Florida Medicaid Retroactive Eligibility Legislative Report

Report to the Florida Legislature

January 10, 2020

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Summary

The Agency for Health Care Administration (Agency) serves as the single state agency responsible for the Florida Medicaid program. The Department of Children and Families (Department) or the Social Security Administration (for SSI recipients) determines Florida Medicaid eligibility.

In accordance with Section 1902(a)(34) of the Social Security Act, medical assistance is available for eligible recipients' care and services furnished in or after the third month before the month in which the Medicaid application is made.

The Florida 2019-2020 General Appropriations Act Implementing Bill (SB 2502) added subsection (12) to section 409.904, Florida Statutes, applying changes to Medicaid retroactive eligibility for non-pregnant adults. This law was effective on July 1, 2019 and expires on July 1, 2020. This law did not change the eligibility period for children (up to age 21) and pregnant women, who may continue to request retroactive Medicaid eligibility for up to 90 days before the month in which an application for Medicaid was submitted. However, this new law required coverage of eligible non-pregnant adults beginning the first day of the month in which an application was submitted.

Through the General Appropriations Act Implementing Bill, the Florida Legislature directed the Agency to provide a report in collaboration with certain state and private stakeholders. This report includes an overview of the Florida Medicaid program, the retroactive eligibility waiver filed as a result of the 2019-2020 Florida law, Agency attempts to collect the data requested, and the federal evaluation of the retroactive eligibility change on individuals, hospitals and nursing homes. The report also includes information on improving outreach and Medicaid coverage among eligible non-pregnant adults.

Section I. Background

Purpose of Report

The 2019 Florida Legislature passed the General Appropriations Act Implementing Bill, Senate Bill 2502, which included Section 25:

> *In order to implement Specific Appropriations 203, 207, 208, 210, 212, and 221 of the 2019-2020 General Appropriations Act:*
>
> *(1) By January 10, 2020, the Agency for Health Care Administration, in consultation with the Department of Children and Families, the Florida Hospital Association, the Safety Net Hospital Alliance of Florida, the Florida Health Care Association, and LeadingAge Florida, shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the impact of the waiver of Medicaid retroactive eligibility on beneficiaries and providers. The report must include but is not limited to:*
>
> *(a) The total unduplicated number of nonpregnant adults who applied for Medicaid at a hospital site from February 1, 2019, through December 6, 2019; and, of those applicants, the number whose Medicaid applications were approved, the number whose Medicaid applications were denied, and the reasons for denial ranked by frequency.*
>
> *(b) The total unduplicated number of nonpregnant adults who applied for Medicaid at a nursing home site from February 1, 2019, through December 6, 2019; and, of those applicants, the number whose Medicaid applications were approved, the number whose Medicaid applications were denied, and the reasons for denial ranked by frequency.*
>
> *(c) The estimated impact of medical debt on people for whom a Medicaid application was not submitted in the same month when the individual became an inpatient of a hospital or resident of a nursing home.*
>
> *(d) Recommendations to improve outreach and Medicaid coverage for nonpregnant adults who would be eligible for Medicaid if they applied before an event that requires hospital or nursing home care.*
>
> *(2) The Agency for Health Care Administration shall also include, as part of the report required by this section, a copy of the evaluation design and performance metrics submitted to the federal Centers for Medicare and Medicaid Services relating to the waiver of Medicaid retroactive eligibility, in conformity with the Special Terms and Conditions of the state's Section 1115 demonstration project, titled Managed Medical Assistance (MMA) Program (Project No. 11-W-00206/4).*

During the 2020 Legislative Session, Senate Bill 52 has been filed, which would remove the July 1, 2020, expiration date following Subsection 12 (b) of Section 409.904, Florida Statutes. The bill would allow the Agency and Department of Children and Families (Department) to continue the current retroactive eligibility policy.

Section II. Florida's Medicaid Program

Medicaid and the Children's Health Insurance Program provide health coverage to 71 million individuals nationwide, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, in accordance with federal requirements in the Social Security Act. Each state operating a Medicaid program has a state plan, which serves as an agreement between the state and the federal government describing how that state administers its Medicaid program.

States and the federal government together fund Medicaid. As of October 2019, over 3.8 million Floridians were enrolled in the Medicaid program. Florida Medicaid had $25.9 billion in expenses for state fiscal year 2018-2019.

