Florida Medicaid

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The Medicaid Program: Authority and Federal Requirements

- Authorized under Title XIX of the Social Security Act (1965)
- Entitlement Program
  - State cannot limit eligibility (cap enrollment)
- Funded jointly by the Federal government and the States
- Administered by the States

The Medicaid Program: Authority and Federal Requirements

- Federal Medicaid regulations mandate certain benefits for certain populations.
  - Mandatory eligibility groups and services must be covered.
- Medicaid programs vary considerably from state to state, and within states over time.
- State Medicaid programs vary because of differences in:
  - optional service coverages.
  - limits on mandatory and optional services.
  - optional eligibility groups.
  - income and asset limits on eligibility.
  - provider reimbursement levels.

The Medicaid Program: Authority and Federal Requirements

- States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS).
- Services must be available statewide in the same amount, duration and scope
- State must operate its Medicaid program in accordance of the State Plan:
  - This means that CMS will only provide federal match for services rendered to covered individuals in accordance with the State Plan.
  - Services approved under the State Plan are eligible for the Federal medical assistance percentage rate.

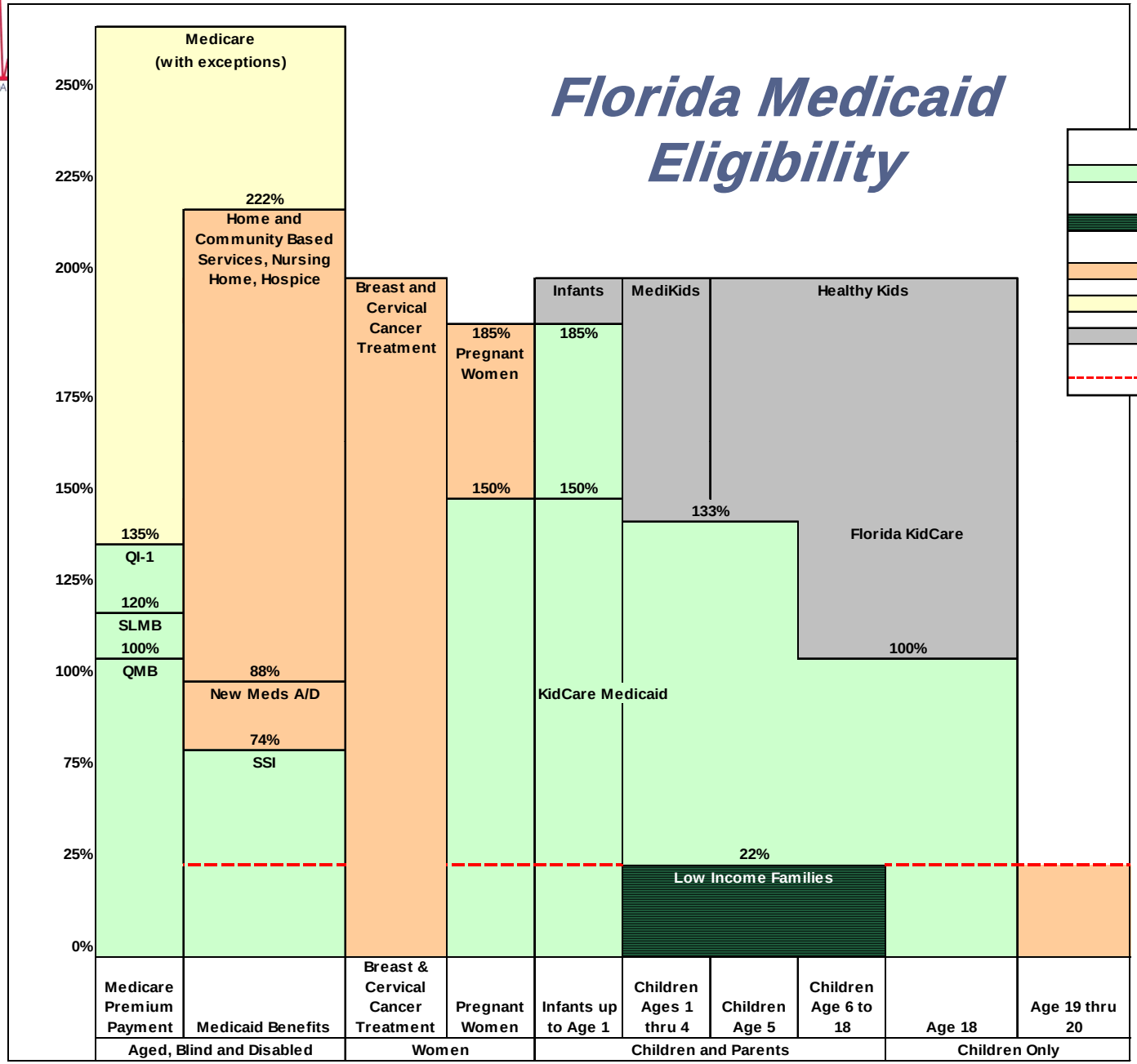
The Medicaid Program: Authority and Federal Requirements

