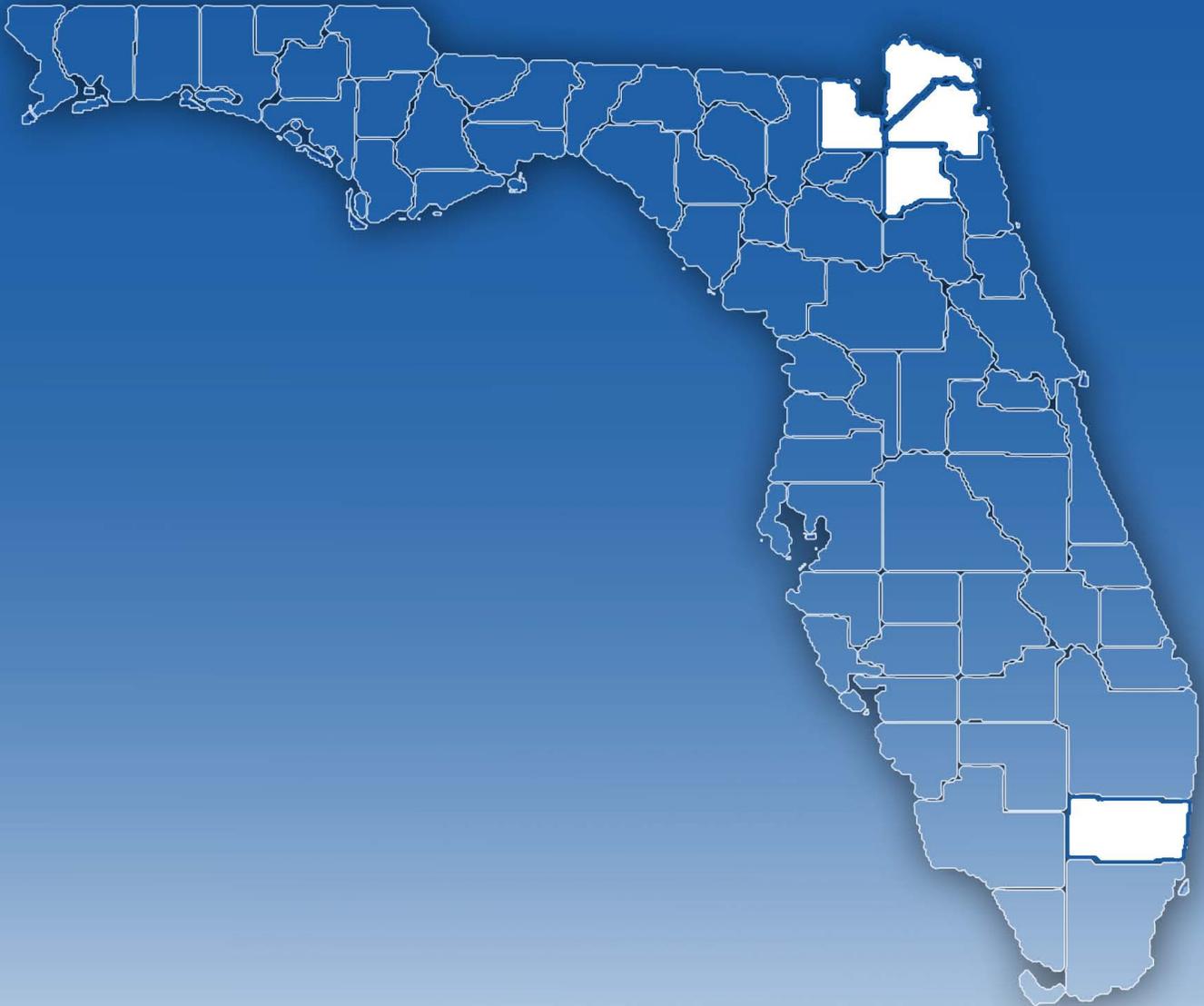




Evaluating Medicaid Reform In Florida

Qualitative Studies Summary

Release Date: June 2010





Qualitative Studies Summary

July 2008

Prepared by the Department of Health Services Research, Management and Policy at the University of Florida under contract to the Agency for Health Care Administration Bureau of Medicaid Quality Management.