The Agency for Health Care Administration (Agency) is the single state Medicaid agency responsible for administering the Florida Medicaid program. Florida provides Medicaid services through competitively selected managed care organizations within the Statewide Medicaid Managed Care (SMMC) program or through the fee-for-service delivery system. Florida's fee-for-service delivery system is a direct billing program where providers receive reimbursement from Florida Medicaid directly through the Agency's claims adjudication system. Approximately 96% of Florida Medicaid recipients who are eligible for full benefits receive their Medicaid services through the SMMC program.

The SMMC program was fully implemented in 2014 and has three components: the Managed Medical Assistance program, the Long-Term Care program, and the Dental program. The Managed Medical Assistance program covers medical care services for health plan enrollees, including substance use disorders and mental health treatment services. The Long-Term Care program provides long-term care services and supports to eligible individuals with disabilities age 18-64 years old and elderly individuals age 65 years or older, including individuals over the age of 18 years with a diagnosis of cystic fibrosis, acquired immune deficiency syndrome, or a traumatic brain or spinal cord injury. The Dental program provides dental services to children and adult Medicaid recipients who are eligible to receive dental benefits. (Examples of recipients not eligible to receive dental benefits through the dental program include individuals for whom the state only pays Medicare cost sharing and individuals residing in institutions where Medicaid pays an all-inclusive rate.)

The Agency partners with other state agencies and entities for various administrative functions, including:

- The Department of Children and Families– determines Medicaid eligibility in Florida.
- The Agency for Persons with Disabilities – operates the Developmental Disabilities Individual Budgeting Waiver.
- The Department of Health – operates the Family Planning Waiver.
- The Department of Elder Affairs – determines clinical eligibility for the Statewide Medicaid Managed Care Long-Term Care program.
- The Aging and Disability Resource Centers –not-for-profit agencies that maintain the waitlist for the Statewide Medicaid Managed Care Long-Term Care program through contracts with the Department of Elder Affairs.

Medicaid Eligibility Determinations

In Florida, the Department of Children and Families (Department) determines Medicaid eligibility for:

- Parents and caretaker relatives of children
- Children (0-20 years of age)
- Pregnant women

- Individuals formerly in foster care (up to 26 years of age)
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

The Social Security Administration (SSA) determines eligibility for SSI recipients. The SSA automatically notifies the Department upon determining that an applicant is eligible for SSI. The SSI program assists disabled adults and children with limited income and resources. Florida residents eligible for SSI are automatically eligible for Medicaid coverage.

Medicaid Application Process

Florida residents can apply for Florida Medicaid eligibility online, by mail, by phone, and in person.

The Department's Automated Community Connection to Economic Self Sufficiency Florida Program (ACCESS) is the electronic application process used for Florida Medicaid and other forms of government assistance. The Department's website contains quick and easy links to determine eligibility, apply for benefits and check existing accounts. Information is available 24 hours a day, 7 days a week. Most applicants choose to apply online. Paper applications are also available on the Department's ACCESS Florida website if an applicant prefers to mail their application.

For applicants who prefer to apply in person, the Department has 53 storefront facilities where an individual can receive a paper application, apply in person, or acquire assistance. The Department also has 2,140 Community Partner Assisted Service sites and 446 Community Partner Self-Service sites to assist in the application process. These Partners are trained by the Department and serve as a point of contact for Medicaid applicants.

If an applicant would like to speak with an agent over the phone, the call center's number is located on the ACCESS website, and the website includes call center wait times. Agents are available Monday through Friday from 8:00 AM to 5:00 PM.

Another entry point for potentially eligible Floridians is through the Federally Facilitated Marketplace (FFM) via Healthcare.gov. The FFM sends information to the Department for applicants who appear to be Medicaid eligible. The Department processes the application based on the information provided. If additional information is required, the Department will contact the applicant and further assist in the application process.

According to 42 CFR § 435.907 and 65A-1.205(1) of the Florida Administrative Code, an application must include the individual's name, address, and signature to start the application process and establish the effective date for Medicaid. Florida may only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the Florida Medicaid State Plan. States are federally required to process applications within 45 days.

