fundamental philosophical doubts about the basic model in which Medicaid services were delivered and financed. Medicaid had been enacted in a context that emphasized fee-for-service payments by means of retrospective reimbursement to providers of care, and the program retained many elements of that basic model. However, by 2005, most of the nation's health care was being financed and delivered in a managed care context that included more intense constraints on provider selection, significant deductibles, and some co-payment and/or co-insurance, as well as numerous forms of management directed toward providers—pre-approvals, utilization reviews, formularies, and the like, all of which were perceived to be means of cost-savings.

Together, the combination of issues noted here gave rise to a determination within Governor Bush's administration that the Medicaid demonstration should be undertaken.

SECTION III: FLORIDA'S MEDICAID REFORM DEMONSTRATION PILOT (DEMONSTRATION)

UNDERSTANDING FLORIDA'S 2006 – 2011 MEDICAID REFORM PROCESS AND SUBSEQUENT RESEARCH AND DEMONSTRATION PILOT (DEMONSTRATION)

THE VISION

As is the case with virtually all policy initiatives, Florida's demonstration began with an idea or set of ideas. In this case, there were three foundational building blocks. First, the delivery and financing of care through the Medicaid program should align with and emulate comparable processes in the private sector. Second, the changes should not result in expenditure increases and should improve the state's abilities (a) to predict direct expenditures for patient care and (b) to manage the Medicaid program and the care it finances. Third, the program should empower enrollees, in their role as consumers, to make choices and selections that would have the effect of generating competition among health plans and providers of care.

Consistent with other aspects of the philosophical foundation underlying the demonstration, it was assumed that such competition was of inherent value as a motivation for MCOs to contain costs while providing quality services. In presenting these basic ideas, it was repeatedly argued that the proposed demonstration should, could, and would be accomplished without "cutting" Medicaid in the sense of removing individual enrollees from the program or reducing quantity or quality of care delivered and financed through the program.

THE POLICY PROCESS

The processes in which an idea becomes a policy and hence a program are complex and subtle under any circumstances, and this was certainly the case with Florida's Medicaid demonstration. The first step was expression of the basic ideas in a form that was clearer, more comprehensive, and more explicit than the three building blocks noted above. This was necessary to support the application for a waiver of federal rules that would ultimately be required. It was also a necessary component in development of Florida legislative support and approval, as that was required before federal involvement could even begin. This first step of clarification was addressed with a "White Paper" that was authored by a small health policy leadership group working directly with Governor Bush. A final version of the White Paper was ultimately published as *Market Principles: The Right Prescription for Medicaid* (Bush, 2006).

The White Paper became the basis for dialogue between federal and state entities, giving rise to legislation. Bills were introduced in both Florida's House of Representatives and Senate, initiating the intricate process of legislation (Duncan, Bell,

Hall, Lemak, & McKay, 2006). A final bill was passed in May 2005 during the last few days of that year's legislative session. The final bill was a compromise. Its key element was authorization of the State's executive branch to seek a federal waiver and implement reforms as described in the bill. The actual content of the described demonstration reflected portions of the original White Paper, each of the bills originally filed, and views expressed by numerous advocacy groups and other interested parties over the course of the legislative process. Key provisions of CS/CS/SB 838 for the demonstration are summarized in Table 1.

TABLE 1: KEY PROVISIONS OF CS/CS/SB 838 FOR FLORIDA'S MEDICAID REFORM DEMONSTRATION

- Authorized AHCA to submit a Medicaid Reform waiver application to CMS. Dependent on federal approval and legislative authorization, Medicaid Reform was initiated in Broward and Duval counties. The Reform expanded to Baker, Clay, and Nassau counties one year later.
- Required AHCA to submit an implementation plan that outlined the activities associated with the Reform process and evaluated the impact of Medicaid Reform on the total Medicaid budget for State Fiscal Year (SFY) 0607 through SFY0910.
- Legislative approval was contingent on the preservation of the hospital upper payment limit (UPL) and hospital disproportionate share (DSH) program. In the demonstration areas, for most Medicaid eligibility groups the Fee-for-Service and MediPass systems were replaced by managed care pilot programs.
- The Managed Care Pilot Program would
  - include all mandatory and optional services including behavioral health services;
  - offer choice of plans;
  - establish a process for risk-adjusting capitation rates;
  - phase in provider service network risk over a three-year period;
  - permit the use of stop-loss provisions and catastrophic coverages;
  - establish a managed care plan credentialing process;
  - implement enrollee Choice Counseling and grievance resolution programs;
  - authorize the development of network provider participation criteria;
  - ensure coordination with school-based health programs;
  - authorize the development of a service delivery alternative for children with chronic medical conditions;
  - authorize AHCA to recommend service delivery alternatives within capitated managed care plans for developmentally disabled individuals and foster care children;
  - permit the assignment of enrollees to managed care plans if they have not chosen a plan within 30 days, provide for a 90-day voluntary disenrollment period, and permit disenrollment for cause;
  - authorize enrollee opt-out and enrollment in employer-sponsored plans;
  - require AHCA to post the federal waiver application on its website 30 days in advance of waiver submission to the federal government;
  - require evaluation of the pilot programs;
  - establish a process for enrollees to opt-out of Medicaid and participate in an employer-sponsored plan; and
  - establish enhanced benefits accounts.

The passage of CS/CS/SB 838 is a clear example of the manner in which significant legislation frequently occurs. Both before and during the legislative process, many organizations and entities took steps to participate and provide input. It is thus reasonable to conclude that virtually all interested participants were heard. Although not every expressed idea or concern made its way into the law, provisions in support of some interests were added to the bill. Other interested parties succeeded in deleting or preventing the inclusion of ideas they found especially problematic. As with most complex initiatives involving people with differing foci and interests, no one participating group achieved everything it preferred.

Core philosophical elements of the demonstration proponents' points of view were enacted. These included formal legislative approval to pursue the waiver, specific program elements clearly derived from proposals in the White Paper, demonstrations of significant size in large counties, a much more contemporary "managed" approach to care, and greater enrollee responsibility, including the opt-out and enhanced benefit provisions. Those who opposed the demonstration ideas were unable to simply block the legislation, but were able to obtain geographic concessions, program limitations, and new opportunities for review.

There are multiple examples confirming that participants including providers of care and interest groups got comparably mixed outcomes. Providers of care, especially the teaching hospitals and other healthcare safety-net organizations providing a substantial level of care for Medicaid enrollees, sought protections against the prospect of payment rate reductions or dramatic increases in uncompensated care. The legislation included a requirement that any waiver approval must include federal concurrence that a key hospital financing mechanism—known as the Upper Payment Limit (UPL)—would be preserved. Interest groups concerned with cultural competency, health literacy, and reducing minority health disparities obtained a commitment that waiver demonstration projects would focus attention on those issues. Some organizations voiced especially strong concerns that the proposed level of enrollee participation in choosing among multiple plans could be successful only if there were substantial investment in a patient education (Choice Counseling) program, and such an investment was included. In summary, no participants got everything they wanted, but a consensus emerged that was sufficient to obtain the required majority vote, such that many contributors to the process achieved at least some elements of their preferred outcomes.

The bill was signed into law (Chapter No. 2005-358) by Governor Bush on June 3, 2005. As authorized by the new law, Florida's designated Medicaid Agency, the Florida Agency for Health Care Administration (AHCA), then applied for the necessary waiver. But that simple statement belies a process that took several months and was, itself, to become controversial. Work on the waiver application was undertaken as a collaborative effort of AHCA, the Governor's office, and Florida's Washington, DC, office, augmented by continuing input from legislative leadership and staff, consultants, and interest/advocacy organizations.

AHCA assumed the appropriate leadership role in preparing the waiver application. Two elements of this phase merit mention. First, it was clear that the waiver application was prepared in a context of extensive, active consultation and negotiation with the federal government, specifically CMS. Second, it was clear that a complex financial issue became central to the conversation with federal officials and would remain a potential deal-breaker until the very end.

The fiscal issue of key interest became clear as the conversations developed. Over the course of time, two financing mechanisms to support safety-net hospitals had evolved in Florida. Collectively, these mechanisms are referred to as the UPL and the Disproportionate Share (DSH) programs. As noted above, CS/CS/SB 838 required that these programs be protected and preserved in any demonstration project approved by waiver. On the other hand, Section 1115 Waivers had to be "budget neutral" from a federal perspective, meaning that approval could not put the federal government at risk for higher contributions to a state's Medicaid program than those which would be expected to occur in the absence of the waiver. Protecting Florida's UPL/DSH financing for safety-net hospitals while implementing the other proposed changes to Medicaid in a manner acceptable to CMS became difficult primarily because a managed care model pays by capitation rather than claims. The establishment and allocation of funding ($1 billion) to the Low Income Pool (LIP) became the solution.

The waiver application itself was completed in late August 2005. Following state and federal requirements, the application was officially disseminated and public comment was invited by posting the document on AHCA's website on August 31, 2005. The waiver and legislative processes required that an interval of not less than 30 days be provided for public response. During the period from August 31 through the month of September, AHCA received 92 comments from the public.

The waiver application was formally submitted to CMS on October 3, 2005. On October 19, 2005, 16 days after formal submission, CMS approved Florida's Medicaid demonstration waiver application with special terms and conditions. The number, detail, specificity, and thoroughness of the special terms and conditions illustrate the full nature, character, and extent of federal involvement in the waiver process. The special terms and conditions outline Florida's responsibilities to CMS throughout the life of the waiver. The duration of the final CMS review period was unusually short and came as a surprise to some observers. There is no official standard for the duration of CMS review of waiver applications. Technically, some waivers have been approved in a period as short as nine days, but this seems to occur only when an application is being resubmitted with changes requested by CMS after a prior review. Other waiver applications have been approved after review periods ranging from two to six months, although some have remained in a review process for years.

As specified in section 409.91211(6), F.S., AHCA submitted the "Florida Medicaid Reform Implementation Plan" to the Florida legislature for approval on November 29, 2005. This Implementation Plan was a template for the rollout of the demonstration in Broward and Duval counties and compared the anticipated costs of Medicaid benefits without the demonstration to the costs of Medicaid benefits with the demonstration. It also served as the core focus of the legislative review that would occur in the special session. With formal approval of the Section 1115 Waiver application and submission of the Implementation Plan, legislative approval was the final step required before attention could turn from proposal to program design and, ultimately, program implementation.

Governor Bush called the Florida Legislature into a special session, scheduled for five days beginning December 5, 2005. While the session included consideration of a number of items, the focus requested by the Governor was Medicaid reform and the recently approved waiver.

On Wednesday, December 14, 2005, a bill approving program implementation was signed by officers of both the House and Senate and presented to the Governor. On December 16, 2005, the bill was signed by the Governor and became law (Chapter No. 2005-358, Laws of Florida). Key provisions of HB 3B for the demonstration are summarized in Table 2.

TABLE 2: KEY PROVISIONS OF HB 3B FOR IMPLEMENTATION OF THE MEDICAID DEMONSTRATION

- Authorized AHCA to implement the Medicaid capitated managed care pilot program in Broward and Duval counties and to expand the waiver to Baker, Clay, and Nassau counties within one year of becoming operational in Broward and Duval counties.
    - Specified the process for statewide expansion in accordance with the special terms and conditions of the approved waiver, with the goal of full statewide implementation by June 30, 2011.
    - Required the matching funds for UPL/LIP program be provided by local governmental entities.
    - Required AHCA to distribute UPL, DSH, and LIP funds according to published federal statutes, regulations, and waivers.
    - Provided legislative intent with respect to the LIP plan required under the waiver.
    - Specified AHCA's powers, duties, and responsibilities with respect to implementing the demonstration.
- Revised legislative intent to include Children's Medical Services Network as an entity authorized by the State under the demonstration.
- Required AHCA to implement demonstration plan standards relating to quality assurance and performance improvement in the demonstration areas.
- Required AHCA to establish an encounter database to collect data on health services provided by healthcare providers who provide healthcare services to individuals enrolled in demonstration managed care plans.
- Required AHCA to implement procedures to reduce the risk of Medicaid fraud and abuse in all demonstration plans.
- Required AHCA to organize a technical advisory panel to advise AHCA on risk-adjusted rate setting, benefit design, and Choice Counseling.
- Specified the phase-in process for risk adjustment.
- Indicated that if any conflicts exist between the demonstration law and other provisions related to the Medicaid demonstration, the demonstration law will take precedence.

Further details about the emergence of the White Paper, both pieces of legislation, the waiver application and review, the process of seeking and obtaining comments and input from the public, and some of the controversy surrounding these various steps are available (Duncan, et al., 2006).

CREATING AND IMPLEMENTING THE DEMONSTRATION

This section describes the design, development, and implementation of programmatic steps necessary to create the demonstration containing authorized reforms.
In the months between final legislative approval in December 2005 and an effective "go live" date for implementation on July 1, 2006, AHCA, participating MCOs, and other stakeholders began to make the transition to the demonstration. Actual implementation proved challenging due to the large number of enrollees transitioning into managed care plans, the number of providers participating in the Medicaid program, the large number of health plans that elected to participate in the demonstration, and the short time frame for implementation. Despite a few bumps in the road and an aggressive

timeline, overall implementation was a success due to project management, strong leadership, significant resource investment, and effective communication.

PROJECT MANAGEMENT

AHCA was committed to implementing the demonstration through a disciplined, specific "project management" approach, which involved organization of key agency stakeholders into teams, including content experts, AHCA staff, and dedicated project managers. Communication among internal departments, including Area Offices, was critical to the management process. AHCA's aggressive timeline for implementation was integrated into the process, and management kept AHCA moving forward. Clear accountability and availability of information was established, and the management approach led to new ways of thinking about development and implementation of other AHCA initiatives.

LEADERSHIP

Strong leadership at all levels was essential for development and implementation of the demonstration. From the Governor's office to front-line AHCA staff, the vision of the demonstration was effectively and repeatedly communicated. Upper management maintained commitment to the success of the demonstration and communicated with internal and external stakeholders, and feedback was solicited from all participants, including Area Offices, enrollees, participating providers, managed care plans, and internal staff. The staff felt empowered to make decisions critical to implementation of the demonstration.

RESOURCE INVESTMENT

Resources were essential for implementation of an initiative of this magnitude. The dedication of resources such as funding, human resources, vendors, information, and time were invaluable for the demonstration's development and implementation. AHCA's human resources were stretched tightly, due to the aggressive timeline and staffing levels; employees were responsible for the demonstration activities in addition to their normal work activities. Therefore, vendors, including consultants and other subject matter experts, were a valuable resource during development and implementation because they provided both experience and manpower.

COMMUNICATION

In the period leading up to implementation and throughout early demonstration operations, AHCA made significant efforts to maintain open lines of communication with internal and external stakeholders. Internally, AHCA and its organizational units learned to communicate more efficiently and effectively through the project management process. New approaches to communicating with external constituents were developed,

and managed care plans participating in the demonstration indicated that access to AHCA staff during the implementation period was unprecedented. Managed care plans enhanced their relationships with Area Offices in local communities, and now these plans rely heavily on the Area Offices for problem-solving Medicaid issues.

Outreach strategies were used to communicate with health plans and enrollees. Efforts to inform enrollees about changes coming to Medicaid included an informational phone line, letters, a media campaign, and a series of town hall style meetings. The legislatively mandated Technical Advisory Panel (TAP) proved to be an important forum for external constituents to communicate with AHCA. The TAP was composed of health plan executives, enrollee advisory group representatives, and providers. AHCA remained flexible throughout the development and implementation of the pilot and continually solicited feedback from various stakeholders and integrated this feedback into the development and implementation process.

IMPLEMENTATION ISSUES

As is the case for all demonstrations, some implementation challenges emerged. In Florida's Medicaid demonstration, the most common of these involved communicating with numerous and diverse stakeholders, many of whom needed very different information. The demonstration evolved somewhat as its implementation matured, necessitating changes and communication about those changes. In some instances, changes made in response to some stakeholders created ambiguities or issues for other participants. MCO stakeholders expressed concerns that by the time they had figured out how to accomplish some specific task associated with the demonstration, the task might very well have changed. Follow-up communication was frequent and effective, but the issue of a "moving target" was frequently expressed in stakeholder interviews.

Despite the aforementioned issues, implementation and early operation of Florida's demonstration appears to have been successful. A large number of enrollees were transitioned to MCOs in a relatively short period of time, and they had a variety of health plans from which to choose. AHCA was successful in identifying and contracting with managed care plans, and as of March 2007, around 80% of enrollees were making voluntary plan choices. Both Broward and Duval counties were successful in achieving greater than 90% enrollment in managed care plans. Participating plans were operating mandatory disease management programs, and they started collecting required quality metrics. The design and implementation of the EBR program was successful, but it did take some time for enrollee participation to begin. Finally, while the Opt-Out program was implemented, low participation in this program was observed.

KEY DIFFERENCES

The version (and vision) of Medicaid as it operated in the demonstration differed from the prior approaches in Florida in several ways.

For the state's Medicaid Agency this alternative approach involved several salient distinctions. First, AHCA had to develop the means and mechanisms for improved contracting and collaboration with managed care organizations as well as individual and organizational providers of care. Prior experience with Medicaid HMOs and a single PSN established a foundation for this transition, but much additional learning was required. Changes included an expansion of payment by means of capitation and the development of a feasible and acceptable means of risk adjustment for the capitation rate. AHCA needed to create a Choice Counseling mechanism that would assist enrollees in selecting the plan which best met their needs. The EBR program was a new endeavor, as were the opt-out mechanism and the LIP. All of these activities had to be designed, implemented, and managed. All represented significant changes from business as usual in Florida's Medicaid programs.

The "regular" (meaning non-demonstration) Medicaid programs covering the enrollees in the 62 other counties had to be continued in parallel with the demonstration. At the agency level, the demonstration and the non-demonstration portions of Florida Medicaid were managed by the same people with only a modest infusion of new human resources.

Two other changes in context are noteworthy. First, the policy process was an evolving one, requiring that AHCA make adjustments to the demonstration throughout. As an example, the initial plan for the demonstration was that in 2009 (after some experience in operating in a managed care environment) participating PSNs would transition to a risk-adjusted capitation payment system comparable to that used for payments to the participating HMOs. Through a series of legislative actions in 2010 and 2011, PSNs must convert to capitation no later than 2013. Systems targeted to the dissolution of the traditional fee-for-service processes and managing a PSN capitation system are already in place.