TABLE OF CONTENTS

BACKGROUND AND CONTEXT1

 MEDICAID..... 1

 FLORIDA’S MEDICAID REFORM DEMONSTRATION AND EVALUATION..... 2

INTRODUCTION3

METHODOLOGY4

 INSTRUMENT DEVELOPMENT 4

 SAMPLING, RECRUITMENT, AND ANALYTIC APPROACH..... 4

 STUDY DATA..... 5

RESEARCH QUESTIONS AND FINDINGS7

SUMMARY12

REFERENCES.....13

BACKGROUND AND CONTEXT

MEDICAID

Medicaid is a joint state-federal program that finances healthcare services for disadvantaged Americans. The program, which has existed since 1965, is managed by states. Medicaid pays hospitals, physicians, and other medical care providers for medical care needed by people who meet eligibility requirements, are uninsured, and are otherwise unable to pay for their care. In addition, it shares with Medicare the responsibility for financing medical care for people who are eligible for Social Security because of disability. Within program constraints, Medicaid pays for physician office visits, related diagnostic tests, treatments, hospital stays, medical equipment, and prescription drugs. The program also pays for long-term care services in either a community or nursing home setting for elders who meet an income eligibility threshold.

Medicaid is an extremely large program. At present, it has about 60 million enrollees throughout the nation (Kaiser Commission on Medicaid and the Uninsured, 2007a). National Medicaid expenditures are substantial, exceeding \$300 billion annually, and are increasing at the rapid rate of growth noted in other parts of the healthcare system (Kaiser Commission on Medicaid and the Uninsured, 2007b). Medicaid has become the single most difficult budget issue facing many state governments. Despite a substantial federal share (generally more than half the total costs), state expenditures for the program can be very high and are always among the two or three largest single components of entire state budgets—often the largest. 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 economic periods when unemployment rises and incomes fall. These conditions often produce unfavorable fiscal impacts for states, often resulting in declining tax revenues, reducing their capacity to meet increasing needs. Since Medicaid is an entitlement program, people who meet the enrollment criteria must be included and providers who deliver care/services need to be paid. Therefore, states have limited capacity to adjust their Medicaid program expenditures to align with their revenue expectations.

It is almost impossible to overstate the importance of Medicaid to its enrollees, the states, and many providers of care. In addition to the budgetary significance of the program to state governments, Medicaid is an important source of payment for many hospitals, clinics, doctors, medical equipment suppliers, and other providers of care. Furthermore, the program is of critical importance to enrollees; it provides some level of financial access to the immediate healthcare needs of millions of people, including those who have no other means with which to pay for care.

FLORIDA'S MEDICAID REFORM DEMONSTRATION AND EVALUATION

States have limited managerial discretion in program operations. A set of minimum program characteristics apply to all states. These must be achieved and maintained in order to establish and retain federal participation. States are free to design, develop, and implement program elements that exceed these minimal characteristics and have greater flexibility in managing those additional elements of their programs. However, any proposed initiatives that might affect 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. The “Section 1115 Research and Demonstration Project Waiver” essentially provides the authority for the state to test the viability and utility of its 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. A health services research team at the University of Florida has been conducting a series of evaluation studies assessing the resulting demonstration program.

Because the Florida demonstration broke new ground in several areas, it was determined that the formal evaluation studies would be enhanced by a series of qualitative studies. These qualitative studies would provide information specific to the enrollee experiences analyses, organizational studies, and analyses of the fiscal consequences of the demonstration.¹

The qualitative studies were intentionally developed to discern themes, context, patterns, and other elements of enrollee experiences to guide the research activities of the other components of the evaluation. They were supported by data collection through focus groups and in-depth telephone interviews. The studies were not intended to provide statistical estimates of frequencies or trends, nor would the findings be used to make generalizations to larger population groups or other segments of the program.

¹ The qualitative studies were originally intended to be longitudinal; that is, they would follow the same recipients over time from before implementation through the end of the study period. However, maintaining the true longitudinal nature of the study was difficult because enrollees were hard to reach or decided they did not wish to continue study participation.

INTRODUCTION

As indicated in Florida's Section 1115 Medicaid Reform waiver application, there are five Medicaid Reform key impact areas, including patient involvement, access to care, quality of care, cost containment, and coverage (Agency for Health Care Administration, 2005). These key impact areas correlate to specific evaluation subprojects, including organizational analyses, enrollee experiences analyses, fiscal analyses, Low-Income Pool analyses, and mental health analyses. These evaluation subproject areas are not exclusive, and data collection activities encompass several areas. For example, the research questions that relate to the key impact areas of patient involvement, access to care, and quality of care are included in the evaluation subproject areas of organizational analyses and enrollee experiences analyses.