Presumptive Eligibility Process

Presumptive eligibility is an option that authorizes certain qualified Medicaid providers to make immediate Medicaid eligibility determinations and provide Medicaid services to individuals who are determined eligible based upon preliminary information. Presumptive eligibility is not available for seniors nor individuals with disabilities who may have long-term care needs (unless they also qualify as a child, parent/caretaker or a pregnant woman). The ability to receive a presumptive eligibility

determination immediately upon seeking treatment ensures that these recipients experience no delay in accessing subsidized medical services through the Medicaid program.

There are two groups of providers who can be qualified to make presumptive eligibility determinations. Qualified Designated Providers (such as County Health Departments, Regional Perinatal Intensive Care Centers, or other agencies approved by DCF) may make presumptive eligibility determinations only for pregnant women. Hospitals that elect to make presumptive eligibility determinations are called Qualified Hospital Providers. They may make presumptive eligibility determinations for infants and children under the age of 19 years old, children formerly in foster care, parents and other caretakers or relatives, and pregnant women. Qualified Hospital Providers must enter into an agreement with the Agency in order to make presumptive eligibility determinations. Currently, Florida has 52 Qualified Hospital Providers.

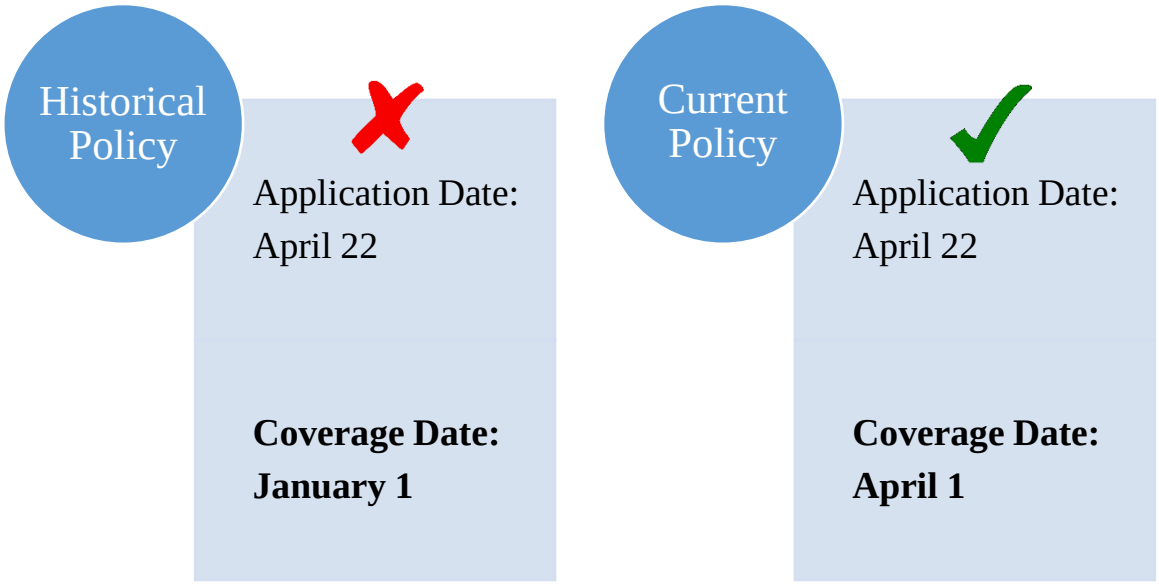
Retroactive Eligibility

The U.S. Code Title 42, Section 1396(a) directs state Medicaid programs to cover a Medicaid recipient's medical bills up to three months (90 days) prior to their application date. To qualify for retroactive coverage, a Medicaid recipient must request retroactive coverage and must have been eligible for coverage three months before the application date. Retroactive coverage is provided for services covered under Medicaid that were provided during that period.[1]

In 2018, the Florida Legislature directed the Agency to request federal approval to eliminate retroactive Medicaid coverage for non-pregnant adults. The Centers for Medicare and Medicaid Services approved the Agency's request to amend its 1115 waiver. The changes to retroactive eligibility took effect on February 1, 2019. The waiver eliminates retroactive Medicaid coverage for non-pregnant adults only, meaning payments for Medicaid-covered services begin the first day of the month in which an application was submitted rather than up to 90 days prior to the month in which an application was submitted. Eligible pregnant women, infants under the age of 1, and individuals under the age of 21 are not affected by this waiver and are still eligible for retroactive Medicaid coverage for up to 90 days prior to the month in which their application was submitted. Additionally, the application date for approved Supplemental Security Income (SSI) benefits is used to automatically establish Florida Medicaid, no matter how recent or old the date.