Second, AHCA found itself in the midst of a policy process that continued to be somewhat contentious and politicized throughout the demonstration. The philosophical, political, and policy conversations that began during the earliest stages of discussion regarding a waiver application continued through at least the first eighteen months of the demonstration itself. Part of the nation's civic culture has for many decades been predicated on a model that even relatively contentious political differences are set aside with the formal passage of a law, as attention turns to program design and development. In the instance of Florida's Medicaid demonstration, the extension of these conversations into the implementation phase required an allocation of administrative (AHCA) effort and energy to ongoing descriptions and defense of the

demonstration's basic tenets and objectives, rather than the enormous challenges of implementation.

For both the state and the participating managed care organizations, three significant changes in the normal process merit mention. First, the new payment structure (risk adjustment) provides the HMOs a level of protection against adverse selection and removes at least some incentives to seek healthier enrollees. Second, the absence of a MediPass program option prevents the state from being at risk for an alternative form of adverse selection. Third, enrollees had the primary opportunity to select whichever participating managed care organization they thought best met their needs. An observed consequence of these changes was the emergence of new managed care organizations including a PSN directed towards children with chronic conditions and a specialty HMO directed towards enrollees with HIV/AIDS.

For the direct providers of clinical care, the changes could be very subtle or quite dramatic. Those who were already members of a defined panel of providers associated with one or more HMOs experienced limited impact, although many found it necessary to "join" multiple networks. Providers whose previous experience was in a relatively unmanaged fee-for-service or MediPass context found themselves dealing with one or more HMOs and/or PSNs, adapting to the managed care constraints and payment policies of those entities rather than a single state agency .

For the enrollees, there were five key areas of difference between the demonstration version of Medicaid and the prior alternative(s). The most obvious, was that enrollees were required to select a managed care organization and obtain their medical care through that entity. Depending upon perspective, this difference was sometimes stated positively (as empowerment and greater autonomy of choice) and sometimes negatively (as forcing vulnerable enrollees to make difficult choices). A second difference was in recognition of the first. AHCA invested in very substantial Choice Counseling activities (e.g., receipt of telephone calls, outreach calls, home visits, public meetings, and use of specialty nurses) that together provided demonstration enrollees with far more information and a more clearly structured process for making their selection than the decision support information available to other Medicaid enrollees. The third difference was one of choice consequences. Enrollees selecting an MCO may have found that no single MCO met all of their needs/preferences. For example, while an enrollee's primary care physician may participate in one MCO, the enrollee's preferred specialist or preferred pharmaceutical benefits program may participate in another MCO. While these kinds of selection consequences were normative in the world of commercial health insurance, they represented a significant change for Medicaid. The fourth difference was the EBR program developed to incentivize enrollees to engage in certain healthy behaviors. Enrollee awareness and participation in the program greatly improved over time. The last major difference for enrollees was the Opt-Out program that offered eligible enrollees the choice of using their Medicaid premium to purchase employer-sponsored insurance. Participation in the Opt-Out program was low.

SECTION IV: THE EVALUATION

ASSESSING THE DEMONSTRATION

Florida's Medicaid managed care demonstration was complex. It involved large numbers of enrollees, a significant number of MCOs, and the simultaneous pursuit of multiple program objectives and research questions. In order to be comprehensive, the demonstration's evaluation must include a parallel complexity.

The evaluation was conducted by a team of researchers pursuing five areas of inquiry in a coordinated fashion that allowed focus in each area, but integration in a single project. The main subdivisions were studies of

- participating organizations, including AHCA, the participating managed care organizations, consultants, contractors, and others;
- enrollees and their experiences;
- fiscal consequences (particularly, Florida's expenditures for care in the demonstration);
- the LIP and its implementation; and
- the demonstration's impact on mental health services.

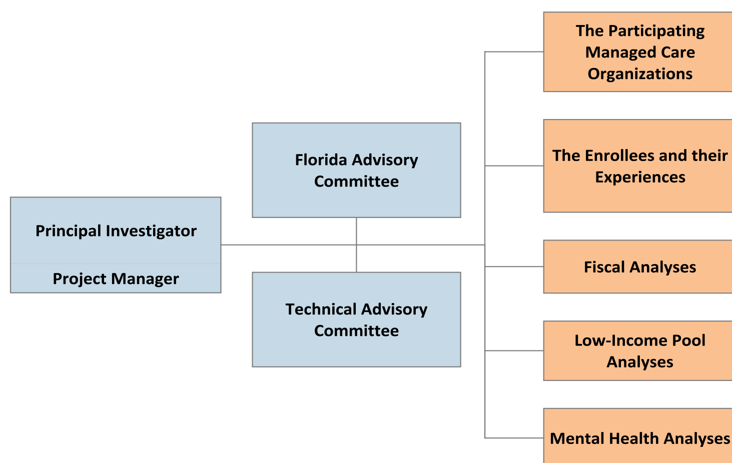
A work group was identified for each area. Each work group was led by a specified senior faculty researcher who accepted responsibility for the area and for coordination of the project in the larger context. Four of the five work groups also had contributions from one or more additional faculty members, and all were supported by graduate student appointees, project management capacity, and computer/data staff. Each work group team prepared a detailed work plan, including a schedule of key tasks and delivery dates for specified products (typically in the form of reports). Each team was also responsible for adapting and modifying the work plan as needed to account for program implementation steps and evolution of the demonstration itself.

The five work groups were coordinated through an overall project management approach and active involvement of the Principal Investigator. Coordination was intended to optimize staff, computing, and statistical resources, and to ensure that findings referred to comparable time periods, geography, enrollees, etc. Inevitably, however, variation occurred among exact time periods or moments of data extraction from the Florida Medicaid Management Information System (FMMIS), dates of survey fieldwork, delivery of LIP data, and similar events in data derivation or analysis.

The evaluation team also made use of two advisory committees, including the Technical Advisory Committee (TAC) and the Florida Advisory Committee (FAC), for provision of research and institutional expertise. TAC members were selected and appointed by the evaluation team and included national experts on Medicaid evaluation studies. FAC members were appointed by AHCA and included key stakeholders with strong interests

in the demonstration. Graphically, evaluation of project organization is depicted below in Figure 1.

FIGURE 1: EVALUATION TEAM ORGANIZATIONAL CHART



THE PARTICIPATING MCOS

MCOs were the fundamental organizational building blocks of the demonstration. Throughout the demonstration, there were many MCO choices for Medicaid enrollees (Lemak, Landry, Billello, Bell, & Van Wert, 2009; Lemak, et al., 2010; Lemak, Yarbrough, Bell, & Van Wert, 2007, 2008). In the initial years, there were as many as 18 health plans and networks participating in the demonstration areas, including both PSNs and HMOs. Over the 5-year project, participating MCOs included

- HMOs and PSNs that had operated in the demonstration counties prior to its implementation,
- PSNs that were formed during the demonstration,
- HMOs that purchased or merged with existing plans/networks in the demonstration areas, and
- Medicaid HMOs already operating in Florida Medicaid, but new to the demonstration counties.

The entry and exit of health plans and networks are documented in other reports and summarized in Table 3 below. During the most volatile period (2008 – 2009), nine plans or networks exited, including the HMO with the largest enrollment in the demonstration counties. During the demonstration period, some PSNs were sold or merged with HMOs and some plans terminated participation in one or more demonstration counties. No MCO participating in the demonstration completely exited Florida Medicaid during the 5-year demonstration project.

TABLE 3: PLAN/NETWORK ENTRY AND EXIT 2006–2010 (CALENDAR YEAR)

	2006	2007	2008	2009	2010
Plans/Networks Entering	15	3	0	3	1
Plans/Networks Exiting	0	0	2	7	1
Total Plans/Networks	15	18	16	12	12

Throughout the demonstration, a variety of managed care organizational types have participated in Florida Medicaid. The organizations currently in the demonstration areas reflect the diversity of organizations involved during the 5-year demonstration. That is, 7 of the 13 plans or networks have a multi-state presence, while the remaining plans operate only in Florida. The seven multi-state plans are all HMOs, and two of these operate in Broward and Duval counties, while one operates in all five demonstration counties.

With regard to plan ownership, four of the participating plans were publicly traded, four were for-profit but privately owned, and five were not-for-profit organizations. The organizational missions of the plans also varied, with six of the participating plans serving a diversified/mixed population and five serving the Medicaid population exclusively. Of these plans, one is operated by a state agency for children with chronic conditions who meet specified clinical criteria to be considered for enrollment in government-sponsored programs and another is operated by the nation's largest HIV/AIDS health care provider. Additionally, two plans focused on governmental payers (not limited to Medicaid).

One notable aspect of the demonstration was a mechanism for the development of PSNs as an alternative to HMOs operating as MCOs. Prior reforms to Florida Medicaid have included the development of PSNs and PSN-like organizations including Minority Physician Networks (MPNs), and a Pediatric Emergency Diversion project that began as pilots under previous Medicaid waivers. Some of these organizations were based in safety-net hospital systems while others were based in physician-related organizations. The key elements of these organizations have been described and analyzed in previous reports (Duncan, Lemak, Vogel, Johnson, & Porter, 2004; Duncan, Lemak, et al., 2008). At the start of the demonstration these organizations operated as PSNs in Broward and Duval counties (initial demonstration counties) and a new PSN began operating in Duval. During the 5-year demonstration two other new PSNs began operations and two new specialty plans entered the market, a PSN serving children with complex health needs (2006) and an HMO serving enrollees with HIV/AIDS (2009) (Lemak, et al., 2009, 2010).

The idea behind the PSN was that a provider organization or network of organizations would provide medical care and assume insurance functions for a defined population (Lemak, et al., 2007). PSNs or PSN-like organizations sponsored by safety-net hospitals cared for a large number of Medicaid enrollees prior to the demonstration. In addition to caring for these patients in a hospital setting, hospital-sponsored PSNs allowed safety-net organizations to better manage care of individuals through managing their

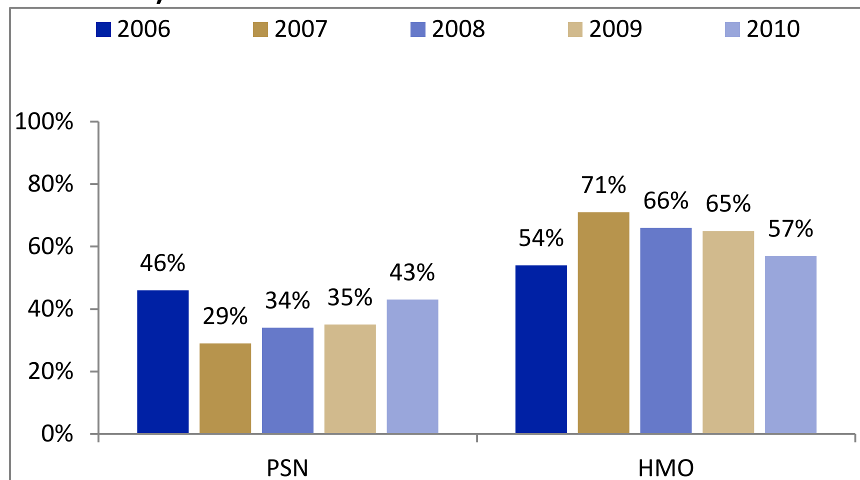
Medicaid benefits. For example, through disease management, the PSN could monitor compliance to chronic disease protocols to avoid unnecessary hospitalizations. Should a patient not previously enrolled in a disease management program seek emergency department services, the PSN could follow-up to facilitate enrollment.

As with safety-net hospital providers, many physicians participating in physician-sponsored PSNs saw a large number of Medicaid patients prior to the demonstration. Through collaborating with and managing their patients' Medicaid benefits, these providers could more effectively manage care of the enrollees they serve. For example, prior to enrollment in a PSN, a physician might not be notified that a Medicaid enrollee visited an emergency department or was admitted to a hospital. Through the PSN, the provider could be notified of the event and facilitate more appropriate disease management for a chronic condition.

PSN providers participating in the demonstration are paid on a fee-for-service basis. Under the demonstration, these PSNs were slated to transition to full capitation, and pay providers directly, like the HMOs participating in the program. However, this transition was postponed. Cost savings through better coordination of care by more closely integrating payment and healthcare delivery functions was a goal of establishing PSNs. PSNs have the potential to achieve cost savings by improving care management, enhancing health, and avoiding unnecessary emergency room visits and hospitalizations.

As shown in Figure 2, the distribution of enrollees among PSNs and HMOs varied over time and by geographic area. PSNs began the demonstration with approximately half of the demonstration enrollees. During 2007 to 2009, HMOs had a much higher market share than PSNs. By December 2010, however, there was a more even split between HMOs and PSNs, with 57% of Medicaid demonstration enrollees in HMOs.

FIGURE 2: MEDICAID DEMONSTRATION PSN/HMO ENROLLMENT (AS OF DECEMBER EACH YEAR)



Note. Enrollment data for 2006 are for Broward and Duval counties only since the demonstration was implemented in Baker, Clay, and Nassau counties in 2007.

In Broward County, a geographic area with many years' experience with Medicaid managed care, there were many health plans and network choices throughout the 5-year demonstration. In the early years, several HMOs operated in Broward County and several had low enrollment. By December 2010, 54% of demonstration participants in Broward County were enrolled in HMOs, despite the number of available demonstration plans that had decreased over the five years.

In Duval County, there were HMO and PSN options throughout the demonstration period, although the composition of organizations changed over time. As of December 2010, about half of the demonstration participants were enrolled in HMOs (52%).

The demonstration was implemented in the rural counties in the second year (2007). In general, there were fewer MCO choices available in these areas. In the first years of the rural demonstration, one PSN and one HMO operated in the three rural counties. By 2009, 70% of rural demonstration enrollees were in a single PSN. That PSN ultimately converted to an HMO. By November 2010, rural enrollees had the choice of a PSN and an HMO.

Table 4 displays the plans and networks that operated during the 2006–2010 demonstration period.

TABLE 4: PLANS AND NETWORKS FOR BROWARD, DUVAL, BAKER, CLAY, AND NASSAU COUNTIES AS OF DECEMBER 2010

Plan Name	Baker	Broward	Clay	Duval	Nassau	Plan Type	Broward & Duval First Enrollment	Baker, Clay & Nassau First Enrollment	Plan Status
Access Health Solutions	X	X	X	X	X	PSN	09/01/2006	09/01/2007	Withdrew in all five counties on 09/01/2009 due to agreement with Sunshine.
Amerigroup Florida, Inc.		X				HMO	09/01/2006		Withdrew 12/01/2009.
Better Health		X				PSN	05/01/2009		Active.
CMS[a]		X		X		PSN	Broward: 12/01/2006 Duval: 05/01/2007		Active.
First Coast Advantage	X		X	X	X	PSN	09/01/2006	12/01/2010	Active.
Florida NetPass		X				PSN	09/01/2006		Withdrew 08/01/2009. Molina Healthcare acquired Florida NetPass.
Freedom Health Plan		X				HMO	12/01/2007		Active.
HealthEase		X		X		HMO	09/01/2006		Withdrew from Broward on 05/01/2009 and Duval on 07/01/2009.
Humana		X				HMO	09/01/2006		Active.
Medica Health Plans of Florida		X				HMO	12/01/2009		Active.
Molina Healthcare		X				HMO	04/01/2009		Active. Acquired Florida NetPass.
Pediatric Associates		X				PSN	10/01/2006		Enrollees transitioned to Access Health Solutions on 02/01/2009.
Positive Healthcare		X				HMO	05/01/2010		Active.
Preferred Medical Plan, Inc.		X				HMO	09/01/2006		Withdrew on 12/01/2009.

Plan Name	Baker	Broward	Clay	Duval	Nassau	Plan Type	Broward & Duval First Enrollment	Baker, Clay & Nassau First Enrollment	Plan Status
South Florida Community Care Network		X				PSN	09/01/2006		Active.
Staywell		X		X		HMO	09/01/2006		Withdrew from Broward on 06/01/2009 and Duval on 05/01/2009.
Sunshine State Health Plan		X	X	X		HMO	Broward: 08/01/2009 Duval: 09/01/2009	09/01/2009	Active in Broward, Duval, and Clay counties. Enrollees transitioned from Access Health Solutions through an agreement (and thus include enrollees who had transitioned from Pediatric Associates). Withdrew from Baker and Nassau counties on 12/31/2010.
Total Health Choice, Inc.		X				HMO	09/01/2006		Withdrew on 05/01/2010. Enrollees transitioned to Better Health.
United Healthcare[b]	X		X	X	X	HMO	09/01/2006	09/01/2007	Active in Duval, Baker, Clay, and Nassau counties. Withdrew from Broward only on 11/01/2008.
Universal Health Care		X		X		HMO	01/01/2007		Active.
Vista Health Plan of S. Florida, Inc. and Vista Health Plan: Buena Vista[c]		X				HMO	09/01/2006		Withdrew on 12/01/2008.

Notes. Adapted from AHCA Monthly Enrollment Reports and AHCA Correspondence. [a]CMS includes CMS North Broward and CMS South Broward Counties and CMS in Duval County. [b]To ensure that enrollees had at least two plan choices in Baker, Clay, and Nassau counties, United only accepted enrollees who self-selected their plan. With the expansion of First Coast Advantage to the rural counties, enrollees have one PSN and one HMO to choose from. [c]Vista Health Plan of South Florida, Inc., and Vista Health Plan (Buena Vista only operated in Broward County).

Under the demonstration, Medicaid plans and networks could modify their benefits for a specific set of services, as long as they verified sufficiency and actuarial equivalency relative to traditional Medicaid benefits. Overall, most demonstration plans did not change their benefits significantly. PSNs, with their fee-for-service (FFS) reimbursement model, were not allowed to develop a customized benefit package but could modify co-payments and offer additional services. Among HMOs that did modify benefits, more plans increased the number of covered benefits and plan limits for durable medical equipment. Furthermore, several demonstration PSNs eliminated or decreased co-payments for hospital inpatient and podiatrist services, and none added or increased co-payments for those benefits. The overall trend for the later years of the demonstration was a decrease in the additional covered services offered by the demonstration plans and the addition of co-payments (Lemak, et al., 2009, 2010).