- State Plan must:
  - designate a single State Medicaid agency
  - establish eligibility standards
  - determine benefits and services
  - set payment rates

Who Is Eligible?

- Medicaid eligibility is determined by:
  - Categorical groups, i.e., pregnant women; families and children; and aged, blind, and disabled individuals.
  - Income.
  - Assets.
  - Citizenship.
  - Residency.
  - Cooperation with Child Support Enforcement (when one or both parents are absent from the home).
  - Medical need for institutional services, such as persons in nursing facilities.
  - Level of medical bills (for Medically Needy).

Florida Medicaid Eligibility



Mandatory Medicaid coverage (entitlement).

Mandatory Medicaid coverage for low-income families using 1996 AFDC income standard (entitlement).

Optional Medicaid coverage (entitlement).

Federal Medicare coverage (entitlement).

Optional child insurance coverage (non-entitlement).

Optional Medically Needy income spend down level (entitlement).

Family Size	**Monthly Income
1	$903
2	$1,214
3	$1,526
4	$1,838
5	$2,149
6	$2,461
7	$2,773
8	$3,084
Each Additional	$312

*Coverage for infants up to 185% Federal Poverty Level is required in order for states to receive Title XXI funding.

**Federal Poverty Level as of January 2009

Mandatory Eligibility Groups

- If a state chooses to participate in the Federal Medicaid program, certain groups must be covered
- Major groups that are mandatory for coverage under a state's Medicaid program include:
  - Low income families with children (TANF)
  - Supplemental Security Income (SSI) recipients
  - Certain people on Medicare

Mandatory Eligibility Groups Expenditures: FY 2010-11 November 2009 SSEC

- The TANF and SSI population make up a majority of Florida's recipients and account for a majority of the $18 billion expenditures under the program.

	Total Budget	Avg Monthly Caseload
Supplemental Security Income (SSI)	$10,566,671,971	604,879
Temporary Assistance for Needy Families (TANF)	$2,816,733,438	866,629
Sub - Total	$13,383,405,409	1,471,508

Note: This does not represent all mandatory groups, but is provided as an example.

Florida Medicaid: Optional Eligibility Groups

- The Florida Medicaid program includes the following optional eligibility groups:
  - Medically Needy
  - Breast and Cervical Cancer
  - SOBRA Pregnant women (150-185% FPL)
  - Children under 1 (150-185% FPL)
  - Children under 1 - Medicaid Expansion under title XXI (185-200% FPL)
  - Children 19 and 20 year olds
  - MEDS-AD (Authorized under 1115 waiver)
  - Family Planning Waiver (Authorized under 1115 waiver)

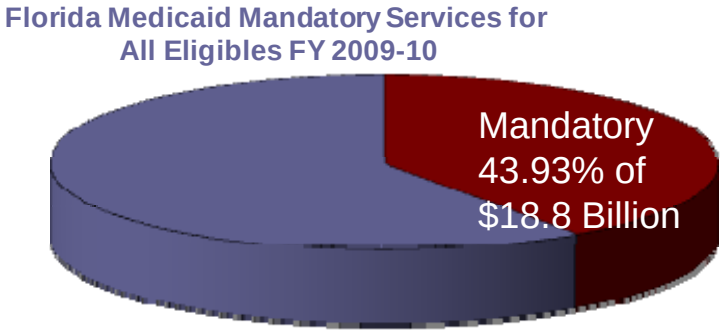
Florida Medicaid Optional Eligibility Groups Expenditures: FY 2010-11 November 2009 SSEC