The illustration below displays the difference between the historical and current retroactive eligibility policy for non-pregnant adults.

[1] According to U.S. Code Title 42, Section 1396(a)(A)34, a state plan for medical assistance must: provide that in the case of any individual who has been determined eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished.



The change to retroactive eligibility policy enhances fiscal predictability, promotes continuity of care, and encourages individuals to apply for Florida Medicaid as soon as possible so they can be placed in a health plan to receive care coordination immediately upon approval of the Medicaid application. By promoting personal responsibility, residents are encouraged to secure and keep health coverage. Individuals should apply for Medicaid without hesitation to encourage continuity of eligibility and enrollment.

Table 1 represents the original and current estimates relating to expenditures incurred during the retroactive period. More than 70% of the services were provided through institutions such as hospitals, nursing homes and hospices.

Table 1: Expenditures for the Retroactive Period: Example Years SFY 2015-2016 and SFY 2017-2018

Data Period	Total Unduplicated Recipients (month 1-3)	Total Expenditures (months 1-3)	Total General Revenue Expenditures (months 1-3)
July 1, 2015 – June 30, 2016	19,625	$98,425,855	$38,082,585
July 1, 2017- June 30, 2018	11,466	$103,599,413	$39,761,455

Section III. Retroactive Eligibility: Hospital and Nursing Home Impacts

The Legislature directed that the Agency consult with the Department of Children and Families (Department), the Florida Hospital Association, the Safety Net Hospital Alliance of Florida, the Florida Health Care Association, and LeadingAge Florida on the impact of the changes in retroactive eligibility on hospitals and nursing facilities[2] and directed the Agency to report on the total unduplicated number of non-pregnant adults who applied for Medicaid at a hospital or nursing facility and, of those applicants, the number whose Medicaid applications were approved, the applications that were denied, and the reasons for the denial.

The Agency requested data from the Department regarding the number of applications that originated from a hospital or nursing facility, but the Department does not collect information on the submitting entity at the time of application.

In the absence of this information, the Agency explored general data elements, such as matching the Department's Medicaid application dates with the Agency's claims data for nursing facility or hospital services received prior to the application date. However, this analysis did not yield the desired information on the impact of retroactive eligibility.

Taking a different approach, the Agency asked providers that assisted patients in the completion of applications for information on the number they submitted. Florida Hospital Association, the Florida Health Care Association, the Safety Net Hospital Alliance of Florida, and LeadingAge informed the Agency that they do not track this type of data. Manual reviews of all patient records would be required to ascertain which patients had Medicaid applications submitted by nursing facilities and hospitals. The providers expressed concern regarding the burden of completing the manual reviews.

The Agency and the Department worked collaboratively to identify additional ways to collect and analyze data to address the impact of retroactive eligibility on hospitals and nursing facilities. The Department currently collects the Internet Protocol (IP) address for each Florida Medicaid application received through the ACCESS system. Each IP address is a string of numbers separated by periods that uniquely identifies each computer using the internet protocol to communicate over a shared network. These IP addresses collected through the ACCESS system can be compared to those from hospitals and nursing facilities, to tie a location to an application.

The Department and the Agency developed survey questions for stakeholder groups, requesting specific IP addresses to match with applications received. These questions were shared with each stakeholder group before asking for submission to the Agency. The Florida Hospital Association expressed security concerns with using hospital IP addresses for data analysis as IP addresses could be used to track and identify personal information and compromise the anonymity and security of the hospitals' information. Because of these concerns, IP addresses were not used to identify the source of applications.

[2] General Appropriations Act, Section (1)(a)(b)

Section IV. Estimated Impact of Medical Debt

The Legislature also directed that the Agency report the estimated impact of medical debt for individuals who submitted a Medicaid application in a different month from when they became an inpatient of a hospital or resident of a nursing home.

Neither the Agency nor the Department collects or maintains data relating to medical debt. The Department, however, allow applicants to indicate on their application whether they have outstanding medical bills at the time of their application. Data is available regarding the total number of applications in which applicants made this indication before and after the retroactive eligibility policy change took effect February 1, 2019. Table 2 shows that the quarterly percentage of applications that indicated outstanding medical bills decreased after the policy change took effect.