An important element of the demonstration was the development and use of risk-adjusted rates to the MCOs. Throughout the demonstration, plans and networks worked in collaboration with the State to develop the capability of submitting encounter data that would be used in rate-setting and plan performance evaluation. While the encounter data was being collected and validated, the State implemented a risk-adjustment model based on pharmacy claims (Lemak, et al., 2009, 2010; Lemak, et al., 2007, 2008). Beginning in SFY 2006–07, behavioral health encounter data were used as part of the managed care rate setting process. Beginning in SFY 2010–11, pharmacy encounter data were used as part of the managed care rate setting process.

During the initial years, there was a risk corridor established, whereby plan rates could not vary by more than 10%. Further, the proportion of payments tied to the enrollee risk level was phased in during the first few years. PSNs were provided a window of time before they would be subject to capitation. Ultimately, PSNs did not move to capitation during the demonstration. Throughout the demonstration period, there was significant debate and negotiation among AHCA, MCOs, hospitals, legislators, and others regarding the rates paid in Medicaid generally and in the demonstration areas specifically.

In an effort to evaluate and improve the performance of Medicaid plans and networks, including those participating in the demonstration, Florida Medicaid increased its efforts to publicly report data on plan performance The State reported Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS) data, and HEDIS-like data on demonstration plan performance on its web site for the first time in 2008. For the two periods reported in the demonstration, plans demonstrated adequate performance on CAHPS indicators (Duncan, Hall, Brumback, Zhang, Bell, et al., 2011; Duncan, Hall, Brumback, Zhang, & Chorba, 2008; Duncan, Hall, Brumback, Zhang, Chorba, Bell, et al., 2011; Duncan, Hall, Brumback, Zhang, Chorba, Bilello, et al., 2011). However, the initial performance of Florida Medicaid health plans on HEDIS and HEDIS-like performance indicators was very low compared to national Medicaid benchmarks. This poor performance was observed in all Florida Medicaid health plans, including demonstration and non-demonstration

plans (Florida Agency for Health Care Administration, 2011a). For many measures, plans in the demonstration areas achieved higher levels of performance than those of plans and networks in non-demonstration areas. Many plans in the demonstration areas did not have sufficient enrollment to report on many of the HEDIS and HEDIS-like measures.

From 2008 to 2009, demonstration plans showed greater improvement than non-demonstration plans. The most improvement occurred in the categories of Well Child Visits (age 0 – 15 months), Prenatal Care, Frequency of Ongoing Prenatal Care—Greater than 81% of Visits, Breast Cancer Screening, and Adolescent Well Care. The least improvement was shown in Comprehensive Diabetes—Nephropathy, Well Child Visits (age 6+), Childhood Immunization Status: Combination 2, Adult Access to Preventative/Ambulatory Health Services, and Cervical Cancer Screening.

From 2008 to 2009, Medicaid non-demonstration plans showed markedly less improvement. For the non-demonstration plans, the most consistent improvement occurred in Breast Cancer Screening, Lead Screening in Children, and Comprehensive Diabetes—LDL Screening. The least improvement was seen in Childhood Immunization: Combination 3 and Antidepressant Medication Management—Effective Continuation Phase Treatment (Florida Agency for Health Care Administration, 2011a).

Although these plans showed improvement, most Florida Medicaid plans ranked below national averages in the majority of quality metrics. When compared with national Medicaid HMOs, the majority of plans performed below the national average in a majority of indicators. However, both demonstration and non-demonstration plans improved from 2008 to 2009, with demonstration plans improving more rapidly and across more categories than non-demonstration MCOs (National Committee for Quality Assurance, 2010a, 2010b). In 2008, only 33% (100 of 299 plan-measure combinations) of Reform measures performed at or above the national average, while in 2009, 44% (64 of 144) performed at or above the national average.

Overall, demonstration plans performed the best in categories of chronic disease management, specifically in categories such as Controlling Blood Pressure and Comprehensive Diabetes—LDL Screening. They performed poorly in categories involving women and child health, including Cervical Cancer Screening, Prenatal Care, and Postpartum Care.

THE ENROLLEES

ENROLLEE CHOICES

Empowering enrollees to take control of their health was one goal of the demonstration. Three strategies were implemented to facilitate this including Choice Counseling, the Opt-Out program, and the Enhanced Benefits Reward$ (EBR) program.

AHCA instituted a new program to support enrollee choice of health plan or network, called Choice Counseling. This process was very successful in the initial years of the demonstration, with a clear majority of Medicaid-eligible individuals self-selecting their health plans. Fewer than 3% of members voluntarily disenrolled from plans they selected or were assigned.

The Choice Counseling program evolved during the demonstration, including the addition of trained clinicians (nurses) who could help enrollees with complex healthcare needs make the appropriate selection of a plan to best meet their needs and cover their prescription medications. The development of the Informed Health Navigator Solution (Navigator), which included the demonstration plans' preferred drug list, enabled enrollees to select a health plan based on their health care and medication needs.

There were two distinguishable phases of Choice Counseling activities. Through the first year of the demonstration, Choice Counselors focused on assisting about 200,000 enrollees transition from existing Medicaid enrollment to the new model. The predominant mode of Choice Counseling was by means of telephone in which the enrollee sought counseling to select among the available MCOs identified and described in printed materials. This primary approach was augmented by such other devices as field counselors, face to face sessions, and outbound calls. Choice Counseling for transition to the demonstration was largely successful, especially considering the sheer number of enrollees involved. It was anticipated that once existing enrollees had transitioned, counseling needs would decline to a smaller number of in-person, telephone, or mail contacts, and be limited to new enrollees entering Medicaid. As the recession took hold, however, Medicaid enrollment increased, and at about the same time Florida experienced a period of frequent market entry/exit decisions by plans and networks (Hall, Young, Bell, Thompson, Elliott, & Dagher, 2008). Both processes contributed to a higher need for Choice Counseling in the post-transition period than had been anticipated. AHCA was responsive to these unanticipated needs but the process remained challenging during this phase (Lemak, et al., 2010).

It should be noted that on May 13, 2008, AHCA was notified by CMS of a conflict of interest by AHCA's enrollment broker vendor, Affiliated Computer Services (ACS). CMS requested that the contract be terminated. AHCA complied, and awarded a new contract to a different vendor after completing the competitive procurement process. Subsequent to the change in vendors, service levels improved, as did the telephone technology available to render choice counseling.

Fewer than 100 Medicaid demonstration-eligible individuals expressed interest or chose to participate in the Opt-Out Program, the mechanism whereby persons otherwise eligible for Medicaid could obtain private health insurance through employers (Florida Agency for Health Care Administration, 2011b).

ENROLLEE SATISFACTION

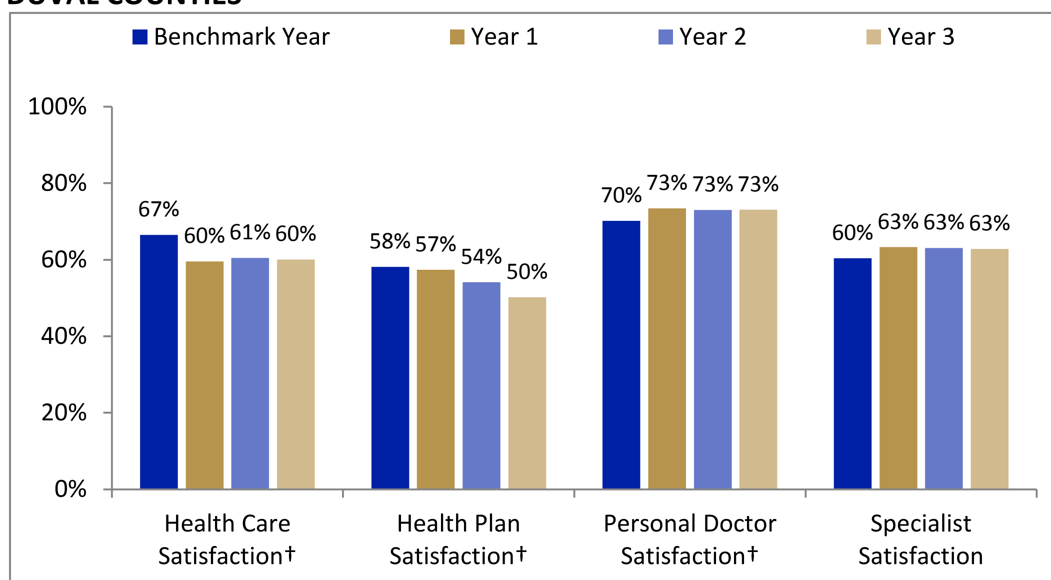
CONSUMER ASSESSMENT OF HEALTH CARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

Under the demonstration, beneficiaries had to select and enroll in a managed care plan. This plan would be responsible for the management of enrollees' care, including access to primary care providers and specialists. For some beneficiaries who had previously been enrolled in the primary care case management program (MediPass), enrollment in a managed care plan represented a major transformation in accessing and using healthcare services.

It was expected that enrollee choice of health plan, and opportunities to change plans if enrollees were unhappy, would encourage competition among the plans. A key component of this evaluation was to monitor enrollee experiences and satisfaction with their health plans, providers, and overall health care. This was accomplished primarily through the annual fielding of the CAHPS survey in the 5 demonstration counties (Duncan, Hall, Brumback, Zhang, Bell, et al., 2011; Duncan, Hall, Brumback, Zhang, & Chorba, 2007; Duncan, Hall, et al., 2008; Duncan, Hall, Brumback, Zhang, Chorba, Bell, et al., 2011; Duncan, Hall, Brumback, Zhang, Chorba, Bilello, et al., 2011). The CAHPS asked respondents about health plan enrollment, ability to access health care, and overall satisfaction. Respondents also rated providers and health plans and experiences with providers and office staff. Four rounds of the survey were completed in the urban counties of Broward and Duval, and three rounds were conducted in the rural counties of Clay, Baker, and Nassau. The first round in urban counties was fielded prior to the demonstration taking effect. In Baker, Clay, and Nassau counties the first round was fielded as the demonstration was being implemented, but respondents had not yet been enrolled.

***Overall trends*—**The proportion of enrollees providing the highest rating for their overall health care declined in the first year following implementation of the demonstration and then remained relatively stable (see Figure 3). Ratings for health plan satisfaction steadily declined over time.[1] However, ratings for personal doctor satisfaction increased in the year after the demonstration and then remained stable throughout the remaining years. Observed changes in ratings for specialty care were not statistically significantly different over time.

FIGURE 3: OVERALL SATISFACTION AT THE HIGHEST LEVEL (9 – 10), BROWARD AND DUVAL COUNTIES

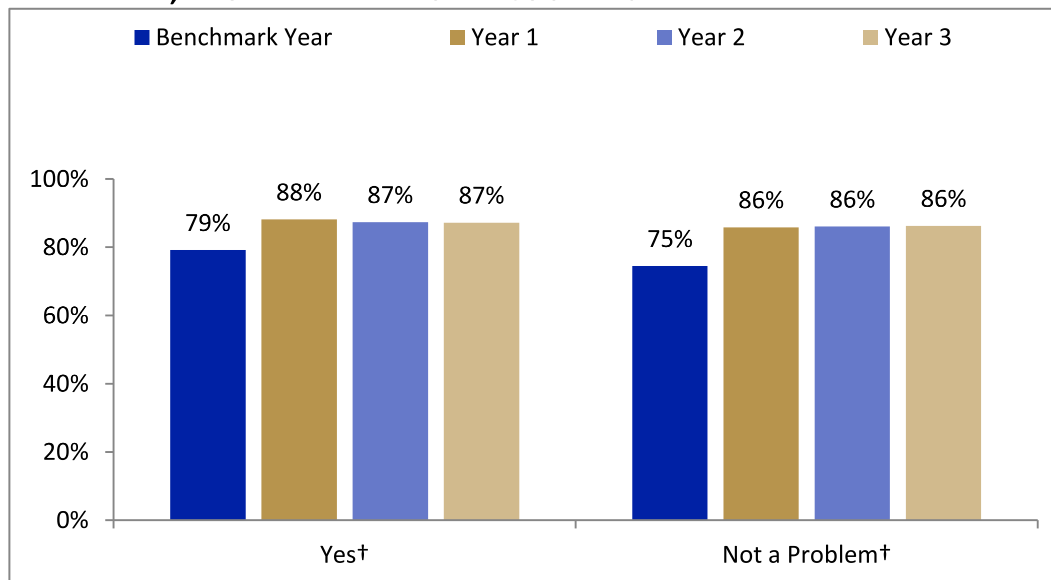


† These findings were statistically significant.

[1] In other analyses, we have observed that enrollees who changed health plans ("switchers") expressed a low level of satisfaction with their health plans (Duncan, Hall, Brumback, Zhang, Bell, et al., 2011; Duncan, Hall, Brumback, Zhang, Chorba, Bell, et al., 2011). It may be that the dissatisfaction of these enrollees has an inordinate impact on the overall measure of enrollee satisfaction, and hence contributes to the observed overall decline in enrollee satisfaction with their health plans.

High personal doctor satisfaction ratings could be due to strong relationships with primary care providers. In the urban counties, survey findings indicated that enrollees reported it was easier to connect with a primary care provider. As shown in Figure 4, the percentage reporting that they had an identified personal provider increased from 79% prior to the demonstration implementation to between 87% and 88% following implementation. Similarly, the proportion of individuals saying that it was "not a problem" getting a personal doctor or healthcare provider with whom they were happy increased from 75% prior to the demonstration to 86% in the years following implementation.

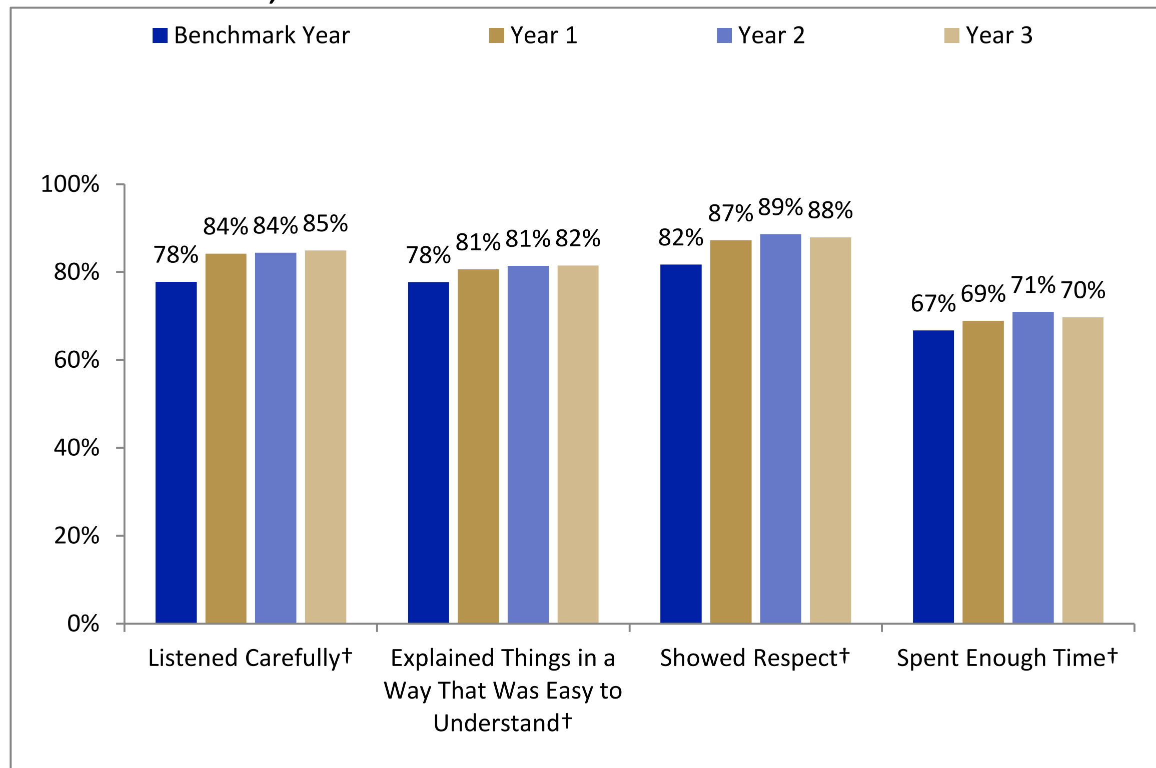
FIGURE 4: ENROLLEES WHO REPORTED WHETHER THEY HAD A PERSONAL DOCTOR AND "NOT A PROBLEM" GETTING A PERSONAL DOCTOR OR HEALTHCARE PROVIDER HAPPY WITH, BROWARD AND DUVAL COUNTIES



† These findings were statistically significant.