The qualitative studies were part of the larger enrollee experiences analyses subproject. The goals of the enrollee experiences subproject were to (1) measure changes in enrollee experiences and health status that resulted from specific aspects of the demonstration, and (2) understand the factors that may have some impact on enrollees' healthcare decision-making processes. Enrollee experiences with the demonstration are also assessed using the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey, analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data, and analysis of other quality indicators.

METHODOLOGY

The qualitative studies utilized a combination of individual telephone interviews and in-person focus groups with adults and parents/guardians of children who were either eligible or currently participating in the pilot counties (Broward, Duval, Baker, Clay, and Nassau). The study period was from October 2006 – June 2008.

INSTRUMENT DEVELOPMENT

The initial development of the focus group and telephone interview instruments was guided by various health beliefs, health communication, and health behavior theories (Glanz, Rimer, & Lewis, 2002). Questions were based on the review of these theories, the related research literature, and other instruments. Qualitative research allows for the constant evolution of the study instrument commensurate with the increased skill and experience of the researcher. Consequently, the interview and focus group guides were modified, refined, and updated as the conversations revealed important questions and issues from enrollees. Interviewers were trained to develop the skill and competence to use the study instrument to capture the detailed perspectives of enrollees. Interview questions focused on attitudes and beliefs about health, experiences in getting health care and health information, past experiences with Medicaid, and knowledge and experiences with the Medicaid Reform demonstration program.

SAMPLING, RECRUITMENT, AND ANALYTIC APPROACH

The qualitative studies used purposeful sampling to strategically select individuals who were likely to be rich sources of information. The intent was to develop an in-depth understanding of those enrollees' experiences with the demonstration to inform the evaluation activities (Patton, 2002). Participants were recruited using a variety of resources, including community liaisons, Agency for Health Care Administration (AHCA) eligibility/enrollment file data extracts, and other community organizations.² To participate in the study, individuals had to be enrolled in Medicaid or be the parent of a Medicaid enrollee, live in the Reform counties, and be participating or eligible to participate in Medicaid Reform. Emphasis was placed on recruiting parents of children enrolled in Medicaid Reform, males, individuals who received Supplemental Social Security Income (SSI), and individuals diagnosed with HIV/AIDS.

In purposeful sampling, sample size is dependent on the point at which the researchers determine that new participants are *not* providing new insights or information (Morse & Richards, 2002). That is, the themes developed from the rigorous analytic process are becoming

² The evaluation team formally contracted with two community liaisons: Broward Regional Health Planning Council (Broward County) and Health Planning Council of Northeast Florida, Inc. (Duval, Baker, Clay, and Nassau Counties) to provide local research support for the evaluation activities. Our contacts in each of these organizations corresponded with other community organizations such as clinics, health departments, advocacy groups, churches, libraries, and other interested individuals as appropriate.

redundant. The study team continued to recruit respondents for the telephone interviews until it was determined that this “point of saturation” had been achieved. Community liaisons and other community organizations were used to identify participants for the seven focus groups (Table 1). These liaisons collaborated with other community organizations to post flyers, recruit participants, and provide locations to host the focus groups. Each focus group lasted approximately 45 – 60 minutes, and each participant received a \$20 gift card.

For the individual interviews, one participant was selected from the focus groups recruited through the community liaisons and five were selected using other community organizations. Twenty-six were selected using AHCA enrollment files (Table 1). All current Medicaid enrollees (adults and children) eligible to participate in the demonstration pilot program were considered eligible to be recruited for in-depth interviews. From AHCA eligibility/enrollment files, a sample of individuals was selected from each of the five demonstration counties based on race, gender, age, eligibility type (Supplemental Social Security [SSI] and Temporary Assistance for Needy Families [TANF]), and HIV/AIDS diagnosis. In the case of minors, the parents or guardians were considered proxy informants. Based on these criteria, individuals were mailed a form that provided them the opportunity to indicate their interest in participating in the study. Enrollees who completed and returned the forms were contacted up to three times by telephone to schedule an interview. Several data extracts and associated mailings were conducted until the team determined that no new information was being garnered from the in-depth interviews (data saturation). Each telephone interview lasted approximately 45 – 60 minutes, and each participant received a \$10 gift card.

All in-depth telephone interviews and focus groups were audio-recorded. Professional transcriptionists transcribed each audio-recorded interview and focus group verbatim. Groups of two team members conducted each audio-recorded interview to ensure quality and integrity. A coding scheme to identify themes was developed based on the initial focus group and in-depth interview instruments. Quotes from each transcript were assigned codes using *Atlas ti 5.0*, analytic qualitative study software. Using the aggregated quotes, each team member developed themes and conclusions for each code. In team meetings, discrepancies in coding and thematic development were identified and consensus was obtained through iterative discussion and clarification of coding categories and specified definitions.