Table 2:
Medicaid Applications, Including Applications With Indication of Outstanding Medical Bills
July 2018 – June 2019

Applications	**2018 Quarter 3** July - Sept 2018	**2018 Quarter 4** Oct - Dec 2018	**2019 Quarter 1** Jan – Mar 2019	**2019 Quarter 2** Apr – Jun 2019
Approved Applications with Reported Medical Debt	42,955	38,379	33,820	24,588
Denied Applications with Reported Medical Debt	22,732	21,157	17,419	12,209
Duplicate, Withdrawn, or Other Applications with Reported Medical Debt	2,969	2,832	2,862	1,933
Total Applications with Reported Medical Debt	68,656	62,368	54,101	38,730
Total Applications	465,210	527,276	563,200	518,774
Percent of Applications with Reported Medical Debt	14.8%	11.8%	9.6%	7.5%

The Agency also contracted with the University of Florida (UF) to create a survey to collect key items of information in order to analyze the enrollment process changes and survey the impact of medical debt on Medicaid applicants and enrollees. The results of this survey will be part of the evaluation of retroactive eligibility, which is anticipated to be completed in Fall 2020.

The Agency researched other states' retroactive eligibility policies to compare Florida's system with states that have also implemented this change. Arizona provided a clear outline of the policy change with their waiver request to eliminate the retroactive eligibility period. As of April 1, 2019, Arizona Medicaid limits retroactive coverage to the first day of the month of application. Arizona listed three objectives for the amended retroactive eligibility policy, which align with Florida Medicaid goals:

1. Encourage members to obtain and continuously maintain health coverage, even when healthy;
2. Encourage members to apply for Medicaid without delays to promote continuity of eligibility and enrollment for improved health status; and
3. Contain Medicaid costs.

Iowa's retroactive policy was effective October 26, 2017. The amendment includes a waiver of the three-month retroactive eligibility period, which applies to all Iowa Medicaid beneficiaries, except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy) and infants under one year of age. Beneficiaries continue to receive Medicaid coverage effective the first day of the month in which their Medicaid application was filed, or as otherwise allowed by the state plan.

Section V. Evaluation Design and Performance Metrics

As part of the report, the Legislature requested that the Agency include a copy of the evaluation design and performance metrics submitted to the federal Centers for Medicare and Medicaid Services (CMS) relating to the 1115 waiver of Medicaid retroactive eligibility. The evaluation design was submitted to CMS on July 24, 2019, and the Agency is awaiting formal approval. CMS is working with states to standardize evaluation methodologies for waivers of retroactive eligibility so that it can better assess the impacts of this policy. To this end, CMS provided detailed evaluation design guidance to be used as a basis for discussions with the evaluators. Florida has used this guidance in its proposed evaluation design.

The Agency must submit a revised draft Evaluation Design within 60 days after receipt of any additional edits from CMS. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to the Florida MMA 1115 waiver Special Terms and Conditions. The Agency will publish the approved Evaluation Design within 30 days of CMS approval.

A full evaluation of the MMA program is due to CMS no later than January 1, 2022. The Agency's contracted evaluation vendor is completing portions of the evaluation over the next year. The portion that assesses the impact of the waiver of retroactive eligibility on Medicaid recipients and providers is anticipated to be completed in Fall 2020.

**See Appendix for the submitted Evaluation Design and Performance Metrics for Section (2) of the report.*

Section VI. Stakeholder Feedback: Improving Outreach and Medicaid Coverage

The Legislature further directed the Agency to collaborate with the Department and certain organizations to provide recommendations for improved outreach and Medicaid coverage for non-pregnant, eligible adults if they applied before an event that requires hospital or nursing home care.

Members of the Florida Hospital Association, Safety Net Hospital Alliance of Florida, LeadingAge Florida, and Florida Health Care Association were tasked with completing an online survey exploring how the policy change has affected hospitals and nursing facilities assisting patients enrolled in Medicaid. Additionally, the survey sought recommendations for improving outreach.

The survey was sent to hospitals and nursing facilities. The survey relied on self-reported data from key informants. As such, responses were subjective and reflect the opinions of the respondents and not necessarily the organizations that employ them. Due to time constraints for survey response and completion, the Agency was unable to incorporate a summary of the results into this report. The results are currently being aggregated and reviewed for utility.