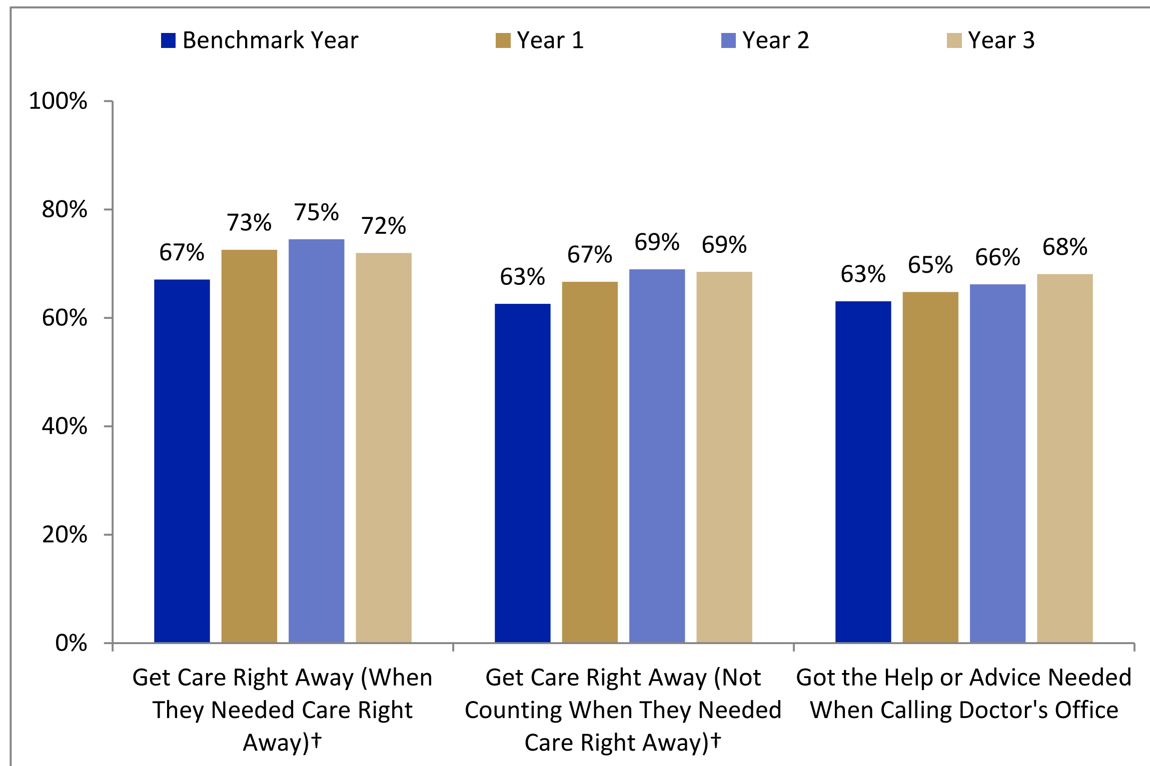
The quality of interactions with health care providers may also be changing following the demonstration implementation. As shown in Figure 5, the proportion of enrollees reporting that their doctor “always” listened carefully, showed respect for what they had to say, spent enough time with them, and explained things in a way that was easy to understand was higher in the post-implementation period compared to the Benchmark. In addition, Figure 6 shows that the proportion reporting that they “always” got care as soon as they thought they needed it was higher during the demonstration years compared to the year prior to implementation.

FIGURE 5: OVERALL RATINGS OF “ALWAYS” FOR ASPECTS OF COMMUNICATION WITH PERSONAL DOCTOR, BROWARD AND DUVAL COUNTIES



† These findings were statistically significant.

FIGURE 6: OVERALL RATINGS OF "ALWAYS" FOR SPECIFIC HEALTHCARE EXPERIENCES, BROWARD AND DUVAL COUNTIES



† These findings were statistically significant.

It is important to note that findings in urban counties do not mirror findings in the rural counties. Over the three years of observation in rural counties, hardly any differences were noted over time in enrollee reports of their care, and there were no statistically significant differences in ratings of care.

Lack of substantive changes in ratings or experiences may simply reflect the underlying structural characteristics of the delivery system in rural counties. Prior to the demonstration, most of the primary care was provided by local health departments and a small number of physician practices. Enrollees may have already established "medical home" relationships with these practices which may have remained largely unchanged throughout the course of the demonstration.

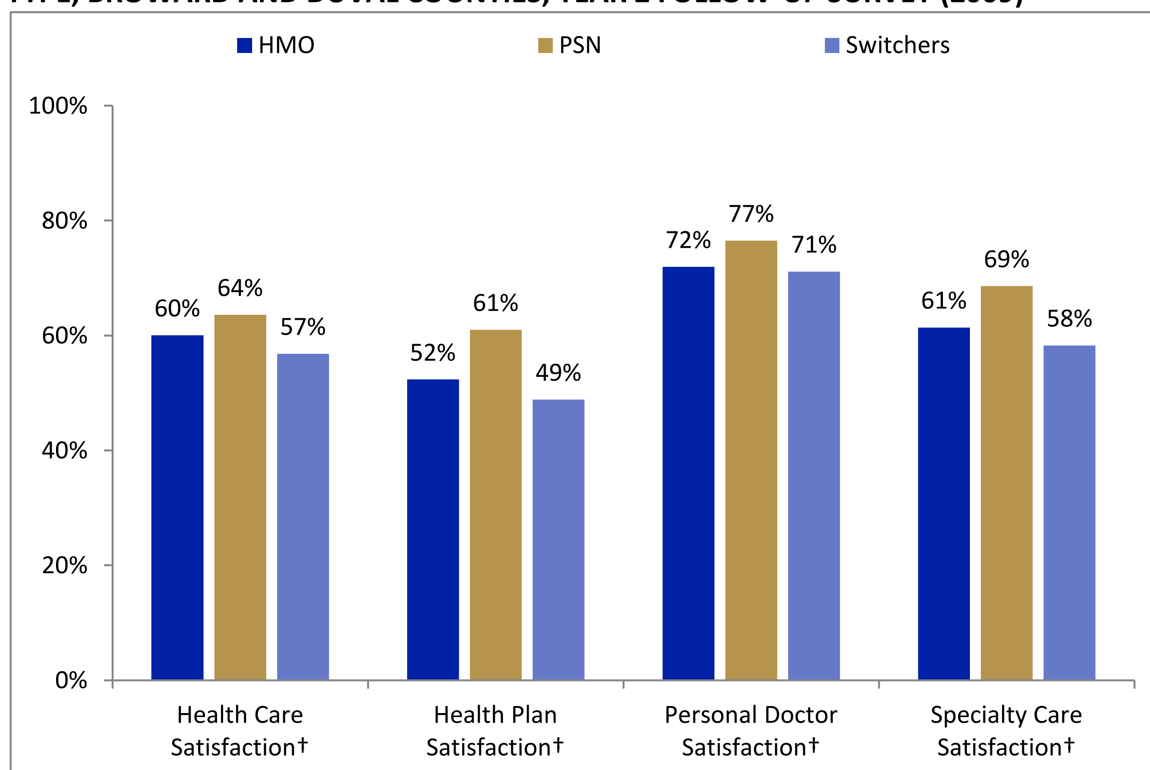
Comparisons across plan type—As noted earlier, two kinds of plans were operational. These two types of managed care arrangements, while similar in some respects, had important structural differences. The PSNs were owned and operated by local physician provider groups or hospitals and paid their network providers on a fee-for-service basis. In contrast, the HMOs were owned by local, state, or national corporate entities and were paid an adjusted capitated amount for each enrollee. The differences in plan ownership and payment arrangement may have led to distinct approaches towards

managing the physician network and enrollee utilization. This may have resulted in differences in patient experiences and satisfaction across the two plan types.

Analysis of the last year of data for both urban and rural counties showed that for most ratings, the observed differences between PSN and HMO enrollees were not statistically significant. One exception was in the rating of health plan satisfaction, where almost 61% of PSN enrollees gave their plan the highest rating compared to 52% of HMO enrollees.

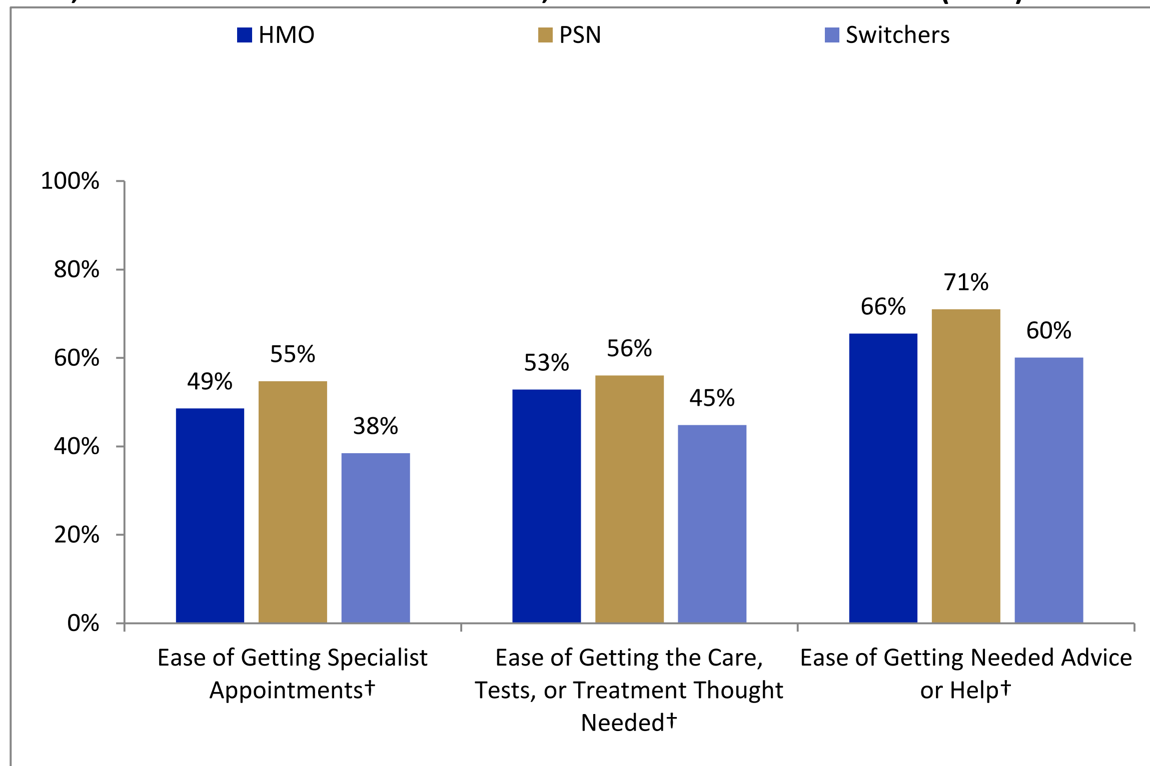
***Individuals who switched health plans*—**In 2009, several health plans ceased participation in the demonstration. This meant that large numbers of enrollees had to switch their health plan during this period of time. Comparisons were then made between enrollees who had to switch health plans and enrollees who did not switch plans. As shown in Figure 7, enrollees living in the urban counties in 2009 who switched their health plans had the lowest proportion reporting aspects of their care at the highest level. In addition, “switchers” were less likely to provide favorable reports of their healthcare experiences (Figure 8). The degree (if any) to which low satisfaction scores reported by switchers may have negatively impacted summary scores is unknown.

FIGURE 7: RATING ASPECTS OF THEIR CARE AT THE HIGHEST LEVEL (9 – 10), BY PLAN TYPE, BROWARD AND DUVAL COUNTIES, YEAR 2 FOLLOW-UP SURVEY (2009)



† These findings were statistically significant.

FIGURE 8: RATING OF "ALWAYS" FOR SPECIFIC HEALTHCARE EXPERIENCES, BY PLAN TYPE, BROWARD AND DUVAL COUNTIES, YEAR 2 FOLLOW-UP SURVEY (2009)



† These findings were statistically significant.

QUALITATIVE INTERVIEWS WITH MEDICAID BENEFICIARIES

To provide additional context for survey findings, in-depth interviews and focus groups were conducted with 89 enrollees during the first two years of the evaluation (Hall, et al., 2008). Overall, most enrollees who participated in the qualitative study had generally positive views of their health care and had not witnessed major changes in the way their health care was delivered. However, some individuals did report some dissatisfaction and articulated certain barriers to care. Perhaps the most significant set of issues had to do with finding a specialist and then securing the necessary referral. Findings from the CAHPS surveys corroborate the enrollee views expressed in the qualitative interviews. For example, during this same time period in the demonstration, only about 46% of enrollees reported that it was always easy to get an appointment with a specialist.

Difficulty finding a specialist is common throughout the healthcare system, including the Medicaid program, probably as an artifact of low specialist participation rates in Medicaid health plans and in Medicaid generally. The qualitative studies also revealed a learning process among enrollees regarding new procedures for referral and authorization (Hall, et al., 2008). For example, some of the concern expressed by

enrollees was associated with the increased restrictions imposed by health plans in obtaining specialty care referrals.

Critics of the demonstration have long argued that the implemented changes to the Medicaid program could adversely impact large numbers of enrollees in terms of their access and use of healthcare services. Findings from the survey and the qualitative data appear to indicate that there were both some positive and negative changes over time in reported experiences and levels of satisfaction.

In reporting these survey findings, both here and in numerous other reports, emphasis is placed on those areas in which observed differences were statistically significant (meaning that the observed differences were unlikely to simply reflect chance). Whether the differences or changes over time have practical policy or health care delivery-relevant implications are not entirely clear. The differences observed between the pre- demonstration period and the demonstration do not provide definitive evidence of sizeable shift—either improvements or declines—in enrollee satisfaction.

EXPERIENCE OF CARE AND HEALTH OUTCOMES (ECHO) SURVEY

The main objective of the Experience of Care and Health Outcomes (ECHO) survey was to understand the impact of the demonstration program on the mental healthcare experiences of individuals with mental illness. In 2009, the survey was conducted in Broward, Duval, Baker, Clay, and Nassau counties (demonstration counties). Since plans in the demonstration are responsible for physical and behavioral health care, which differs from non-demonstration counties, the survey was also conducted in a non-demonstration (control) county, Orange County (Duncan, et al., 2009). Specifically, the survey was used to assess enrollees' health plan satisfaction and experiences with care. Eligibility for the survey was limited to people who filled prescriptions for psychotropic medication used to treat severe mental illness (SMI) or severe emotional disturbances (SED) in the demonstration counties. Findings reported here are limited to respondents in the urban demonstration counties due to small sample sizes in the rural demonstration counties. Results are compared to those who filled the same types of prescriptions but who lived in a non- demonstration county. Satisfaction levels of enrollees in the two different types of health plan options (HMOs/PSNs) within the two urban demonstration counties were also compared.

There were no statistically significantly differences in urban demonstration and control county enrollees who rated satisfaction with mental health counseling/treatment and their health plan at the highest level. However, urban demonstration enrollees were statistically significantly more likely to rate their mental health provider at the highest level than those in the control county (Figure 9).

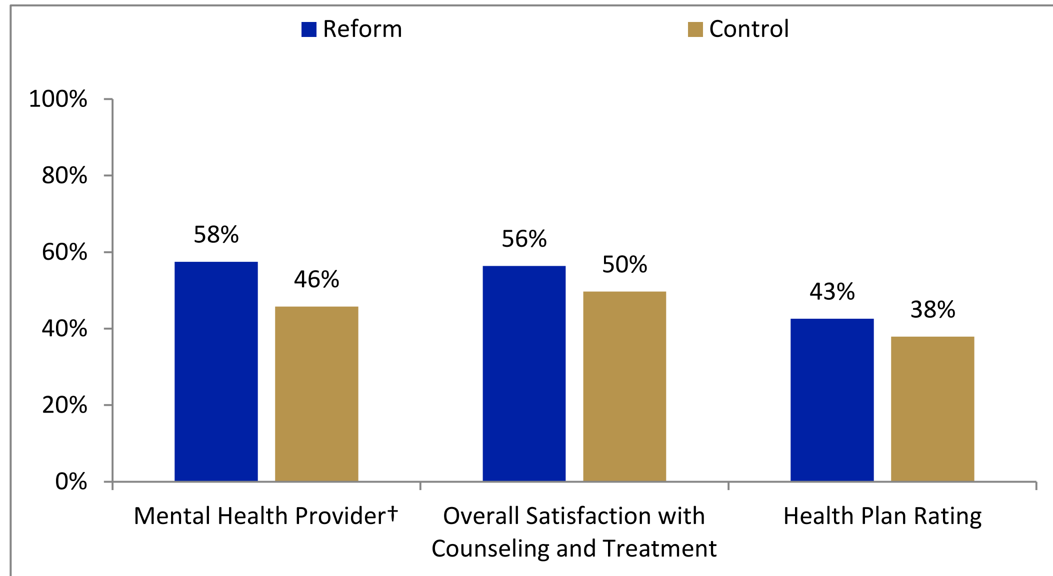
Compared to HMO enrollees in the urban demonstration counties, PSN enrollees in the demonstration were statistically significantly more likely to rate their health plan at the

highest level, to indicate it was "not a problem" getting a mental health provider or healthcare provider they were happy with, to state they had not used up all their benefits within the last six months, and to recommend their plan to family and friends (Figure 10). There were very few statistically significant differences in satisfaction between parents/guardians of children and adults in the urban demonstration counties. Since satisfaction measures may be affected by differences in age, race, and ethnicity, an ordered logistic regression analysis was also conducted to assess the relationship among mental health provider rating, satisfaction with counseling and treatment, and health plan rating (Table 5). Ordered logistic regression findings are presented as odds or odds ratios. Enrollees in the demonstration had statistically significantly greater odds of rating their mental health provider in the next highest level than enrollees in the control county (1.683, 95% CI = 1.162, 2.439). Similarly, they were statistically significantly more likely to rate their counseling or treatment in the next highest level than enrollees in the control county (1.539, 95% CI = 1.055, 2.246). There were no statistically significant differences observed between enrollees in the demonstration and the control counties in rating their health plan.

In the urban demonstration counties, there were no statistically significant differences in the odds of PSN enrollees rating their mental health provider and counseling or treatment more positively than HMO enrollees (Table 5). However, PSN enrollees had significantly greater odds of rating their health plan at a higher level than HMO enrollees (1.294, 95% CI = 1.016, 1.647).