	Total Budget	Avg Monthly Caseload
Medically Needy	$595,619,503	22,271
MEDS AD Waiver	$300,848,971	16,012
SOBRA Pregnant Women 150-185% FPL	$63,496,225	6,245
Children Under 1 (150-185% FPL)	$61,221,277	28,174
Medicaid Expansion Under Title XXI (Children Under 1 (185-200% FPL)	$3,602,636	844
Family Planning Waiver	$9,776,757	59,398
19 and 20 year olds	$28,978,000	10,345
Breast and Cervical Cancer	$9,206,584	490
TOTAL	**$1,072,749,963**	

Note: Budget amount provided for the Medically Needy and MEDS AD program assume that the programs are reduced (Medically Needy) or eliminated (MED AD) as per current statute.

Florida Medicaid Mandatory Services

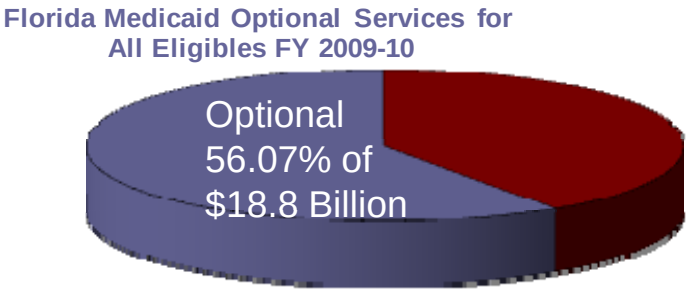
- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Skilled Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy Services
- Rural Health/ FQHC
- Therapeutic Services for Children
- Transportation



Florida Medicaid Optional Services*

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Facility Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management

*States are required to provide any medically necessary care required by child eligibles.



Florida Medicaid Optional Services

- Total projected expenditures for Optional services for SFY 09-10 is $10,532,399,436.
- Some optional services that have large expenditures for Florida are:

Optional Service	FY 2009-10 Estimated Expenditure (Nov 2009 SSEC)
Prescribed Medicine	$1,141,093,849
Home & Community Based Services	$1,007,396,736
Intermediate Care Facility/ DD	$346,149,572
Nursing Home Diversion Waiver	$338,177,730
Durable Medical Equipment	$91,338,452

- Would eliminating optional services really save the state?
  - Potential cost shift to mandatory services

What is a Medicaid Waiver?

- In order for states to implement programs which deviate from their State Plan (to vary by geographic areas, amount, duration and scope), the state must request a waiver.
- A waiver is a program requested by a state and approved by the Centers for Medicare and Medicaid Services (CMS) that waives certain provisions of the Social Security Act.
- The type of waiver requested indicates which provisions of the Social Security Act are waived.
- Waiver types:
  - 1115 Research and Demonstration Waiver
  - 1915(b) Freedom of Choice Waivers;
  - 1915(c) Home and Community-Based Services Waivers; and
  - 1915(b)/(c) Combination Waivers

1915 (b) Waivers

- Freedom of Choice

  Purpose: Allow state Medicaid programs to waive the requirement that "any willing qualified provider" can enroll and provide Medicaid reimbursable services. This is often done to improve continuity of care and ensure cost-savings.

  Provisions waived: Any section of 1902 of the Social Security Act depending on the design of the waiver request. A waiver request can include any or all of these components:

  1915(b)(1): Managed Care

  1915(b)(2): Locality Acting as a Broker

  1915(b)(3): Additional Services from Cost Savings

  1915(b)(4): Selective Contracting Waiver

- Florida has five approved 1915 (b) waivers.

Florida's 1915(b) Managed Care Waiver

- Sections Waived:
  - 1902(a)(1) Statewideness (not all programs statewide);
  - 1902(a)(19)(B) Comparability (includes services not covered by State Plan);
  - 1902(a)(23) Restrict choice of providers;
  - 1902(a)(4) Mandates recipients into program & restrict disenrollment in managed care plans.

Enrollment and Eligibility Under Florida's 1915(b) Managed Care Waiver

- Florida's 1915(b) Managed Care Waiver (non-reform) provides the State with the authority to mandatorily assign eligible beneficiaries and, within specific areas of the state, limit choice to approved providers.
- Under Federal requirements, Medicaid recipients must have a choice of providers. Under Florida's 1915(b) Managed Care waiver, a recipient must have choice, either between two or more managed care plans, or between one available managed care plan and MediPass.