Outreach Opportunities and Best Practices

Following approval of the waiver, the Agency performed outreach activities to the general public and Medicaid providers to raise awareness of the change to the retroactive eligibility policy. The activities included the following:

- Electronic provider alerts
- Developing and posting a page on the Agency's website dedicated to retroactive eligibility[3]
- Communication by email blasts to providers
- Phone conversations and in-person discussions with associations representing hospitals and nursing facilities
- Provided relevant information to Agency call centers in order to assist in alerting the public about the changes to retroactive eligibility.

The Department developed an internal spotlight communication available to both internal Department staff and interested external parties. The Department also engaged community partners with information sharing on the changes to retroactive eligibility.

In addition to this specific outreach on the change to retroactive eligibility policy, the Department and the Agency provide an array of outreach to raise awareness of all of the assistance programs offered and how to apply. Through the different educational programs and community networks, the Department provides awareness to a diverse population.

The Department has several Supplemental Nutrition Assistance Programs (SNAP) that include educational and outreach components to increase customers' ability to access SNAP program information. If a person applies for SNAP, they can also use the same application process to apply for Medicaid.

The Department uses its network of Community Partner Liaisons (CPL) to engage in different pathways for outreach and increased awareness of resources customers can access, including but not limited to the

[3] Retroactive Eligibility Agency web page: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/eligibility/retro_elig.shtml

Medicaid program. Community Partner Liaisons distribute Economic Self-Sufficiency (ESS) materials, conduct ESS presentations, and work directly with community members while networking with appropriate community organizations. The CPL's also assist in community outreach and health fair activities. The CPL's attend up to 80 community fair events a year, per region.

The Department has made extensive use of social media tools, press releases and website alerts as pathways to increase outreach and engagement to customers accessing benefits.

The Agency has had success with the different forms of outreach through its contract with the Florida Healthy Kids Corporation. The Florida Healthy Kids Corporation is tasked in statute with promoting Kidcare, the State of Florida's high-quality, low-cost health insurance for children, from birth through age 18. This includes three types of health insurance coverage for children: Medicaid for children, the subsidized Children's Health Insurance Program, and state-sponsored child coverage whose cost is fully paid by the child's family. Although Florida Kidcare is primarily concerned with a different population than the focus of this report, the program has demonstrated multiple successful marketing strategies for targeted outreach to a traditionally difficult-to-contact population. When an individual applies for Kidcare for a child, they can also apply for coverage for adult Medicaid. Research has shown that outreach and marketing for CHIP also increases enrollment in Medicaid, and vice versa, since the application process can be initiated through either program.

Florida Healthy Kids utilizes a broad network of community partners providing 'boots on the ground' and a trusted, one-on-one avenue for application. Healthy Kids has routinely employed newsletters, community events, text alerts, online alerts, and infographics, for the purpose of communicating targeted Medicaid information to a variety of audiences, including partnering with area non-profits and hospitals.

Additionally, digital and social media advertising expands awareness, generates applications and supports enrollment growth. Benefit-specific messaging differentiates Florida Kidcare plans from private market offerings, while encouraging utilization and retention. Between October 2018 and June 2019, paid search advertising generated 15,575 completed applications. During October of 2018, a mental health awareness social media advertising campaign was launched on Facebook and Instagram to highlight the mental and behavioral health benefits available through Florida KidCare. This one-month campaign reached 670,799 Florida parents, and total of 141 new accounts were created.

Social media advertising has provided consistent outreach and can be a useful tool to use for outreach efforts in additional programs. A pilot paid advertising campaign leveraging a new online eligibility calculator ran in June of 2019 on Facebook, Instagram, and Programmatic Display. The campaign generated 2,519,787 total impressions and 559 new accounts.

Conclusion

The Agency and the Department made multiple attempts to obtain the data requested in Section (1) (a) and (1) (b) of Section 25 of the 2019-2020 General Appropriations Act Implementing Bill. The Department's ACCESS system does not collect information on the source of Medicaid applications. The Agency asked hospitals and nursing facilities to provide information on applications they submitted on behalf of patients, but they reported that they would have to manually review patient files to compile this information. The agencies explored the possibility of collecting IP addresses through the ACCESS system to comply with the data request, however, Florida Hospital Association identified data security concerns with this approach. The Agency was able to determine that, for applications that indicated the individual had outstanding medical bills, the average percentage of denied applications declined after the retroactive eligibility change.