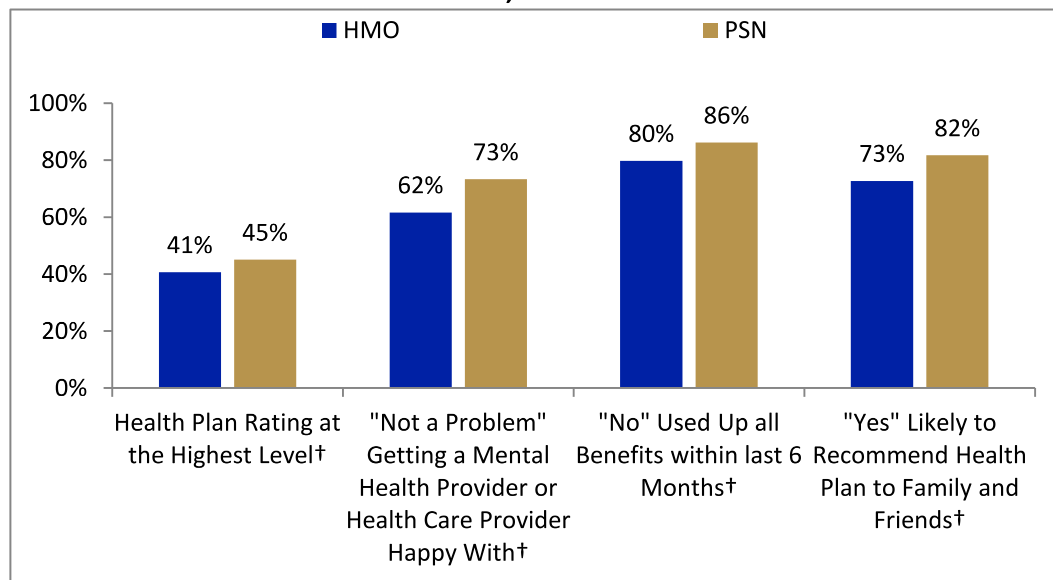
Compared to the control county, the demonstration had a positive impact on enrollees' satisfaction with their mental health provider and counseling or treatment. The observed differences between HMOs and PSNs in chi square tests were not as distinct in the regression analyses. In fact, after controlling for differences in patient characteristics, there were very few differences in enrollee satisfaction with behavioral healthcare services between HMOs and PSNs, except for health plan ratings.
These analyses indicate that the demonstration positively impacted enrollees' satisfaction with their mental health services, indicating that policy interventions to include mental health services within a larger managed care initiative can be accomplished and are well received by enrollees. Expected differences between the managed care and the fee-for-service plan types on satisfaction with providers or treatment were not observed, although enrollees in PSNs were more satisfied with their health plan overall than enrollees in HMOs. Additional analyses are needed to further understand the impact of the demonstration on enrollees' access and quality of mental health care (and fiscal impact as well) on mental health services that compare the two types of plan options and their reimbursement methodologies.

FIGURE 9: ECHO ENROLLEE SATISFACTION AT THE HIGHEST LEVEL (9 – 10), DEMONSTRATION VS. CONTROL



† These findings were statistically significant.

FIGURE 10: RATING ASPECTS OF CARE, HMO VS. PSN



† These findings were statistically significant.

TABLE 5: ORDINAL LOGISTIC REGRESSION ANALYSIS OF ECHO SURVEY ENROLLEE SATISFACTION RATINGS

	Mental Health Provider Rating		Overall Satisfaction with Counseling/Treatment Rating		Health Plan Rating	
	OR	95% CI	OR	95% CI	OR	95% CI
Demonstration vs. Control						
Demonstration	**1.683**	**(1.161, 2.439)**	**1.539**	**(1.055, 2.246)**	1.184	(0.919, 1.526)
Age	1.000	(0.991, 1.009)	0.997	(0.988, 1.006)	0.998	(0.992, 1.004)
Black	1.006	(0.665, 1.522)	0.946	(0.631, 1.417)	**1.580**	**(1.200, 2.080)**
Hispanic	1.352	(0.772, 2.370)	**1.805**	**(1.044, 3.121)**	1.323	(0.918, 1.906)
Other	0.961	(0.609, 1.516)	1.001	(0.631, 1.588)	**1.407**	**(1.022, 1.936)**
PSN vs. HMO						
PSN	1.077	(0.757, 1.532)	1.143	(0.806, 1.620)	**1.294**	**(1.016, 1.647)**
Age	1.003	(0.993, 1.014)	0.997	(0.987, 1.007)	0.996	(0.990, 1.003)
Black	1.140	(0.712, 1.825)	1.110	(0.721, 1.709)	**1.595**	**(1.188, 2.141)**
Hispanic	0.990	(0.523, 1.874)	1.296	(0.670, 2.506)	1.496	(0.953, 2.350)
Other	1.021	(0.647, 1.611)	0.983	(0.600, 1.611)	1.209	(0.856, 1.706)

Notes. OR refers to Odds Ratio and CI refers to Confidence Interval. Findings that were statistically significantly different at $p < .05$ are in bold type.

THE ENHANCED BENEFITS REWARD$ (EBR) PROGRAM

The EBR program was a novel component to the demonstration. The program was designed to incentivize enrollees to take an active role in their health by engaging in certain healthcare behaviors. Enrollees who engaged in an approved list of health behaviors would receive a credit, which could be redeemed at a Medicaid participating pharmacy. Incentive programs can only be successful to the extent that patients or consumers are aware that such programs exist. Recognizing this fact, AHCA throughout the demonstration program conducted outreach activities aimed at educating enrollees about the EBR program.

The CAHPS surveys were used to monitor enrollee knowledge and participation in the EBR program. All respondents were asked if they had heard of or were aware of the EBR program. If the respondent answered yes, they were then asked if they participated in an approved activity. Questions about the EBR program were asked in the CAHPS Year One and Year Two Follow-Up surveys. As shown in Table 6, the proportion of enrollees reporting awareness of the EBR program and engagement in an activity increased between Year 1 and Year 2.

TABLE 6: AWARENESS AND PARTICIPATION IN THE ENHANCED BENEFITS REWARD$ (EBR) PROGRAM INCREASED BETWEEN 2008 AND 2009

	Year 1	Year 2
Percent aware of the EBR program	59	77
Percent of those aware who engaged in an activity	61	71

Notes. The CAHPS Year One and Year Two Follow-Up surveys were fielded in 2008 and 2009, respectively. Differences between the two years (Years 1 and 2) are statistically significant at $p < .001$.

Additional multiple regression analyses of the Year Two Follow-Up survey showed that the level of awareness and participation in an approved healthy behavior is not uniform across groups of Medicaid enrollees. Table 7 shows certain groups of individuals were less likely than other groups (indicated by a minus sign) to participate in the program and other groups were more likely to participate (indicated by a plus sign). For example, non-English speakers were less likely to be aware of the program compared to English speakers. Relative to PSN enrollees, HMO enrollees were more likely to engage in an approved behavior. Findings clearly indicated that connections to the healthcare system, i.e., a regular source of care and an increasing number of visits, were positively correlated with being aware of the EBR program and engaging in an approved behavior. Qualitative interviews with enrollees also revealed that physicians are a major source of health information (Hall, et al., 2008). Thus, this strong link between enrollee awareness, participation in the EBR program, and enrollees having a regular source of care is not surprising.

TABLE 7: MEDICAID ENROLLEE CHARACTERISTICS AND THE LIKELIHOOD OF BEING AWARE AND ENGAGING IN AN EBR APPROVED HEALTH BEHAVIOR

	Awareness	Engagement in an Approved Behavior
Non-English speakers (English speakers)	-	-
Hispanic ethnicity (non-Hispanic)		-
Individuals in poorer health (individuals in excellent, very good, or good health)		-
HMO enrollees (PSN enrollees)		+
Duval County enrollees (Broward County enrollees)	+	+
Regular source of care (no regular source of care)	+	+
Number of physician visits[a]	+	+

Notes. Cells with neither plus nor minus indicate no statistically significant difference. Reference groups are denoted in parentheses.
[a]As the number of physician visits increases, the likelihood of awareness and engagement in an approved behavior increases.

FISCAL IMPACT

The primary goal of the fiscal analysis was to assess the impact of the demonstration on per member per month (PMPM) Medicaid expenditures. To accomplish that goal, the average PMPM expenditures for two years pre-demonstration implementation were compared to the average PMPM expenditures for four years post-implementation. Because it is possible that other factors influenced the time trend in PMPM expenditures across all of Florida's Medicaid program, the analytic approach was focused on change in PMPM expenditures in the demonstration counties over this time period compared to the change in PMPM expenditures over this same time period in

two control counties, which were Hillsborough and Orange counties. The difference in the change in expenditures over time between the demonstration and control counties was then attributed to the demonstration.

Specifically, average PMPM expenditures were calculated for the two fiscal years prior to implementation of the demonstration (July 1, 2004 – June 30, 2006) and for the four state fiscal years after implementation (July 1, 2006 – June 30, 2010). The average expenditures were calculated separately for enrollees in the demonstration counties (Broward and Duval) and the control counties (Orange and Hillsborough). Additionally, because the medical needs of the Medicaid population varies significantly based on eligibility category, PMPM expenditures were calculated separately for enrollees eligible through Supplemental Security Income (SSI) and enrollees eligible through Temporary Assistance to Needy Families (TANF). Because there are differences by county in the mix of age, race, and gender of Medicaid enrollees which may affect PMPM expenditures independent of the demonstration, multivariate regression analyses were conducted to control for these enrollee characteristics. Finally, to assess whether demonstration HMOs or PSNs were more effective in controlling costs, changes in PMPM expenditures were compared for HMOs and PSNs. Overall, a total of 12,523,114 person-months of observations were used in the calculations of PMPM expenditures for the demonstration counties and 14,496,872 person-months of observations were used in the control county calculations. These calculations excluded all individuals in home and community-based waiver programs, those who received services through the Statewide Inpatient Psychiatric Program (SIPP) program, or those who were eligible for Medicaid through a program other than TANF or SSI.

Without adjusting for differences in the enrollee populations between the demonstration and control counties, it appears that average PMPM expenditures were better controlled in the demonstration counties than the control counties (see Table 8). The change in PMPM expenditures for SSI enrollees in the demonstration counties was $263 less than the change in PMPM expenditure for SSI enrollees in the control counties, while the change in PMPM expenditure for TANF enrollees in the demonstration counties was $35 less than the change for TANF enrollees in the control counties. These results hold even after adjusting for demographic differences, although the magnitude of the difference between the demonstration and control counties is not as large as the unadjusted difference (see Figure 11), with PMPM expenditures for SSI enrollees decreasing by $11 in the demonstration counties but increasing by $194 in the control counties. Thus, the change in expenditures was $205 less in the demonstration counties relative to the control counties. Similarly, PMPM expenditures for TANF enrollees decreased by $3 in the demonstration counties but increased by $29 in the control counties resulting in $32 smaller change in expenditures.

The multivariate analysis includes a variable capturing change over time, and confirms a downward trend in expenditures over time compared to the control counties, suggesting that the demonstration was able to “bend the cost curve.” When examining

the impact of the demonstration separately for enrollees who selected HMOs compared to PSNs, it appeared that the PSNs were containing costs better than the HMOs, with adjusted PMPM expenditures for SSI enrollees decreasing by $14 in PSNs compared to a $12 decrease in HMOs, and decreasing by $5 for TANF enrollees in PSNs while decreasing by $1 in HMOs.

An additional analysis was conducted with only those individuals that had at least 3 or 6 months of Medicaid eligibility in both the pre-demonstration period (July 1, 2004 – June 30, 2006) and demonstration period (September 1, 2006 – July 1, 2010) to determine if the impact of the demonstration was different among those individuals with more stable Medicaid enrollment. When limited to these individuals, it again appeared that expenditures in the demonstration counties were lower than in the control counties for both the SSI and TANF populations, although the expenditure reductions were smaller among SSI enrollees than in the full sample ($67 vs. $205), and were larger for the TANF population ($54 vs. $32).

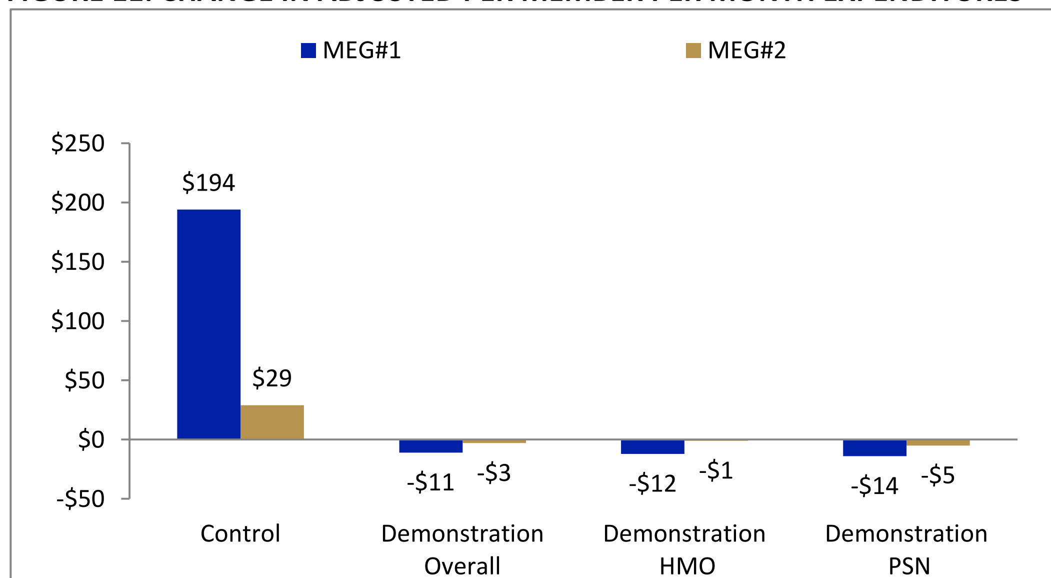
In conclusion, it appeared that the demonstration resulted in reductions in PMPM expenditures when examining all SSI and TANF enrollees. Demonstration PSNs, in particular, appeared to control expenditures better than both demonstration HMOs and Medicaid programs in control counties. Therefore, results of this analysis suggested that the key demonstration attribute of requiring all Medicaid enrollees to enroll in either an HMOs or PSNs may control PMPM expenditures better than standard FFS Medicaid or non-demonstration Medicaid HMOs (the programs being operated in the control counties). PSNs may achieve greater expenditure reductions than HMOs. However, it should be noted that this study did not determine how the expenditure reductions were achieved.

TABLE 8: UNADJUSTED CHANGES IN PMPM EXPENDITURES

	Broward/Duval		Hillsborough/Orange		Difference-in-Difference	
	Reform Counties		Control Counties		Control-Reform	
	SSI	TANF	SSI	TANF	SSI	TANF
All Plans						
PreReform	*865*	*131*	*683*	*126*		
Reform	*764*	*118*	*845*	*148*		
Reform-PreReform	*-101*	*-13*	*162*	*22*	*263*	*35*
HMO						
PreReform	*668*	*126*	*512*	*118*		
Reform	*676*	*115*	*670*	*138*		
Reform-PreReform	*8*	*-11*	*158*	*20*	*150*	*31*
PSN and MediPass						
PreReform	*982*	*137*	*860*	*139*		
Reform	*889*	*126*	*1046*	*154*		
Reform-PreReform	*-93*	*-11*	*186*	*15*	*279*	*26*

Note. PMPM = per member per month, preReform period is SFY0405 and SFY0506, and Reform period is SFY0607 – SFY0910.

FIGURE 11: CHANGE IN ADJUSTED PER MEMBER PER MONTH EXPENDITURES



THE LOW INCOME POOL

Among the numerous components of the demonstration was the establishment of the Low Income Pool (LIP). Starting July 1, 2006, the State of Florida began distributing a capped annual allotment of $1 billion (the "Pool") to qualified providers with the funding coming primarily from intergovernmental transfers from local governments matched by federal funds.

The stated purpose of the LIP was "to ensure continued government support for the provision of healthcare services to Medicaid, underinsured and uninsured populations" (Centers for Medicare and Medicaid Services, 2005, p. 24). The LIP thus was intended to supply additional funding for providers with large numbers of patients who are low-income and/or with little or no insurance coverage.

In addition to LIP funding, the evaluation includes funding from similar programs, the Disproportionate Share Hospital (DSH) program and the Medicaid hospital exemptions to reimbursement ceilings program, because these programs also provide supplemental funding for providers having a large volume of Medicaid, underinsured, and uninsured patients.[2]

This section summarizes findings from the various detailed reports evaluating the LIP that were prepared as part of the overall evaluation (McKay, 2007, 2008a, 2008b, 2008c, 2008d, 2009, 2010a, 2010b, 2010c). All the LIP evaluation studies used data on LIP and LIP-related payments as provided by AHCA, but two different data sets were used to assess the amount of services provided. One set of studies used data from the Florida Hospital Uniform Reporting System (FHURS), which collects financial and utilization statistics each year from hospitals in Florida. The second set of studies used data collected as part of the LIP Milestone Reporting Requirements for CMS. The studies covered periods both before and after the demonstration was implemented, for purposes of comparison.

PAYMENTS

This section summarizes LIP and LIP-related payments for the three years preceding the demonstration (SFY0304, SFY0405, and SFY0506) and for the first three years of the demonstration (SFY0607, SFY0708, and SFY0809). Table 9 compares payments over the

[2] It is important to note that the LIP and LIP-related payments do not include the base per diem hospital payment for Medicaid patients. Virtually all acute-care hospitals serve some Medicaid patients, and all hospitals receive a base per diem Medicaid payment for those individuals. LIP and LIP-related payments are supplemental to this base payment.

six-year period of analysis, with the payments being adjusted for inflation in order to compare real changes in funding over time.[3]

SPECIAL MEDICAID PAYMENTS (SMP)/LOW INCOME POOL (LIP) PROGRAMS

Prior to the demonstration, funds from the SMP program were distributed to qualified hospitals under the hospital inpatient UPL program. During the demonstration, the LIP program was substituted for the SMP program. Consequently, payments are reported for the SMP program in SFY0304, SFY0405, and SFY0506 and for the LIP program in SFY0607, SFY0708, and SFY0809.

The UPL program provided the opportunity for certain providers to receive increased Medicaid matching funds from the federal government. The SMP program was one component of the UPL program in the pre-LIP period. In SFY0607, the LIP replaced the SMP. The SMP and LIP programs are similar in that both provided supplemental payments for qualified providers offering healthcare services to Medicaid, underinsured, and uninsured populations. However, the LIP and SMP programs differ in two important ways. First, the LIP was capped at an annual allotment of $1 billion (the “pool”), whereas the SMP, calculated annually, was capped by the UPL amount which is based on Medicare reimbursement rates. Second, while SMPs went exclusively to hospitals, LIP payments were made to Provider Access Systems, which included both hospitals and non-hospital providers, such as certain Federally Qualified Health Centers, county health initiatives emphasizing the expansion of primary care services provided by county health departments, and a rural health network.

LIP-RELATED PROGRAMS

The objective of the Medicaid Disproportionate Share (DSH) program is to increase compensation for hospitals that provide a disproportionate share of Medicaid and/or charity care services. The exemptions to ceilings program, which falls under the Medicaid UPL program, allows local governments (healthcare taxing districts and counties) to provide additional funding as the state share to draw federal funds for qualified providers to be exempt from the ceilings on hospital reimbursement under Medicaid.

