



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

November 21, 2012

Ms. Vickie Wachino, Director  
Division of State Demonstrations & Waivers  
Center for Medicaid & CHIP Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, MD 21244-1850

Dear Ms. Wachino:

Enclosed for your review is a proposal for a new section 1115 Research and Demonstration Waiver to implement provisions of Florida law enacted in 2011 related to the Medically Needy program. The proposed Demonstration seeks to improve the effectiveness of the Medically Needy program by providing access for this population to an integrated service delivery system of health care and improving continuity of care delivery in the most efficient and effective setting.

The state is seeking a waiver of specified provisions of the Social Security Act (SSA) in order to provide for costs not otherwise matchable for continuous eligibility for up to twelve months for individuals who become eligible for Medicaid through the Medically Needy program. The state would further request waiver of applicable provisions of the SSA in order to have managed care organizations collect a premium, not to exceed the SOC amount. In addition, waiver of the following sections of the Social Security Act is requested in accordance with section 1115 of the Social Security Act:

1. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the State to impose a premium.
2. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).
3. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

Under this proposed demonstration, the criteria for initial eligibility would not be more restrictive than the current Florida Medicaid State Plan criteria, and persons eligible through the Medically Needy program would receive additional months of eligibility, regardless of whether their incurred bills exceed their SOC amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full twelve additional months of coverage; however, enrollees would receive a grace period of 90-days of coverage before being disenrolled for non-payment.



The proposed program is shown to be budget neutral to the federal government as compared to a program that could be implemented under the State Plan. "Without waiver" projections are made using both the current program population and eligibility extensions that could be made under the State Plan (up to six months for adults and up to twelve months for children). The "with waiver" projection shows that moving these populations to managed care and implementing the enrollee premium generates enough savings to cover the remaining six months of eligibility for adults.

In addition, waiver of the following sections of the Social Security Act is requested in accordance with section 1115 of the Social Security Act.

4. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the State to impose a premium.
5. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).
6. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

We appreciate your consideration of this request. Please contact me at (850) 412-4007 with any questions.

Sincerely,

  
Justin M. Senior  
Deputy Secretary for Medicaid

JMS/md

Enclosures

cc: Allison Orris, CMS/CO  
Paul Boben, CMS/RO  
Rob Nelb, CMS/RO

# **1115 Research and Demonstration Waiver Application**

## **Florida's Medically Needy Program**

**Submitted November 21, 2012**



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# **I. Purpose, Goals and Objectives**

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## **A. Statement of Purpose**

The State of Florida is requesting a new section 1115 Research and Demonstration Waiver to implement provisions of Florida law enacted in 2011 related to the Medically Needy program. The Agency is seeking a waiver of specified provisions of the Social Security Act (SSA) in order to provide for costs not otherwise matchable for continuous eligibility for up to 12 months for individuals who become eligible for Medicaid through the Medically Needy program. The Agency would further request waiver of applicable provisions of the SSA in order to collect a premium in lieu of share of cost (SOC), not to exceed the SOC amount. Under this proposed demonstration, the criteria for initial eligibility would not be more restrictive than the current Florida Medicaid State Plan criteria, and persons eligible through the Medically Needy program would receive additional months of eligibility, regardless of whether their incurred bills exceeded their SOC amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full 12 additional months of coverage; however, enrollees would receive a grace period of 90-days of coverage before being disenrolled for non-payment.

## **B. Current Medically Needy Program**

The Medically Needy program is currently authorized by the Florida Medicaid State Plan for persons who would otherwise be eligible except that their family income or assets exceeds the Florida Medicaid State Plan threshold for Medicaid eligibility. Currently, in the event that subtracting the amount of allowable medical expenses incurred by these individuals from their monthly income would cause the remainder to fall below the Medically Needy Income Level (MNIL), these individuals become eligible for Medicaid. The MNIL is currently based on the amount of maximum monthly cash benefit paid to recipients of Temporary Assistance for Needy Families (TANF)<sup>1</sup>.