CMS is working with states to standardize evaluation methodologies for waivers of retroactive eligibility so that it can better assess the impacts of this policy. To this end, CMS provided detailed evaluation design guidance to be used as a basis for discussions with the evaluators. Florida has used this guidance in its proposed evaluation design. The Agency has contracted with the University of Florida to evaluate the Florida Medicaid 1115 waiver, including a segment on the change to retroactive eligibility policy. The evaluation of retroactive eligibility policy, including its impact on medical debt, is anticipated to be completed in Fall 2020.

Appendix

Evaluation Design

The following evaluation design was submitted to Centers for Medicare and Medicaid Services (CMS) on July 24, 2019. The Agency is awaiting formal approval from CMS.

The below research questions are for component nine of the waiver evaluation design. This component will be addressed beginning in January 2020, when the first year of data reflective of the waiver of retroactive eligibility become available. Research questions, outcome measures, sample populations, data sources, and analytic methods are detailed below.

Table 3: Retroactive Eligibility Waiver Research Design

Research Question	Outcome Measures	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
9A. How will eliminating or reducing retroactive eligibility change enrollment continuity?	-Enrollment duration in months for Medicaid cohorts both before and after the policy change -Qualitative information on how hospitals and nursing facilities have changed their enrollment procedures following or in anticipation of the policy change	-Enrollment duration for (1) Medicaid enrollee cohort as of January 2019 (last month prior to policy change) and (2) Medicaid enrollee cohort as of last month available after the policy change	-Medicaid eligibility and enrollment data -Qualitative results of surveys/interviews of hospital and nursing facility administrators	-Pre-post duration models of enrollment length (e.g., Cox proportional hazards model or accelerated failure time model) -Qualitative methods (open-ended surveys and/or key informant interviews)
9B. How will eliminating or reducing retroactive eligibility change the enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility?	-Clinical Risk Groups (CRGs) (Averill et al., 1999; Hughes et al., 2004), a widely-used measure of health status calculated from claims and encounter data	-New Medicaid enrollees	-Medicaid encounter data for new enrollees completing their first year of enrollment both before and after the policy change	-Difference-in-differences testing (if possible) or pre-post statistical models of the distribution of new Medicaid enrollees across the five major CRG categories both before and after the policy change -The evaluation team will also explore administering the SF-12 tool using a telephone survey of new enrollees following the policy change to measure health status. Comparing health status as measured by the CRGs to health status as measured by the SF-12 will help validate the broader

				application of the CRGs in RQ 9B
9C. How will eliminating or reducing retroactive eligibility affect new enrollee financial burden?	-Hospital utilization and charges with self-pay payor status from the three-months prior to Medicaid application date both before and after the policy change	-New Medicaid enrollees	-Linked (1) statewide Florida Health Information and Transparency (FHIT) Center hospital inpatient, outpatient, ambulatory, and ED utilization data, (2) Medicaid new enrollee encounter data both before and after the policy change for the three months prior to Medicaid application date	-Pre-post testing of self-pay utilization and charges in the three-months prior to Medicaid application using linked encounter data both before and after the policy change. In particular, self-pay charges will measure the amount of health care charges previously covered by Medicaid under retroactive eligibility that will now fall to the self-pay patient and/or provider uncompensated care. The evaluation team will also examine Medicaid FFS and Medicaid MMA payor classes
Note: Results from 9C will determine whether 9D through 9F are applicable.				
9D. How will eliminating or reducing retroactive eligibility affect provider uncompensated care amounts?	-Hospital and SNF Uncompensated Care Expenditures -Hospital and SNF net income and rates of return -Hospital net change impact of UCC: UCC – LIP payments Hospital and SNF Uncompensated Care Expenditures -Hospital and SNF net income and rates of return -Hospital net change impact of UCC: UCC – LIP payments	-Florida hospital and SNFs serving Medicaid enrollees Florida hospital and SNFs serving Medicaid enrollees	-Florida Hospital Uniform Reporting System (FHURS) -CMS Medicare Hospital and SNF Cost Reports -Florida Low Income Pool expenditure reports	-Difference-in-Differences models (if possible) or pre-post statistical models examining uncompensated care amounts, net income/rates of return, and uncompensated care net of LIP payments
9E. How will eliminating or reducing retroactive eligibility affect provider financial performance (income after expenses)?				
9F. How will eliminating or reducing retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?				