It is also important to examine these LIP-related programs for two reasons. First, the overarching objective of all three programs (SMP, UPL, and LIP) is to provide supplemental funding for providers with a large volume of Medicaid, underinsured, and uninsured patients. Second, recommendations by the Florida LIP Council are made

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[3]Because LIP and LIP-related payments come from taxes, the adjustment for inflation should reflect price changes in the economy as a whole. Consequently, the implicit price deflator for Gross Domestic Product, published by the U.S. Department of Commerce, Bureau of Economic Analysis (2005 = 100) was used, see http://www.bea.gov/.

jointly for all three programs, with allocations under any one program reflecting both the objectives of that particular program and total allocations.

KEY FINDINGS REGARDING LIP AND LIP-RELATED PAYMENTS

- The number of hospitals receiving LIP funding increased in comparison to those receiving funding from the SMP program: 90 hospitals received SMP funding in SFY0304, 89 in SFY0405, and 87 in SFY0506, compared to 163, 164, and 162 hospitals receiving LIP funding in SFY0607, SFY0708, and SFY0809, respectively.
- Non-hospital providers began receiving funding under the LIP program: 43 and 44 non-hospital providers received LIP payments in SFY0607 and SFY0708, respectively, increasing to 59 non-hospital providers receiving LIP payments in SFY0809.
- Total funding increased under the LIP program in comparison to the SMP program: when adjusted for inflation (2005 = 100), total SMP payments were approximately $597.2 million in SFY0304, $660.8 million in SFY0405, and $666.9 million in SFY0506, compared to total LIP payments of approximately $967.1 million in SFY0607, $941.7 million in SFY0708, and $807.8 million in SFY0809.
- When including all LIP and LIP-related programs, total funding increased during the first three years of the demonstration compared to the three years prior: when adjusted for inflation (2005 = 100), total LIP and LIP-related payments were approximately $1.14 billion in SFY0304, $1.18 billion in SFY0405, and $1.24 billion in SFY0506, compared to approximately $1.59 billion in SFY0607, $1.76 billion in SFY0708, and $1.59 billion in SFY0809.

SERVICES PROVIDED: FHURS DATA

Each year, hospitals in Florida must submit data on financial and utilization statistics; this is known as the Florida Hospital Uniform Reporting System (FHURS). The FHURS is the first data set used to measure services provided to Medicaid, underinsured, and uninsured individuals.

Using FHURS data, services provided to Medicaid, underinsured, and uninsured patients are measured as the sum of services provided to Medicaid patients and uncompensated care—with uncompensated care being the sum of charity care and bad debt. The primary measure of services provided is a volume measure, adjusted days (total inpatient days adjusted by patient-care revenues for outpatient services).[4]

[4]The detailed reports using the FHURS data also measure services in terms of gross revenue (payment that would have been received at "full charges"), net revenue (payment received after deductions), and operating expense (the dollar value of resources used to provide the services) (McKay, 2007, 2008a, 2008c, 2010a, 2010b).

KEY FINDINGS ABOUT SERVICES PROVIDED USING FHURS DATA

- Hospitals receiving SMP/LIP or LIP-related payments provided an estimated total of approximately 2.9 to 3.2 million adjusted days of services to Medicaid and uncompensated care patients in SFY0304 through SFY0506, compared to approximately 3.6 million adjusted days in SFY0607 and approximately 4.2 million adjusted days in SFY0708.
- The percentage of all adjusted days of service to Medicaid and uncompensated care patients in the State of Florida provided by hospitals receiving SMP/LIP or LIP-related payments increased from approximately 79% – 80% in SFY0304 through SFY0506 to approximately 94% – 96% in SFY0607 and SFY0708.
- In the second year of the demonstration, SFY0708, hospitals receiving LIP or LIP-related payments provided approximately 13 adjusted days of services to Medicaid and uncompensated care patients for each $1,000 of funding received. The estimated total operating expense of providing those adjusted days of care was approximately $21,000.

SERVICES PROVIDED: MILESTONE DATA

The second data set used to evaluate services provided to Medicaid, underinsured, and uninsured individuals comes from information collected as part of the LIP Milestone Reporting Requirements for CMS, called the milestone data. AHCA's "Low Income Pool Reimbursement and Funding Methodology" document required that all providers receiving LIP funding report data related to the number of individuals served and the types of services provided (Florida Agency for Health Care Administration, 2005).

Any provider receiving LIP funds in SFY0607, the first year of the demonstration, was required to submit milestone data for that year and for SFY0506, the year preceding the demonstration, even if no payments were received in that year. In addition, any provider receiving LIP funds in SFY0708 or SFY0809, the second and third years of the demonstration, was required to submit milestone data for that year. AHCA provided data for all providers receiving LIP payments who had submitted milestone data. Consequently, the analysis is based on less than 100% of providers in each year (see detailed reports for additional details).[5]

The most comprehensive measure of services is the number of individuals served. For the LIP milestone reporting, hospitals must provide an unduplicated count of individuals served in the following categories: Medicaid (inpatient, outpatient, and total) and uninsured/underinsured (inpatient, outpatient, and total), where the total is also an

[5]Data for analysis for SFY 2006-–07 came from 85% of hospitals and 65% of non-hospital providers; for SFY0708 come, data came from 94% of hospitals and 89% of non-hospital providers; and for SFY0809 come, data came from 93% of hospitals and 64% of non-hospital providers.

unduplicated count.[6] Because all their services are outpatient, non-hospital providers must provide only an unduplicated count of individuals served for Medicaid and for uninsured/underinsured.[7]

KEY FINDINGS ABOUT SERVICES PROVIDED USING MILESTONE DATA

- Hospitals receiving LIP payments served an estimated total of approximately 3.6 – 3.8 million Medicaid, uninsured, and underinsured individuals each year in the first three years of the demonstration.
- Non-hospital providers receiving LIP payments served an estimated total of approximately 800,000 – 1,000,000 Medicaid, uninsured, and underinsured individuals each year in the first three years of the demonstration.
- For hospitals, the average number of Medicaid, underinsured, and uninsured individuals served for every $1,000 of (SMP or) LIP payment received, after adjusting for inflation, was approximately the same over the period SFY0506 through SFY0708 (about 25 – 28), then increased to 34 in SFY0809.
- For non-hospital providers, the average number of Medicaid, underinsured, and uninsured individuals served for every $1,000 of LIP payment received, after adjusting for inflation, was approximately 138 in SFY0506, 98 in SFY0708, and 97 in SFY0809.
- Results based on individuals served must be used with caution given that they are based only on data for hospitals and non-hospital providers that reported milestone data at the time of the initial analysis. The percentage of providers receiving payments that reported milestone data varied across years from 85% – 94% for hospitals and from 64% – 89% for non-hospital providers. Particularly in years with a low reporting percentage, results might demonstrate a different pattern if all providers had reported milestone data.

[6] That is, if the same Medicaid enrollee received both inpatient and outpatient services at a given hospital, the total count would report one individual served.

[7] The detailed reports also provide information about the type and amount of specific services provided. For hospitals, measures of services provided include hospital discharges, hospital inpatient days, emergency care encounters, outpatient encounters, and number of prescriptions filled. For non-hospital providers, measures include primary care encounters, OB/GYN encounters, disease management encounters, mental health/substance abuse encounters, dental services encounters, number of prescriptions filled, laboratory services encounters, radiology services encounters, specialty encounters, and care coordination encounters.

TABLE 9: COMPARISON OF LIP AND LIP-RELATED PAYMENTS AFTER ADJUSTMENT FOR INFLATION: SFYS 2003–04, 2004–05, 2005–06, 2006–07, 2007–08, AND 2008–09

	SMP/LIP		DSH		Exempt		TOTAL	
	# Providers	Total Payments/ millions	# Providers	Total Payments/ millions	# Providers	Total Payments/ millions	# Providers	Total Payments/ millions
2003–04	90	$597.2	56	$264.8	45	$282.6	108	$1,144.6
2004–05	89	$660.8	53	$216.8	46	$299.6	109	$1,177.2
2005–06	87	$666.9	53	$209.7	53	$361.8	114	$1,238.4
2006–07[a]	206	$967.1	58	$203.9	50	$419.7	208	$1,590.7
2007–08[b]	208	$941.7	61	$205.1	58	$608.4	212	$1,755.2
2008–09[c]	221	$807.8	62	$210.5	56	$572.7	227	$1,591.0

Notes. Adjusted for inflation using implicit price deflator for GDP; 2005 = 100 (http:/www.bea.gov/).
[a]Includes LIP payments of $15.6 million to 43 non-hospital providers. [b]Includes LIP payments of $17.4 million to 44 non-hospital providers. [c]Includes LIP payments of $19.8 million to 59 non-hospital providers.

MENTAL HEALTH SERVICES

The demonstration required all healthcare services, including mental health, physical health, and prescription drugs, to be provided through HMOs or PSNs. Evaluation of the impact of the demonstration on recipients of mental health services in Broward, Duval, Baker, Clay, and Nassau counties included the satisfaction surveys noted previously, as well as analyses of two outcome indicators among adults diagnosed with severe mental illness (SMI) and children diagnosed with serious emotional disturbances (SED) (Robst, Murin, & Qi, 2010). Primary questions included (1) What were the rates of Baker Act examinations (involuntary evaluation and treatment when an individual appears to be mentally ill and dangerous to themselves or others) among adults diagnosed with SMI and children diagnosed with SED in Broward, Duval, Baker, Clay, and Nassau counties pre- and post-implementation of the demonstration? (2) What were the rates of arrests among adults diagnosed with SMI and rates of juvenile justice encounters among youth in Broward, Duval, Baker, Clay, and Nassau counties pre- and post-implementation of the demonstration? and (3) How did the rates of Baker Act examinations, arrests, and juvenile justice encounters in the demonstration counties compare to the rates observed in other Florida counties where Medicaid managed mental health care has been implemented?

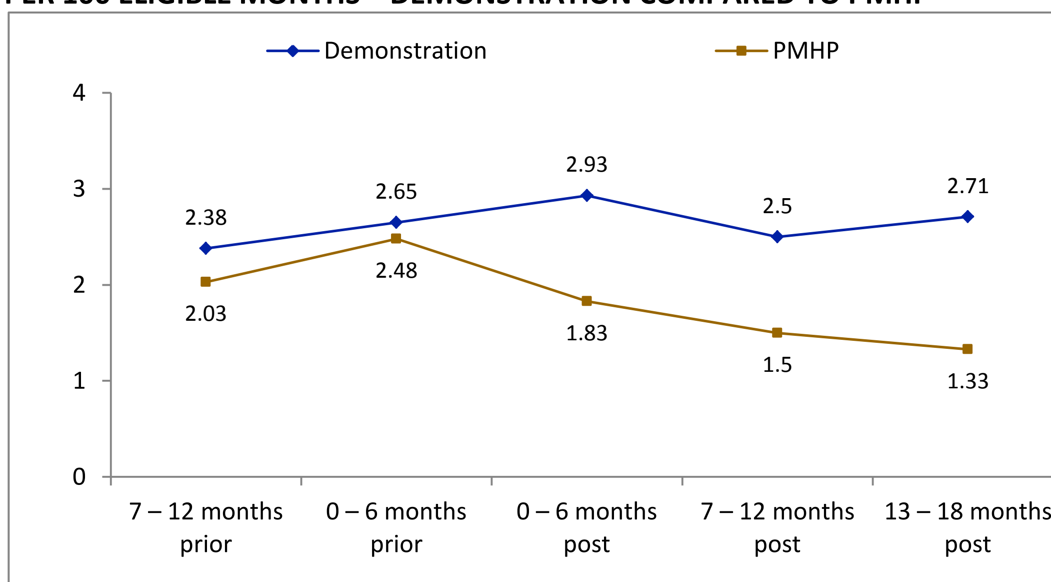
The analyses combined Medicaid eligibility and claims files with data from the Offices of Mental Health and Substance Abuse of the Florida Department of Children and Families, the Baker Act database, the Florida Department of Law Enforcement, and the Florida Department of Juvenile Justice. To be included in the analyses, Medicaid recipients must have been enrolled in the demonstration or have resided in Florida Medicaid Areas 5 (St. Petersburg) or 7 (Orlando) and enrolled in a Prepaid Mental Health Plan (PMHP).[8] A

[8] In 1996, AHCA implemented a PMHP demonstration in Florida Medicaid Area 6 (Tampa Bay region) under the authority of a 1915b waiver. A PMHP providing specialty behavioral health managed care was established to provide or arrange for all mental health services for its plan participants. By 2007, the

12-month time period before managed care implementation and an 18-month follow-up period after implementation were compared for individuals in the demonstration and PMHP counties. A total of 35,155 individuals in the PMHP areas and 14,949 individuals in the demonstration areas were included in the analyses.

Figure 12 (results of the descriptive analysis) suggests that adults with SMI in the demonstration fared as well on Baker Act examinations after the implementation of managed care as before. However, for adults, there was a significant reduction in Baker Act examinations and arrests with the implementation of the PMHP program that was not observed with the demonstration. The implementation of the demonstration was not associated with significant changes in Baker Act examinations, arrests, or juvenile justice encounters. The implementation of the demonstration did not have statistically significantly different effects for children than the implementation of the PMHP program.

FIGURE 12: BAKER ACT EXAMINATIONS FOR ADULTS WITH SERIOUS MENTAL ILLNESS PER 100 ELIGIBLE MONTHS—DEMONSTRATION COMPARED TO PMHP

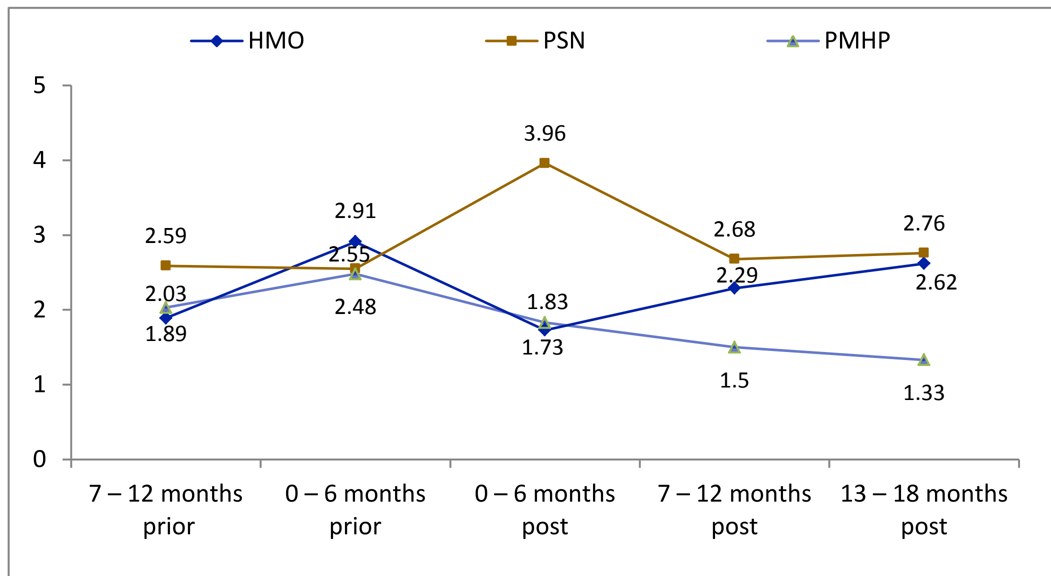


Baker Act examinations, arrests, and juvenile justice contacts all increased in the first six months following the demonstration. While some observed differences appear to be statistically significant, in general the increases tended to be small (e.g., arrest rates increased from 1.63 to 1.66 per 100 eligible months) and in most instances rates returned to their pre-implementation levels by the second six month period after implementation (Robst, et al., 2010).

PMHP was implemented statewide with the exception of the demonstration counties. The PMHP program was selected as a comparison as absent the demonstration, individuals would have likely been transitioned to the PMHP program.

Some differences were evident when distinguishing between demonstration HMOs and PSNs. These included an increase in Baker Act examinations among adults in PSNs in the first six months after the demonstration but returned to their pre-implementation levels in the following periods (Figure 13). Arrest rates among adults in PSNs also increased in the first six months after the demonstration (Robst, et al., 2010). While they declined in the following periods, the rates did not return to pre-implementation levels.

FIGURE 13: BAKER ACT EXAMINATIONS FOR ADULTS WITH SERIOUS MENTAL ILLNESS PER 100 ELIGIBLE MONTHS—DEMONSTRATION HMO AND PSN COMPARED TO PMHP



SECTION V: DISCUSSION AND CONCLUSIONS

In the following pages the evaluation team provides a brief discussion of lessons learned from the research and demonstration project during its first five years.

THE DEMONSTRATION WAS IMPLEMENTED EFFECTIVELY

First, the demonstration was implemented very quickly. Even considering that some preparatory and planning steps might be taken during the legislative process, a true “go decision” could not be made until after the special legislative session of December 2005. The mandated start date of July 1, 2006, was extremely ambitious by any standard. AHCA was committed to meeting its legislated timeline. Second, the use of a carefully structured Project Management methodology was helpful to achieving the start time. The process organized key participants into teams that included staff from various AHCA bureaus, content experts, and trained, experienced project managers. Third, strong leadership at all levels was clearly demonstrated in the development and implementation of the demonstration. Effective internal communication and external communication were critical success factors in the development and implementation of the demonstration. Finally, the State’s dedication of significant resources to the demonstration’s development and implementation contributed to the initiative’s success.

Implementation challenges emerged with reference to (a) communicating with a very large number and diversity of stakeholders, many of whom needed very different information, and (b) the degree to which the demonstration itself became a part of ongoing political and policy conversations that had begun during the earliest stages of discussing the idea of a demonstration. This had the effect of requiring an allocation of administrative (AHCA) effort and energy to ongoing description and defense of the demonstration’s basic tenets and objectives, rather than the enormous challenges of implementation.

THE DEMONSTRATION DID NOT FUNDAMENTALLY CHANGE MCO INTEREST IN MEDICAID—EXCEPT FOR PSNS

Early conversations about the planned demonstration included significant concerns about the degree to which MCOs (currently extant as well as those that might choose to enter the market) were interested in the demonstration and/or willing to participate. For many of the plans, a major reason for participating in the demonstration was their intention to remain in the Medicaid business, specifically in Florida. Most plans were participating in Medicaid prior to the demonstration, and they wanted to maintain their enrollee bases. The demonstration was unusual in providing plans with some latitude in benefit design, but most reported only minimal changes to their benefit structure from pre-demonstration plans. Additionally, plans did not make major changes to their

provider networks, and problems with contracting that existed prior to the demonstration remain.