STUDY DATA

Eighty-five individuals took part in the qualitative data collection activities. Four individuals were interviewed twice for 89 complete interviews. There were 28 unique telephone interviews and 57 participants from 7 focus groups. Of the 28 individuals who participated in individual interviews, four participants (three adults and one parent on behalf of their child) were interviewed twice, for 32 total individual interviews.

Participants were between the ages of 12 – 73. All focus group participants were adults. For the individual interviews, 25 participants were adults and seven participants responded on behalf of their child. While both males and females were included, there were more female than male subjects, as would be expected given Medicaid enrollment. Participants self-reported their race/ethnicity as Whites (29), African Americans (44), Hispanic (10), Asian (3), and Other (2). One individual did not specify. Focus group and in-depth interview participants were recruited from each of the five demonstration counties: 31 from Broward County, 38 from Duval County, 11 from Baker County, 5 from Clay County, and 4 from Nassau County.

Table 1: Subject Characteristics (n=89)

	Focus Groups	Individual Interviews ^a
Recruitment Source		
Community Liaison	57	1
Medicaid Eligibility/Enrollment Files	0	26
Other Community Organizations ^b	0	5
Total Sample	57	32
Adults/Children		
Adults	57	25
Children ^c	0	7
Gender		
Female	50	15
Male	7	16
Race/Ethnicity		
White	18	11
African American	29	15
Hispanic	8	2
Asian	0	3
Other	2	0
None specified	0	1
County		
Broward	10	21
Duval	29	9
Baker	10	1
Clay	5	0
Nassau	3	1

^a Includes data from four individuals who were interviewed twice. ^bCommunity liaisons collaborated with other community organizations to facilitate data collection activities. Other community organizations included clinics, health departments, advocacy groups, churches, libraries, and other interested individuals as appropriate. ^cInterviews were conducted by parents or guardians on behalf of their children.

RESEARCH QUESTIONS AND FINDINGS

The qualitative studies were intended to provide context for the enrollee experiences findings as discerned in the first two rounds of the CAHPS surveys, to better understand the factors that may influence enrollees' healthcare decision-making, and to further direct the overall evaluation goals. This component of the enrollee experiences analysis allowed the research team to develop a thorough review of the demonstration based on specific enrollee experiences. Tables 2 – 6 organize the enrollee experiences analyses research questions and findings by key impact areas.

Table 2: Enrollee Experiences Research Questions—Quality of Care

Research Question	Anticipated Data Source
<ul style="list-style-type: none"> • Will health status and outcomes of Reform enrollees improve? • Will enrollee satisfaction with the quality of care improve? • Will health status improve for the target populations when compared to similar population that is not enrolled in a specialty network? 	<ul style="list-style-type: none"> • Enrollee Survey • Qualitative Studies • HEDIS data

Some of the themes developed through the qualitative studies track closely with findings discussed in the first enrollee survey report “Medicaid Reform Enrollee Satisfaction: Year 1 Follow-Up Survey” (Duncan, Hall, Brumback, Zhang, & Chorba, 2008). As documented in the survey report, enrollees have generally positive views of their experiences with their health care and with their personal healthcare provider. However, some of the individuals with whom we had conversations did report some dissatisfaction with aspects of the demonstration and their healthcare experiences in general and had mixed opinions about the quality of care received. For example, some enrollees noted what they perceived to be overcrowding among doctors who accept Medicaid enrollees. Others reported incidents such as long waits for appointments and long delays in the reception area relative to short visits with the doctors. Some enrollees expressed a general belief that a lower quality of care was offered to Medicaid enrollees. Positive comments about quality of care were mostly focused on specific providers.