Enrollment and Eligibility Under Florida's 1915(b) Managed Care Waiver

- Some beneficiaries are *required* to enroll with a managed care provider, some have the *option* of enrolling with a managed care provider and some are *prohibited* from enrolling with a managed care provider. These beneficiaries can be referred to as "mandatory", "voluntary", or "excluded" from managed care enrollment.
- Managed Care Plans are defined in s. 409.9122, Florida Statutes, as health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs.

1115 Research and Demonstration Waivers

- Experimental, Pilot or Demonstration Projects:
  - Benefit Packages, Reimbursement Methodologies, Covering Expanded Groups.
  - States Commit to a Policy Experiment that must be formally evaluated.
- 1115(a)(1) allows the Secretary of Health and Human Services to waive compliance with most of the requirements in the Medicaid and SCHIP State Plans.
- 1115(a)(2) allows the Secretary to regard as expenditures costs that would not otherwise be matchable under Medicaid or SCHIP.
- There is no statutory requirement regarding the length of time that CMS must review and provide a State with a decision.
- If granted, the initial approval period is a 5 years and the State may request two 3 year extensions of the program.

1115 Research and Demonstration Waivers

- This is the most comprehensive waiver authority and the Secretary of Health and Human Services has broad authority in granting these waivers, but there are limitations.
- Statutory Limitations:
  - All medically necessary service to Pregnant Women and Children under 19 must be provided
  - Drug Rebate Provisions
  - FMAP Rate
  - Cost Sharing
  - SCHIP Allotments
- Policy Limitations
  - Budget Neutrality

Florida's 1115 Medicaid Reform Waiver

- Allows Florida Medicaid to conduct a Pilot requiring managed care plan enrollment for most Medicaid eligibles in certain areas of the state.
- Provides authority to enroll additional populations not included under the 1915(b) Managed Care Waiver:
  - Children with Chronic Conditions
  - Children in Foster Care
  - SOBRA Pregnant women
  - Individuals with Medicare coverage

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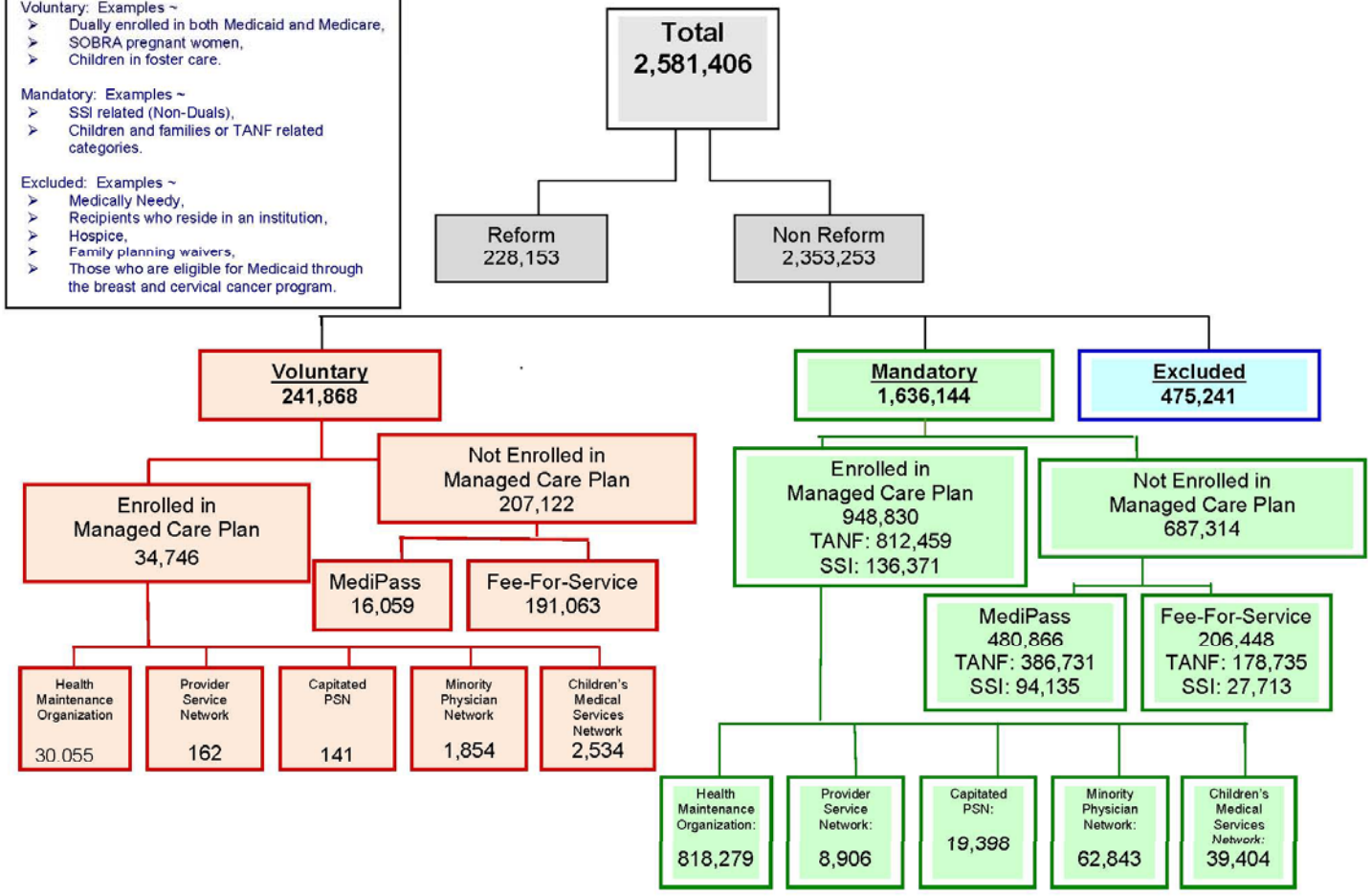
Statewide Medicaid Enrollment ~ Monthly Enrollment as of September 1, 2009
Managed Care Plan vs. MediPass and Fee-For-Service Enrollment