The key idea underlying the concept of a PSN is to create a group of providers that will provide care and be accountable for a defined population. In the case at hand, this population is Medicaid enrollees. The PSN concept allows for shared savings upon the achievement of certain quality standards and cost reductions (Duncan, Lemak, et al., 2008). This is similar to the arrangement under Florida's Minority Physician Network Program, a waiver that demonstrated the potential for improved quality and cost savings (Lemak, et al., 2004).

The challenges of an impending capitation requirement were of concern to some physician-sponsored PSNs. Acquisitions occurred with the goal of combining the existing provider networks with more sophisticated infrastructure of established health plans.

MARKET DYNAMICS WERE SIGNIFICANT

New competitive relationships emerged during the demonstration. Many plans felt that HMOs and PSNs were not "on a level playing field" in the marketplace. Interestingly, both types of organizations expressed strongly held views that the other had an advantageous circumstance. HMOs indicated that provider-affiliated PSNs had an advantage with regard to contracting. A key issue concerned the ability of hospitals to demand "above-market payment rates" from health plans that they now competed with as PSNs. Some PSNs, however, suggested that HMOs had a market advantage with regard to flexibility in benefit design and mechanisms used to pay providers.

The later demonstration years saw continued changes in the demonstration Medicaid markets. The departure of the predominant HMO (WellCare) and its two plans (HealthEase and Staywell) from all of the demonstration counties led to dramatic increases in enrollment for several of the other MCOs. Specifically, the two hospital-affiliated PSNs (South Florida Community Care Network and First Coast Advantage) more than doubled their enrollment and one health plan (Total Health Choice) saw a four-fold increase in membership during a two-month period in 2009.

For many plans, the growth in enrollment resulting from WellCare's departure from the market meant they had to build additional network capacity and place a greater emphasis on physician relationships. Most of them reported that they were successful in this process. Even within the context of this specific set of market circumstances, many health plans continued to suggest that hospital-owned PSNs had an unfair advantage in negotiating hospital rates and gaining access to key specialists.

In contrast to dramatic enrollment increases in some plans, several others maintained a freeze on enrollment in the demonstration counties, essentially preventing any future growth for themselves in the pilot areas. Payment rates perceived as low and the high

administrative costs that health plans considered to be specifically associated with the requirements of the demonstration were cited as the primary reasons for such freezes. Plans found rates in the demonstration to be particularly problematic, but they had no desire to leave Florida Medicaid overall (Lemak, et al., 2010).

MANAGED CARE BROUGHT INNOVATIVE TOOLS AND INCREASED ACCOUNTABILITY

There was some evidence that some demonstration health plans and networks brought innovative tools to bear on the Medicaid managed care market in the demonstration counties. Further, some demonstration plans with multiple lines of business reported using the same care management processes across plans (including Medicaid). Early evidence suggested that all types of Medicaid providers had a greater degree of accountability for practice patterns in the demonstration counties because the providers were now being more carefully managed.

Under the demonstration, significant responsibility for managing providers shifted from AHCA to the MCOs. Health plans put in place a variety of tools to educate and communicate with contracted providers. Early evidence found that some plans were also using innovative ways to work with and communicate with providers (Lemak, Bell, Duncan, & Hall, 2006; Lemak & Yarbrough, 2008).

AHCA instituted new quality improvement plan reporting requirements with the demonstration. These requirements went further than any previously existing in MediPass and further than previous requirements for non-Reform Medicaid HMOs.

LITTLE TO NO CHANGE IN PROVIDER ACCESS

The demonstration plans reported that their Medicaid provider networks remained largely the same as their pre-demonstration networks. Additionally, AHCA conducted an analysis of provider networks and concluded that access was not reduced as a result of the demonstration (Florida Agency for Health Care Administration, 2011b). Access to specific types of specialty care continued to be a challenge in the demonstration areas, generally indicating that the demonstration neither mitigated nor exacerbated a pre-existing circumstance. Some suggested that access to specialists improved in the demonstration due to partnerships with local hospital districts and in the case of Duval County, the addition of a PSN. Additionally, plans have a greater ability to contract with providers on a case-by-case basis to increase enrollee access to specialty care. However, surveys of enrollees showed no statistically significant difference in beneficiary ratings of specialty care access.

ENROLLEE SATISFACTION DID NOT CHANGE SUBSTANTIALLY

The current national context of medical care in the United States reflects a growing interest in managed care as a means to improve the efficiency and quality of care while controlling costs. It is generally assumed that these goals will be best achieved if there is robust competition among multiple MCOs. Further, it is expected that MCOs will have to focus on the satisfaction of their enrollees if they are to obtain and retain the number of enrollees required to achieve the cost and quality outcomes noted. It is understood that managed care may create constraints or other limitations on care that will be undesirable for enrollees or members whose prior experience of medical care was more open-ended, and hence it is recognized that satisfaction levels may decline as patients move from care that is less managed to care that is managed. When choosing among managed care options, it is expected that satisfaction will impact plan selection. This same basic construct underlies the use of competitive managed care models in Medicaid, including Florida's demonstration project.

Enrollee satisfaction has been assessed throughout the demonstration primarily by use of CAHPS telephone surveys. Specific measures included enrollee satisfaction with care overall, with the health plan, with the doctor or other provider, with office staff, with specialty care, and several other dimensions.

On the whole, satisfaction levels did not change dramatically in the transition to the managed care model and have remained quite stable over the period of the demonstration. There is some indication of declines in satisfaction with health plans, and satisfaction with overall health care. Improvement in satisfaction with the enrollees' personal doctor, personnel in the doctor's office, and direct interaction with providers of care have also been observed and reported.

In the relatively few areas where changes in satisfaction are noted and are statistically significant, the magnitude of the observed changes are modest. In all instances where a difference is noted the observed differentials are fewer than 10 percentage points.

In general, PSN enrollees have slightly higher levels of satisfaction than those in HMOs, perhaps reflecting a more constrained level of care management among the latter. The observed differences between PSN and HMO enrollee satisfaction scores are not consistent across all measured dimensions and are not large.

The fundamental finding is that for the majority of all measures taken, Florida Medicaid enrollees' satisfaction with care did not change as a result of transition to the demonstration, and did not change during the course of the demonstration. For the minority of measures in which changes were observed, the differences were modest, with some representing improvements while others represented declines. In general, these findings are comparable to similar surveys conducted for various populations throughout the nation over approximately the same period of time.

Key lessons for other states and interested observers are (a) Medicaid enrollees can and will make plan selection decisions and will change plans if they expect a competing organization might better serve their needs, and (b) Medicaid enrollees reflect some of the same concerns about care management and health plan policies/procedures that have been observed in the world of commercial health insurance. In general, they are satisfied with the medical care they receive in a managed care context. Anecdotal reports indicate that enrollees are dissatisfied if they are required to change plans not as a result of their own preference, but because of decisions (such as withdrawals and acquisitions) made by the organizations.

FISCAL CONSEQUENCES ARE OBSERVED

Careful assessments of key fiscal elements in a demonstration such as this are methodologically challenging and subtle. Over the first four years of the demonstration, the State of Florida has spent less money on the medical care of enrollees in the demonstration than it would have spent on comparable enrollees in those same counties had there been no demonstration. The lower expenditures are not literally a reduction. They represent a lower amount of increase in expenditures than would have been expected over that time period. The expenditures are measured in dollars per member per month. The observed difference in expenditures was greater for SSI enrollees ($263 PMPM) than for those enrollees whose eligibility for Medicaid derives from their TANF eligibility ($35 PMPM). The differences in expenditures were greater for enrollees whose Medicaid managed care participation was in a PSN than for those whose managed care organization was an HMO. Similar, but slightly smaller reductions in the growth in expenditures were seen even after controlling for differences in enrollee characteristics between the demonstration and control counties. It is important to note that to date no analyses have been conducted to estimate or better understand the source of the observed differences in expenditures, which may derive from many sources or combinations thereof.

THE LIP PROGRAM ACHIEVED ITS OBJECTIVES

The primary objectives associated with the Low Income Pool were to (a) maintain the state's commitment to providing resources that assist safety-net hospitals in the achievement of their traditional commitment to providing needed care to the Medicaid, underinsured, and uninsured populations; and (b) extend the distribution of resources for that same purpose to a larger number of hospitals and to non-hospital providers of care.

By setting the Low Income Pool at $1.0 billion per year throughout the demonstration, the first objective was accomplished in the aggregate.

Total funding under the LIP program increased in comparison to the program in place before the Medicaid demonstration (the Special Medicaid Payments—SMP—program).

During the demonstration, LIP funding was distributed to more hospitals than prior to the demonstration. Non-hospital providers also began receiving funding under the LIP program. Hospitals receiving LIP funding served an average of approximately 30 Medicaid, underinsured, and uninsured individuals for every $1,000 of LIP payments, while non-hospital providers receiving LIP funding served an average of approximately 120 Medicaid, underinsured, and uninsured individuals for every $1,000 of LIP payments.

It might be argued that a decline in the per patient amounts allocated to the traditional safety-net hospitals represents a failure to maintain the prior levels of commitment. If the general issue is whether or not Florida balanced the inherent inconsistencies of objectives (a) and (b) above, it seems clear that the LIP achieved its objectives.

SECTION VI: APPENDIX

LIST OF EVALUATION REPORTS

The table below provides a list of all evaluation reports (excluding administrative reports) such as deliverable reports, posters, presentations, and journal articles produced during the evaluation project. Selected reports are available at http://mre.phhp.ufl.edu/.

Report Type	Name
Enrollee Experiences	
Project Report	Medicaid Reform Preliminary Baseline Findings from Longitudinal Study
Project Report	Medicaid Reform Enrollee Satisfaction: Baseline CAHPS Survey in Broward and Duval Counties.
Project Report	Medicaid Reform: Interim Findings From Round 2 of the Longitudinal Study
Project Report	Medicaid Reform: Qualitative Studies Summary
Project Report	Medicaid Reform Enrollee Satisfaction: Year 1 Follow-Up Survey
Project Report	Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey Volume 1: County Estimates
Project Report	Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey Volume 2: Plan Type Estimates
Project Report	Medicaid Reform Enrollee Satisfaction Year Two Follow-Up Survey Volume 3: Race and Ethnicity Estimates
Project Report	Medicaid Reform Enrollee Satisfaction Year Three Follow-Up Survey
Journal Article	Brumback, B., Winner, L. H., Casella, G., Ghosh, M., Hall, A. G., Zhang, J., et al. (2008). Estimating a weighted average of Stratum-Specific Parameters. Statistics in Medicine.
Presentation	Hall, A. G., Lemak, C. H., & Landry, A. K. (2010, November 6). Consumer knowledge and engagement in Florida Medicaid's Enhanced Benefits Reward$ program. PowerPoint presented at the American Public Health Association Annual Meeting, Denver, CO.
Presentation	Duncan, R. P. (2010, October 27). Enrollee satisfaction with Medicaid Managed Care in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Medicaid Business in Focus: CFO Forum, Arlington, VA.
Presentation	Hall, A. G. (2010, September 16). Evaluating Medicaid Reform in Florida: Enrollee satisfaction. PowerPoint presented at the Agency for Health Care Administration, Tallahassee, FL.
Presentation	Duncan, R. P. (2010, April 27). Moving towards Consumer-Driven Health Care: Medicaid enrollee satisfaction in Florida's Reform

Report Type	Name
	Initiative. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Symposium presented at the Medicaid Innovations Forum, Washington, DC.
Presentation	Duncan, R.P., & Harman, J. S. (2009, February 23). Florida Medicaid Reform Evaluation: Preliminary findings on enrollee satisfaction. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the 21st Annual Southeast Evaluation Association Conference, Tallahassee, FL.
Presentation	Lemak, C.H. (2009, January 20). Enhanced Benefits Reward$ Program. Ann Arbor, Michigan: University of Michigan, Department of Health Management and Policy. PowerPoint presented to the Department of Health Management and Policy, Ann Arbor, MI.
Presentation	Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., & Chorba, L. P. (2007, July 18). CMS site visit Medicaid Reform Waiver: Medicaid Reform CAHPS Survey (Benchmark Survey). Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented by Paul Duncan at the Centers for Medicare and Medicaid Services Site Visit at the Agency for Health Care Administration Headquarters in Tallahassee, FL.
Presentation	Brumback, B. (2007, March 13). Using Hierarchical Models to estimate a weighted average of stratum-specific parameters. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Spring meeting of the ENAR International Biometrics Society, Atlanta, GA.
Poster	Boyle, E. L., Hall, A. G., & Duncan, R. P. (2011, March 23). Impact of Medicaid plan type and chronic illness on health care satisfaction. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster presented at the 2011 PHHP Research Day, Gainesville, FL.
Poster	Duncan, R. P., Hall, A. G., Elliott, K., Chorba, L. P., Brumback, B., & Zhang, J. (2010, June 27). Enrollee Satisfaction and Decision-Making in a Changing Medicaid Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Thompson, K.S., Young, G. C., Hall, A. G., Bell, L. L., & Elliott, K. S. (2010, June 27). Medicaid Reform in Florida and Prescription Drug Access. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.

Report Type	Name
Poster	Zhang, J., Chorba, L. P., Shah, R., Bali, S., Elliott, K., Lemak, C. H., Hall, A. G., & Duncan, R. P. (2010, June 27). Development of an Over-the-Counter Therapeutic Classification Metric for analysis of Florida Medicaid Enhanced Benefits Reward$ usage patterns. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Hall, A.G., Lemak, C. H., Landry, A. Y., & Duncan, R. P. (2010, June 28). Consumer knowledge and engagement in Florida Medicaid's Enhanced Benefits Reward$ Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Elliott, K. S., Zhong, Y., Hall, A. G., Lemak, C. H., & Zhang, J. (2010, April 13). Incentivized health behaviors by subgroups in Florida Medicaid's EBR Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster presented at the 2010 PHHP Research Day, Gainesville, FL.
Poster	Thompson, K., Young, G., Hall, A. G., & Elliott, K. (2010, April 13). Medicaid Reform in Florida and Prescription Drug Access. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster presented at the 2010 PHHP Research Day, Gainesville, FL.
Poster	Elliott, K., Lemak, C., Zhang, J. (2009, June 29). Financial incentives for healthy behaviors: Early data from Florida's Medicaid Enhanced Benefits Rewards Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.
Poster	Duncan, R. P., Hall, A., Chorba, L., Brumback, B., Zhang, J. (2009, June 29). Enrollee satisfaction in a changing Medicaid program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.
Poster	Dagher, R. & Hall, A. (2009, June 29). Healthcare experiences of Medicaid Enrollees in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.

Report Type	Name
Poster	Young, G., Thompson, K., Hall, A., Elliott, K., Bell, L. (2009, June 28). Should Medicaid enrollees' health beliefs be an important factor in the Consumerism Debate? Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.
Poster	Thompson, K., Young, G., Hall, A., Elliott, K., Bell, L. (2009, June 28). Predictors of consumer decision-making support under Florida's Medicaid Reform. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.
Poster	Thompson, K. S., Young, G. C., Hall, A. G., & Elliott, K. S. (2009, April 16). Medicaid Reform in Florida and Prescription Drug Access. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster presented at the 2009 PHHP Research Day, Gainesville, FL.
Poster	Thompson, K., Young, G. C., Hall, A. G., Bell, L. L., Elliott, K. S. (2008, June 9). Enrollees' perceived barriers to access under Florida Medicaid Reform. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Washington, D.C.
Poster	Young, G., Thompson, K. S., Hall, A. G., Bell, L. L., Elliott, K. S. (2008, June 9). Perceived factors that influence enrollee decision making and health choices in Florida Medicaid Reform. Poster session presented at the Annual Research Meeting of the AcademyHealth, Washington, D.C.
Poster	Elliot, K. S., Bell, L. L., Young, G. C., Thompson, K. S., Hall, A. G. (2008, February 28). Understanding the influence of enrollees' health beliefs and behaviors on Enhanced Benefits Accounts Program participation. Poster session presented at the 20th Annual Southeast Evaluation Association meeting, Tallahassee, FL.
Poster	Young, G., Thompson, K., Hall, A., Bell, L., Elliott, K. (2007, June 28). Preliminary Focus Group findings: Enrollee experiences under Medicaid Reform in Florida. Poster session presented at the 2008 Florida Conference on Medicaid and the Uninsured, Tallahassee, FL
Fiscal Analyses	
Project Report	An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration
Project Report	An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration: Multivariate Analysis.