Table 3: Enrollee Experiences Research Questions—Patient Involvement

Research Question	Anticipated Data Source
<ul style="list-style-type: none"> • When presented with a greater number of plan choices and customized benefit packages, will enrollees actively participate in the selection of their health plan? • What is the rate of active selection of health plans? • Will pro-active involvement by a Choice Counselor increase the frequency of enrollee plan selection, thus reducing auto-assignment rates? • What are the auto-assignment rates? • Will the Choice Counselor enhance enrollees’ exposure to, search for, obtaining and use of, health information? Will such enhancement result in increased health literacy of Medicaid enrollees, thus increasing enrollee demand for appropriate services and decreasing demand for inappropriate services? 	<ul style="list-style-type: none"> • Choice Counseling Contractors e.g., ACS State Healthcare LLC (ACS) and Florida State University (MediRITE) • Enrollee Survey • Qualitative Studies

Notably, the qualitative findings derived from our conversations with enrollees indicate that a key objective of the demonstration pilot is being met—enrollees are active and engaged in their health plan and provider selection. Compared to baseline findings of the qualitative studies, enrollees are more aware of the Choice Counseling and health plan selection processes. Some enrollees had positive experiences with Choice Counselors and expressed high satisfaction with the process. Some enrollees expressed discontent with Choice Counselors and noted that the Counselors sometimes were misinformed and provided incorrect information. Choice Counselors were useful to other individuals in primary care provider and health plan selection.

Findings from the Year 1 Follow-Up CAHPS survey showed that about 81% of enrollees in Broward County and 76% in Duval County stated that they chose their health plan. The qualitative studies indicate that plan and provider selection was influenced not only by information obtained from Choice Counselors, but was also based on advice from providers, family, and friends. Maintaining continuity of care with a provider was a major reason for selecting a particular health plan.

Table 4: Enrollee Experiences Research Questions—Access to Care

Research Question	Anticipated Data Source
<ul style="list-style-type: none"> Do customized benefit packages and specialty networks increase enrollee access to care? 	<ul style="list-style-type: none"> Enrollee Survey Qualitative Studies

Like consumers throughout all segments of the healthcare system, Medicaid enrollees experience certain barriers to obtaining care. Perhaps the most significant sets of issues have to do with finding a specialist and then securing the necessary referral as part of their plan's benefit package (Backus, et al., 2001). Interview and focus group comments clearly indicate some frustration with this aspect of their care. About 46% of respondents to the Year 1 Follow-Up CAHPS survey in Broward and Duval reported that it was always easy to get an appointment with a specialist, a frequency that reflects the lessons learned in the qualitative studies. Difficulty finding a specialist is common throughout the healthcare system, and especially so for Medicaid enrollees, probably as an artifact of low specialist participation rates in Medicaid health plans and in Medicaid generally (Bindman, Yoon, & Grumbach, 2003; Cunningham & O'Malley, 2009). In addition, problems with transportation not included as part of enrollees' plan benefits appeared to exacerbate the issues related to finding specialists and other kinds of care. For example, concerns about transportation were given within the context of discussion of the difficulty in finding providers close by or in enrollees' communities.

Obtaining a referral is a new process for many enrollees and their providers and can cause delays in getting care. Approximately 10% of Broward and Duval County respondents to the Year 1 Follow-Up CAHPS surveys reported a delay in getting approval for necessary treatment. Of those respondents, 49% in Broward County and 44% in Duval County said that this caused a "big problem." The qualitative studies revealed a learning process among enrollees regarding new procedures for referral and authorization. For example, some of the concern expressed by enrollees was associated with the increased restrictions imposed by health plans in obtaining specialty care referrals.

Getting prescription drug medications and adjusting to health plan formularies is another issue raised by participants in the qualitative studies. However, between 64 – 70% of Broward and Duval County respondents to the Year 1 Follow-Up CAHPS survey needing a prescription drug said that it was "always easy" to get their medicine through their health plan. Perhaps providers may need to become more knowledgeable about plan restrictions and prescribing preferences and will have to educate their enrollees about these changes. Over time, confusion around formularies may decline as enrollees and doctors become more accustomed to the restrictions.

Table 5: Enrollee Experiences Research Questions—Coverage

Research Question	Anticipated Data Source
<ul style="list-style-type: none"> Are enrollees more satisfied with the health plan selection and the customized benefit package when compared to areas without customized benefit packages? 	<ul style="list-style-type: none"> Enrollee Survey Qualitative Studies

Because the Enhanced Benefits Rewards (EBR) program is a new concept to Medicaid programs, early conversations revealed relatively limited knowledge of the program, some skepticism about program participation, and some problems associated with redeeming credits. Florida’s program required the development of new administrative systems as well as marketing campaigns to educate enrollees about the program’s existence and potential benefits. Over the course of several months subsequent to those initial interviews, more people became aware of the program. About 60% of Broward and Duval County respondents to the Year 1 Follow-Up CAHPS survey indicated that they had heard of the EBR program. Our assessment from the qualitative studies is that knowledge of the EBR program has grown throughout the life of the evaluation.