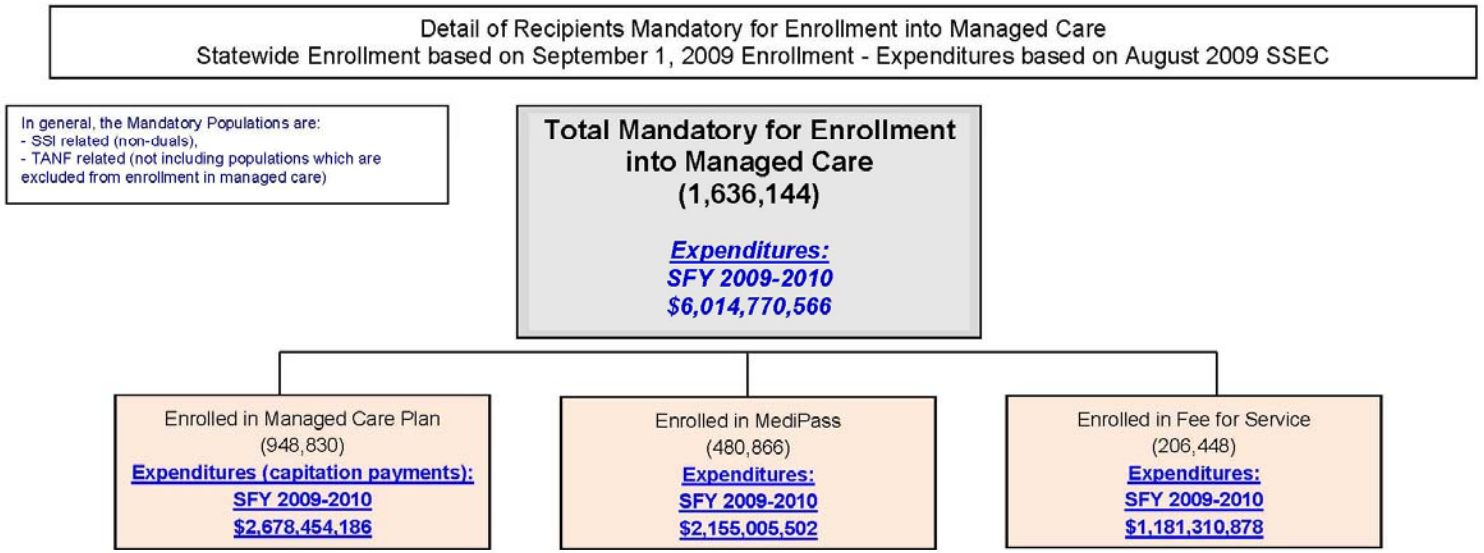
Managed Care Enrollment:

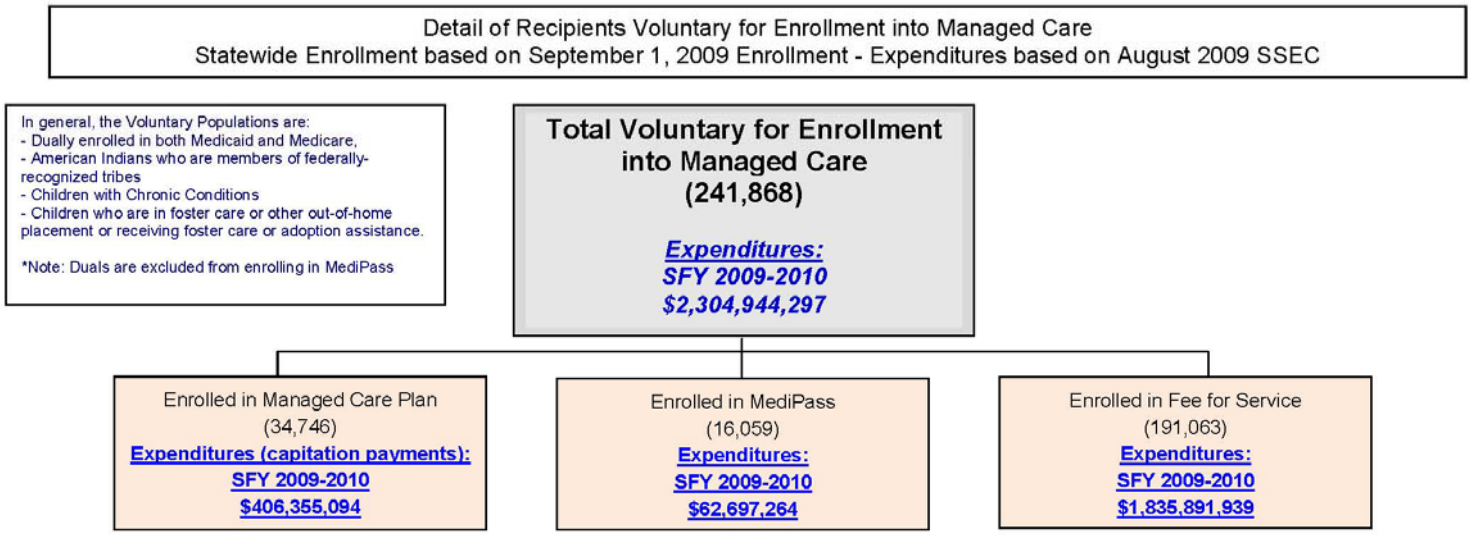
Voluntary: Examples ~
- Dually enrolled in both Medicaid and Medicare,
- SOBRA pregnant women,
- Children in foster care.

Mandatory: Examples ~
- SSI related (Non-Duals),
- Children and families or TANF related categories.

Excluded: Examples ~
- Medically Needy,
- Recipients who reside in an institution,
- Hospice,
- Family planning waivers,
- Those who are eligible for Medicaid through the breast and cervical cancer program.




Detail of Recipients Mandatory for Enrollment into Managed Care
Statewide Enrollment based on September 1, 2009 Enrollment - Expenditures based on August 2009 SSEC
In general, the Mandatory Populations are:
- SSI related (non-duals),
- TANF related (not including populations which are excluded from enrollment in managed care)
Total Mandatory for Enrollment into Managed Care
(1,636,144)
Expenditures:
SFY 2009-2010
$6,014,770,566
Enrolled in Managed Care Plan
(948,830)
Expenditures (capitation payments):
SFY 2009-2010
$2,678,454,186
Enrolled in MediPass
(480,866)
Expenditures:
SFY 2009-2010
$2,155,005,502
Enrolled in Fee for Service
(206,448)
Expenditures:
SFY 2009-2010
$1,181,310,878