Report Type	Name
Journal Article	Harman, J. S., Lemak, C. H., Al-Amin, M., Hall, A. G., & Duncan, R. P. (2011). Changes in per member per month expenditures after implementation of Florida's Medicaid Reform Demonstration. Health Services Research, 46(3), 787-804.
Presentation	Harman, J. (2010, September 16). Evaluating Medicaid Reform in Florida: Fiscal analyses update. PowerPoint presented at the Florida Agency for Health Care Administration, Tallahassee, FL.
Presentation	Duncan, R. P., Harman, J. S., (2009, August 10). Evaluating Medicaid Reform: Fiscal analyses update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration Reform Technical Advisory Panel, Tallahassee, FL.
Poster	Harman, J.S. (2010, June 27). Changes in Medicaid Expenditures after implementation of Florida's Reform Pilot Demonstration. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Harman, J., Yang, S., Xin, H., Duncan, R.P. (2009 June, 29). Florida Medicaid expenditures before and after implementation of the Demonstration Pilot Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Chicago, IL.
Low Income Pool	
Project Report	Pre-Reform Evaluation of Low Income Pool Program Using FHURS Data: SFY 2003–04
Project Report	Pre-Reform Evaluation of Low Income Pool Program Using FHURS Data: SFY 2004–05
Project Report	Evaluation of Low Income Pool Program Using Milestone Data: SFY 2005–06 and SFY 2006–07
Project Report	Supplemental Analysis of Low Income Pool Program Using Milestone Data: SFY 2005–06 and SFY 2006–07
Project Report	Evaluation of Low Income Pool Program Using FHURS Data: SFY 2005–06
Project Report	Evaluation of Low Income Pool Program Using Milestone Data: SFY 2007–08
Project Report	Evaluation of Low Income Pool Program Using FHURS Data: SFY 2006–07
Project Report	Evaluation of Low Income Pool Program Using Milestone Data: SFY 2008–09
Project Report	Evaluation of Low Income Pool Program Using FHURS Data: SFY 2007–08

Report Type	Name
Project Report	Evaluation of Low Income Pool Program Using Milestone Data: SFY 2009–10
Poster	McKay, N.L. (2007, June). Florida's Low Income Pool (LIP) Program: Distribution of LIP-related payments before Reform. Poster session presented at Annual Meeting of the AcademyHealth, Orlando, FL.
Impact on Mental Health Services	
Project Report	Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 1: Enrollee Experiences with Mental Health and Substance Abuse Treatment
Project Report	Evaluating the Impact of Florida Medicaid Reform on Recipients of Mental Health Services Subproject 2: The Effect of Medicaid Reform on Baker Act examinations and Criminal Justice Encounters
Presentation	Harman, J.S., Robst, J., Bell, L. L. (2010, April 13). Impact of Florida's Medicaid Reform on recipients of mental health services. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Symposium presented at The Quality of Behavioral Healthcare: A Drive for Change Through Research Conference, Clearwater Beach, FL.
Poster	Bell, L. L., Harman, J. S., Duncan, R. P., Brumback, B., Zhang, J., Chorba, L. P., & Bilello, L. (2010, June 28). Enrollee experiences with Mental Health Services in Florida's Medicaid Reform Demonstration Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Harman, J.S. (2010, June 28). Changes in Pharmacotherapy for enrollees with severe mental illness after implementation of Florida's Medicaid Reform Pilot Demonstration. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Bilello, L., Harman, J.S., Duncan, R. P., Zhang, J., Brumback, B., Bell, L. L., Chorba, L.P. (2010, April 13). Enrollee experiences with Mental Health Services in Florida's Medicaid Reform Pilot Program. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster presented at the 2010 PHHP Research Day, Gainesville, FL.
Organizational Analyses	
Project Report	Medicaid Reform Health Plans and Networks As of July 1, 2006
Project Report	Medicaid Reform Organizational Analyses: July 2006 – March 2007
Project Report	Medicaid Reform Organizational Analyses: April 2007 – March 2008
Project Report	Medicaid Reform Organizational Analyses: April 2008 – March 2009
Project Report	Medicaid Reform Organizational Analyses: April 2009 – March 2010

Report Type	Name
Journal Article	Landry, A. Y., Lemak, C. H., & Hall, A. G. (2011). Successful implementation in the Public Sector: Lessons learned from Florida's Medicaid Reform Program. J Public Health Management Practice, 7(2), 154–163.
Poster	Al-Amin, M., Lemak, C. H., & Bell, L. L. (2010, June 28). Structural Inertia, Health Plans, and Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. Poster session presented at Annual Research Meeting of the AcademyHealth, Boston, MA.
Poster	Yarbrough, A.K., & Lemak, C.H. (2007, June). The Impact of Organizational Characteristics on Medicaid Managed Care Enrollees: Evidence from Florida's Medicaid Reform. Poster session presented at the Annual Research meeting of the AcademyHealth, Orlando, FL.
Overall Evaluation	
Project Report	Summary Report on Section 1115 Waiver Process.
Presentation	Duncan, R. P. (2010, August 16). Medicaid Reform in Florida & national health care reform. PowerPoint presented at the Florida Conference on Aging 2010 Better Together: Life After 55, Orlando, FL.
Presentation	Duncan, R. P. (2010, June 8). Evaluating Medicaid Reform in Florida: Lessons for other states. PowerPoint presented at the National Medicaid Congress, Washington, DC.
Presentation	Duncan, R. P. (2010, June 2). Evaluating Medicaid Reform in Florida: Key findings to date. PowerPoint presented at the Technical Advisory Panel, Tallahassee, FL.
Presentation	Duncan, R. P. (2010, March 5). Evaluation update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida House of Representatives Select Policy Council on Strategic & Economic Planning, Tallahassee, FL.
Presentation	Duncan, R. P. (2010, February 10). Evaluation update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida Senate Health and Human Services Appropriations Committee, Tallahassee, FL.
Presentation	Duncan, R. P. (2010, February 3). Evaluation update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida Senate Health Regulation Committee, Tallahassee, FL.
Presentation	Duncan, R. P. (2010, January 15). Medicaid Reform evaluation update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration Reform Technical Advisory Panel, Tallahassee, FL.

Report Type	Name
Presentation	Duncan, R. P. (2009, August 19). Evaluating Medicaid Reform: Update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration Medical Care Advisory Committee, Tallahassee, FL.
Presentation	Duncan, R.P. (2009, May 7). Evaluating Medicaid Reform in Florida update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration Reform Technical Advisory Panel, Tallahassee, FL.
Presentation	Duncan, R.P., Hall, A.G., Harman, J.S., Lemak, C.H., & McKay, N.L. (2009, March 27). Evaluating Medicaid Reform in Florida update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the 3rd Annual Meeting of the MRE Technical Advisory Committee, Gainesville, FL.
Presentation	Duncan, R.P., Hall, A.G., Harman, J.S., Lemak, C.H., & McKay, N.L. (2009, March 6). Medicaid Managed Care pilot evaluation/MRE Site visit. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration, Gainesville, FL.
Presentation	Duncan, R.P. (2009, February 4). Florida Medicaid Reform Evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida Senate Health Regulation Committee, Tallahassee, FL.
Presentation	Duncan, R.P. (2008, December 18). Florida Medicaid Reform Evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Agency for Health Care Administration Reform Technical Advisory Panel, Tallahassee, FL.
Presentation	Duncan, R.P. (2008, September 12). Florida Research Initiatives: Medicaid Reform Evaluation & the Florida Health Insurance studies. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the 2008 Florida Conference on Medicaid and the Uninsured, Tallahassee, FL.
Presentation	Hall, A.G. (2008, June 7). Evaluating Medicaid Reform in Florida: Early findings. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the AcademyHealth: State Health Policy Interest Group, Washington, D.C.

Report Type	Name
Presentation	Lemak, C.H. (2008, May 21). Florida Medicaid Reform. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Alachua County Health Department, Gainesville, FL.
Presentation	Duncan, R.P., Hall, A.G., Harman, J.S., Lemak, C.H., & McKay, N.L. (2008, March 7). Florida Medicaid Reform Evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Technical Advisory Committee, Gainesville, FL.
Presentation	Duncan, R.P. (2008, February 29). Evaluating Medicaid Reform in Florida: Update. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to Agency for Health Care Administration Headquarters, Tallahassee, FL.
Presentation	Duncan R.P., Hall, A.G. Harman, J. S., & Lemak, C.H. (2008, January 11). Miami-Dade Medicaid Forum. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Third Miami-Dade Medicaid Forum, Miami, FL.
Presentation	Duncan R.P., Hall, A.G. Harman, J. S., Lemak, C.H., McKay, N. L., Yarbrough, A. K., Dagher, R., & Bell, L.L. (2007, December 12). Florida Medicaid Reform Evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida Advisory Committee, Tallahassee, FL.
Presentation	Duncan, R. P. (2007, October 29). Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Technical Advisory Panel Meeting, Tallahassee, FL.
Presentation	Duncan R.P., Hall, A.G., Harman, J.S., Lemak, C.H., McKay, N. L., & Bell, L.L. (2007, July 18). CMS site visit Medicaid Reform Waiver: Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented by Paul Duncan at the Centers for Medicare and Medicaid Services Site Visit at the Agency for Health Care Administration Headquarters in Tallahassee, FL.
Presentation	Hall, A.G. (2007, June 8). Florida Medicaid Managed Care Reforms. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the annual Health Care Summit of the South Florida Hospital and Healthcare Association, Davie, FL.

Report Type	Name
Presentation	Duncan R.P. (2007, May 10). Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Institute for Public Policy and Leadership Public Policy Forum, Sarasota, FL.
Presentation	Duncan R.P., Hall, A.G., Harman, J.S., Lemak, C.H., McKay, N. L., & Bell, L.L. (2007, March 9). Technical Advisory Committee Annual Meeting. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Technical Advisory Committee, Orlando, FL.
Presentation	Duncan R.P. (2007, February 26). Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Florida Department of Health Monthly Medicaid Reform Conference Call, Tallahassee, FL.
Presentation	Duncan R.P. (2007, February 23). Florida Medicaid: Interim Report. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Duval County Medical Society/Academy of Medicine, Jacksonville, FL.
Presentation	Lemak, C. H. (2007, January 30). Florida Medicaid Reform: Update and evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Sarasota Memorial Health Care System Executive Team, Sarasota, FL.
Presentation	Duncan, R.P. (2007, January 19). Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Senate Health Policy Committee, Tallahassee, FL.
Presentation	Hall, A. G. (2007, January 17). Medicaid Reform Evaluation: A case study on the challenge of doing public policy research. Presented at the SEA Conference: Southeast Evaluation Association 19th Annual Conference: Ethics, Evaluation and Accountability, Tallahassee, FL.
Presentation	Duncan R.P., Hall, A.G., Harman, J.S., Lemak, C.H., McKay, N. L., & Bell, L.L. (2006, December 13). Florida Advisory Committee 1st Annual Meeting. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented to the Florida Advisory Committee, Tallahassee, FL.
Presentation	McKay, N.L. (2006 September 20). Evaluating Medicaid Reform in Florida. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Fall Conference of the Healthcare Financial Management Association Florida Chapter, St. Augustine, FL.

Report Type	Name
Presentation	Lemak, C.H. (2006, August 4). Medicaid Reform in Florida: Overview and evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the Annual State Coverage Initiatives Workshop for State Officials, Chicago, IL.
Presentation	Hall, A.G. (2006, July 25). Medicaid Reform in Florida: Research questions. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the annual research meeting of the AcademyHealth, Seattle, WA.
Presentation	Duncan, R.P., (2006, June 1). Update: Medicaid Reform Evaluation. Gainesville, Florida: University of Florida, Department of Health Services Research, Management and Policy. PowerPoint presented at the 5th Annual Medicaid Research Conference, Tallahassee, FL.

REFERENCES

Arnold, T. W. (2004). *Florida Medicaid: A case for modernization*. Retrieved from the Florida Agency for Health Care Administration website: http://ahca.myflorida.com/Medicaid/medicaid_reform/2004meetings.shtml.

Bush, J. (2005a). Florida Medicaid Modernization Proposal: Office of the Governor.

Bush, J. (2005b). Medicaid revisited. *Modern Health Care, 35*(47).

Bush, J. (2006). Market Principles: The right prescription for Medicaid. *Stanford Law & Policy Review, 17*(1), 33-56.

Centers for Medicare and Medicaid Services. (2005). *Medicaid Reform Section 1115 Demonstration: Special terms and conditions*. (Report No. 11-W-00206-4). Retrieved from http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/pdf/cms_stc.pdf

Duncan, R. P., Bell, L. L., Hall, A. G., Lemak, C. H., & McKay, N. L. (2006). Summary report on Section 1115 Waiver process. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., Bell, L. L., Chorba, L. P., et al. (2011). Medicaid reform enrollee satisfaction year two follow-up survey volume 2: Plan type estimates. Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy

Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., & Chorba, L. P. (2007). Medicaid reform enrollee satisfaction: Baseline CAHPS survey in Broward and Duval counties. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., & Chorba, L. P. (2008). Medicaid reform enrollee satisfaction: Year 1 follow-up survey. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., Chorba, L. P., Bell, L. L., et al. (2011). Medicaid Reform enrollee satisfaction year two follow-up survey volume 3: Race and ethnicity estimates Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy

Duncan, R. P., Hall, A. G., Brumback, B., Zhang, J., Chorba, L. P., Bilello, L., et al. (2011). Medicaid reform enrollee satisfaction year two follow-up survey volume 1: County estimates. Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy.

Duncan, R. P., Harman, J. S., Brumback, B., Zhang, J., Chorba, L. P., Billello, L., et al. (2009). Evaluating the impact of Florida Medicaid Reform on recipients of mental health services subproject 1: Enrollee experiences with mental health and substance abuse treatment. Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy.

Duncan, R. P., Lemak, C. H., Vogel, B., Johnson, C. E., & Porter, C. K. (2004). *Evaluating Florida's Medicaid Provider Service Network demonstration project: Summary report*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Duncan, R. P., Lemak, C. H., Vogel, B. W., Johnson, C. E., Hall, A. G., & Porter, C. K. (2008). Evaluating Florida's Medicaid Provider Services Network Demonstration. *Health Services Research, 43*(1p2), 384-400. doi: 10.1111/j.1475-6773.2007.00768.x

Florida Agency for Health Care Administration. (2005). *Low-Income Pool funding and reimbursement methodology.* Retrieved www.fdhc.state.fl.us/medicaid/medicaid_reform/.../AGENDAITEM5a.pdf

Florida Agency for Health Care Administration. (2011a). *Florida Medicaid quality in managed care.* Retrieved http://ahca.myflorida.com/medicaid/quality_mc/index.shtml

Florida Agency for Health Care Administration. (2011b). *Florida Medicaid Reform Year 4, draft annual report, July 1, 2009 - June 30, 2010.* Retrieved http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml

Hall, A. G., Young, G. C., Bell, L. L., Thompson, K. S., Elliott, K. S., & Dagher, R. K. (2008). Qualitative studies summary. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Henry J. Kaiser Family Foundation. (2011). Medicaid Enrollment: June 2010 Data Snapshot. Washington, D.C.: Kaiser Family Foundation's Comission on Medicaid and the Uninsured

Holahan, J., Clemans-Cope, L., Lawton, E., & Rousseau, D. (2011). *Medicaid spending growth over the last decade and the Great Recession, 2000 - 2009*. (Report No. 8152). Retrieved from the Kaiser Commission on Medicaid and the Unisured website: http://www.kff.org/about/kcmu.cfm.

Holahan, J., & Garrett, A. B. (2009). *Rising unemployment, Medicaid and the uninsured*. (Report No. 7850). Retrieved from the Kaiser Commission on Medicaid and the Unisured website: http://www.kff.org/about/kcmu.cfm.

Kaiser Commission on Medicaid and the Uninsured. (2010). *Medicaid: A primer*. (Report No. 7334-04). Retrieved from http://www.kff.org/about/kcmu.cfm.

Kaiser Commission on Medicaid and the Uninsured. (2011). *Medicaid matters: Understanding Medicaid's role in our health care system*. (Report No. 8165). Retrieved from http://www.kff.org/about/kcmu.cfm.

Klees, B. S., Wolfe, C. J., & Curtis, C. A. (2010). Medicaid Program description and Legislative history: http://www.ssa.gov/policy/docs/statcomps/supplement/2010/medicaid.html#mn1

Lemak, C. H., Bell, L. L., Duncan, R. P., & Hall, A. G. (2006). Medicaid reform health plans and networks as of July 1, 2006. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Lemak, C. H., Hall, A. G., Johnson, C. E., Saxena, P., Aftuck, C., & Johnson, C. (2004). *Evaluation of Florida's Minority Physician Network (MPN) Program: Final project report*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Lemak, C. H., Landry, A. Y., Billello, L., Bell, L. L., & Van Wert, P. A. (2009). *Medicaid Reform organizational analyses: April 2008 - March 2009*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Lemak, C. H., Landry, A. Y., Billello, L., Bell, L. L., & Van Wert, P. A. (2010). *Medicaid Reform organizational analyses: April 2009 - March 2010*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Lemak, C. H., & Yarbrough, A. K. (2008). *Medicaid Reform organizational analyses: Reform organizations July 2006 - March 2007*. (Issue Brief No. 1). Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy.

Lemak, C. H., Yarbrough, A. K., Bell, L. L., & Van Wert, P. A. (2007). *Medicaid Reform organizational analyses: July 2006 - March 2007*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

Lemak, C. H., Yarbrough, A. K., Bell, L. L., & Van Wert, P. A. (2008). *Medicaid Reform organizational analyses: April 2007 - March 2008*. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2007). Pre-reform evaluation of low-income pool program using FHURS Data: SFY 2003-04. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2008a). Evaluation of Low-Income Pool program using FHURS data: SFY 2005-06. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2008b). Evaluation of the Low-Income Pool program using Milestone data: SFY 2005-06 and SFY 2006-07. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2008c). Pre-reform evaluation of Low-Income Pool program using FHURS data: SFY 2004-05. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2008d). Supplemental analysis of the Low-Income Pool program using Milestone data: SFY 2005-06 and SFY 2006-07. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2009). Evaluation of Low-Income Pool program using Milestone data: SFY 2007-08. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

McKay, N. L. (2010a). Evaluation of Low-Income Pool program using FHURS data: SFY 2006 - 2007. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy

McKay, N. L. (2010b). Evaluation of Low-Income Pool program using FHURS data: SFY 2007- 2008. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy

McKay, N. L. (2010c). Evaluation of Low-Income Pool program using Milestone data: SFY 2008- 2009. Gainesville, FL: University of Florida, Department of Health Services Research, Management, and Policy.

National Committee for Quality Assurance. (2010a). *Medicaid managed care quality benchmarking project: Final report.* Retrieved https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/NCQAMBench.pdf

National Committee for Quality Assurance. (2010b). *The state of health care quality: Reform, the quality agenda and resource use.* Retrieved www.ncqa.org/.../state%20of%20health%20care/.../sohc%202010%20-%20full2.pdf

Robst, J., Murin, M. R., & Qi, I. (2010). Evaluating the impact of Florida Medicaid reform on recipients of mental health services subproject 2: The effect of Medicaid reform on baker acts and criminal justice encounters. Gainesville, FL: University of Florida, Department of Health Services Research, Management and Policy.

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In the final analysis, most program evaluation research concerns itself with assessing the impact of a program on the people being served by the program in question. In this case, that is the Medicaid enrollees in the demonstration and the medical/health care professionals and organizations who serve those enrollees. Whether in the context of individual key informant interviews, focus groups, telephone surveys assessing enrollee satisfaction, the extraction and analysis of enrollment or other administrative/financial data, the research reported here and in the project's numerous related reports could not have been accomplished without the contributions of time, knowledge, opinions and understanding of the enrollees and providers who were our ultimate source of information. We are extremely grateful.