Table 6: Qualitative Studies Research Questions—Costs

Research Question	Anticipated Data Source
<ul style="list-style-type: none"> • Will increased enrollee involvement in health care decisions and increased health literacy result in more appropriate use of services? • Will increased enrollee involvement in health care decisions result in decreased ER care and prevent ambulatory sensitive hospitalizations for select services? 	<ul style="list-style-type: none"> • Enrollee Survey • Qualitative Studies

The fundamental premise of the EBR program is to promote healthy behaviors by rewarding enrollees for participating in such activities. Enrollees' initial skepticism towards the program developed into an appreciation for being rewarded. The consumerism idea indicates that if enrollees are active in their healthcare decision making, their health care can be better managed, and could result in lower healthcare costs over time. Findings in this area from the qualitative studies indicate that enrollees' beliefs may have some impact on their ability and willingness to control, manage, and participate in their healthcare decision making and behaviors and are now serving as a foundation for much more detailed investigation of the EBR program. Further, the qualitative studies found that although physicians are major sources of health information in their decision-making processes, consumers also look to a variety of other resources (e.g., the internet, library) for information on their health and health care. Notably, social networks were important to gaining information on providers and health plans.

SUMMARY

The qualitative data derived from the focus groups and in-depth interviews provide an overview of how enrollees reacted to changes in the Medicaid program during the study period. Specifically, the qualitative studies provide important information on enrollees' health beliefs and control of their health and experiences as factors that influence their healthcare decision making. From a policy perspective, if the goal is to change behavior, it is important to understand prior beliefs, and ensure that policy changes align with that reality.

Unlike quantitative studies, the validity and reliability of qualitative studies is not based on selecting a sample size that can be generalized to the population but on the richness and context of the data collected (Morse & Richards, 2002; Patton, 2002). Therefore, while the themes discerned are based on the study participants' experiences, they are not generalizable to the overall demonstration. The focus of these qualitative studies was to provide context for understanding findings from other components of the evaluation and for highlighting potential areas for further evaluation.

Many of the lessons extracted from these studies have been and are currently being applied in formal surveys of enrollees and their caregivers, as well as the organizational studies, the mental health analyses, and other aspects of the overall project.

Further, the qualitative work revealed the salience of the EBR program. While the EBR has been touched upon across several of the study areas within the larger evaluation, additional focus is certainly warranted. We propose redirecting study efforts and resources from the qualitative research to a greater depth of analysis focused on the EBR. The specific elements of that proposed expansion of effort are currently under discussion. In order to accomplish the additional work required to achieve a fuller understanding of the EBR program, the qualitative research endeavor is considered complete.

REFERENCES

- Agency for Health Care Administration (2005). *Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver August 30, 2005*. Retrieved May, 2009, from http://ahca.myflorida.com/Medicaid/medicaid_Reform/waiver/pdfs/medicaid_Reform_waiver_final_101905.pdf
- Backus, L., Osmond, D., Grumbach, K., Vranizan, K., Phuong, L., & Bindman, A. B. (2001). Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care. *Journal of General Internal Medicine*, 16(12), 815-821.
- Bindman, A. B. M. D., Yoon, J. M. H. S., & Grumbach, K. M. D. (2003). Trends in Physician Participation in Medicaid: The California Experience. *Journal of Ambulatory Care Management The Crisis Confronting Medicaid October/December*, 26(4), 334-343.
- Cunningham, P. J., & O'Malley, A. S. (2009). Do Reimbursement Delays Discourage Medicaid Participation By Physicians? *Health Affairs*, 28(1), w17-w28.
- 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.
- Glanz, K., Rimer, B. K., & Lewis, F. M. (Eds.). (2002). *Health Behavior and Health Education. Theory, Research, and Practice* (3 ed.). San Fransisco, CA: Jossey-Bass.
- Kaiser Commission on Medicaid and the Uninsured (2007a). *Total Medicaid Enrollment, FY2006* (Updated 2009). Retrieved April 14, 2009, from <http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4>
- Kaiser Commission on Medicaid and the Uninsured (2007b). *Why did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment: 2000-2006*. Retrieved April 16, 2009, from <http://www.kff.org/medicaid/upload/7697.pdf>
- Morse, J. M., & Richards, L. (2002). *Readme First for a User's Guide to Qualitative Methods*. Thousand Oaks, CA: Sage Publications Inc.
- Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* (3 ed.). Thousand Oaks, CA: Sage Publications, Inc.