Detail of Recipients Voluntary for Enrollment into Managed Care
Statewide Enrollment based on September 1, 2009 Enrollment - Expenditures based on August 2009 SSEC
In general, the Voluntary Populations are:
- Dually enrolled in both Medicaid and Medicare,
- American Indians who are members of federally-recognized tribes
- Children with Chronic Conditions
- Children who are in foster care or other out-of-home placement or receiving foster care or adoption assistance.
*Note: Duals are excluded from enrolling in MediPass
Total Voluntary for Enrollment into Managed Care
(241,868)
Expenditures:
SFY 2009-2010
$2,304,944,297
Enrolled in Managed Care Plan
(34,746)
Expenditures (capitation payments):
SFY 2009-2010
$406,355,094
Enrolled in MediPass
(16,059)
Expenditures:
SFY 2009-2010
$62,697,264
Enrolled in Fee for Service
(191,063)
Expenditures:
SFY 2009-2010
$1,835,891,939

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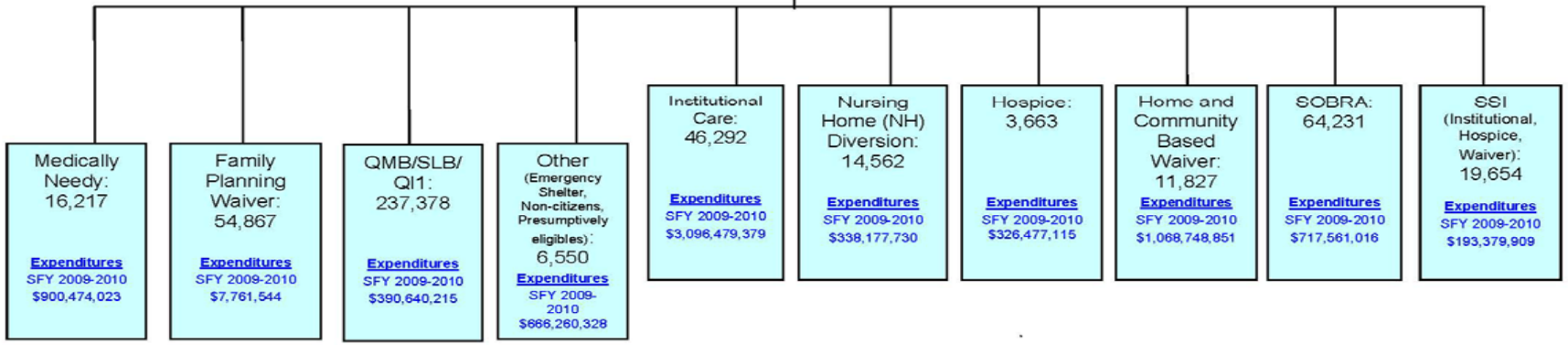
Detail of Recipients Excluded from Florida Medicaid Managed Care
Statewide Enrollment Based on September 1, 2009 Monthly Enrollment - Expenditures based on August 2009 SSEC

Total Excluded From Florida Medicaid Managed Care
(475,241 in FFS)
Expenditures:
SFY 2009-2010: $7,705,960,110



1915 (c) Waivers

- Home and Community Based Services
  - Purpose: Allow state Medicaid programs to cover services traditionally viewed as "long-term care" and provide them in a community setting to individuals that would otherwise require nursing home or ICF/DD care.
  - Provisions waived:
    - Comparability: 1915(c) waiver services may be limited to a targeted group of individuals (e.g., elderly or disabled adults).
    - State-wideness: 1915(c) waiver services may be limited to particular geographic areas (e.g., county, region).
- Florida has fifteen 1915 (c) Home and Community Based waivers.

Medicaid Home and Community Based Services: Long-Term Care Programs for Elderly and Physically Disabled Individuals

- Adult Day Health Care
- Aged and Disabled Adult
- Alzheimer's Disease
- Assistive Care Services
- Assisted Living for the Elderly
- Channeling
- Developmental Disabilities (includes the Family and Support Living Waiver and Tiers 1, 2, and 3 of the Developmental Disabilities Waiver)
- Nursing Home Diversion Program
- Project AIDS Care
- Traumatic Brain and Spinal Cord Injury
- Adult Cystic Fibrosis
- Model waiver (Kati Becket)
- Familial Dysautonomia (Riley-Day)

Long Term Care Potential Cost Efficiencies

- Consolidate Home and Community Based Waivers.
- Reduce nursing home bed hold days from 8 days to 7 days per hospital admission.
- Strengthen utilization management for the remaining home and community-based waiver programs.
- Transition to a more appropriate reimbursement methodology for all long term care programs based on resident acuity and needs.

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