For TANF eligible assistance groups, all persons in the assistance group become eligible for Medicaid on the date that incurred medical expenses would cause the assistance group income to fall below the MNIL. For SSI-related individuals and spouses, the eligible individual or eligible couple become eligible when the incurred medical expenses cause the countable income to fall below the MNIL. For purposes of this document “Medically Needy recipient” will be used to describe individuals, eligible assistance groups and SSI related individuals and spouses who have become eligible through the Medically Needy program.

Eligibility is restricted to individuals or families with limited assets, such as savings or property (other than a residence). Under this proposed concept, the current income levels and asset limits would not change. The current Medically Needy Income Limits and Resource Limits are shown in Table 1.

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<sup>1</sup> The TANF limit is the same as the AID to Families with Dependent Children (AFDC) income limit in effect as of July 12, 1996

<b>Table 1</b> <b>Medically Needy Income Limits and Resource Limits by Family Size</b>		
<b>Family Size</b>	<b>Medically Needy Income Level (Monthly)</b>	<b>Resource Limits</b>
1	\$180	\$5,000
2	\$241	\$6,000
3	\$303	\$6,000
4	\$364	\$6,500
5	\$426	\$7,000
Additional persons	Increases by \$61 or \$62 per person	Increases by \$500 per person

The difference between the family's income and the MNIL is called the SOC. Currently, when the assistance group incurs medical expenses sufficient to reduce available income below the MNIL for that month, the Medically Needy recipient(s) in the assistance group meet the SOC and are eligible from the day the SOC is met through the end of that month only. Medical expenses incurred before the day that SOC is met are not paid by Medicaid and remain the responsibility of the assistance group. On the date the SOC is met through incurred medical expenses, the Medically Needy individuals in the assistance group become eligible for fee-for-service (FFS) Medicaid for the balance of the month and medically necessary expenses are reimbursed by Medicaid.

The Medically Needy program covers all medical services covered by Florida Medicaid except for long-term care (skilled nursing facility care, services in an Intermediate Care Facility for the Developmentally Disabled and services under a home and community-based waiver). Eligibility for the Medically Needy program is determined by the Florida Department of Children and Families (DCF) and payment for provision of covered services is administered by the Agency for Health Care Administration (Agency), the state's designated single state agency under Title XIX.

The Medically Needy program was implemented in Florida in 1986 and since that time the Florida Legislature has considered a myriad of changes to coverage of this optional population. Although full coverage for all Medicaid services (except long-term care) for eligible recipients has continued through the present, changes to limit the types of services, covered groups and even elimination of the program have been considered (see the following "State Law" section for specific provisions passed by the Florida Legislature during the 2011 session).

Currently, the Medically Needy program serves an average of 48,158 individuals during any month, and provides services for at least one month to more than 250,000 individuals annually. Total expenditures for Medicaid services reimbursed for the program for State Fiscal Year (SFY) 2010-11 were \$808.6 million, and costs for the program for SFY 2011-12 are estimated to be \$938.6 million.

### **C. State Law**

Prior to the 2011 legislative session, section (s.) 409.904(2)(a), Florida Statutes (F.S.), authorized the Medically Needy program with an ending date for non-pregnant adults of June 30, 2011. During the 2011 legislative session, the Legislature considered several alternative approaches to the Medically Needy program. In the bills (House Bills 7107 and 7109) that were enacted, the Legislature continued the Medically Needy program and directed the Agency to seek federal waiver authority to change the program to provide additional months of coverage,

to implement a premium that would not exceed the SOC and to provide care coordination and utilization management to achieve more cost-effective services.

Specifically, 2011 House Bill 7107 made significant changes to the Medically Needy program. The specific Medically Needy statutory provisions are as follows:

- Section 409.972(1), Florida Statutes (F.S.), provides that persons eligible for the program known as “Medically Needy” pursuant to s. 409.904(2), F.S., shall enroll in managed care plans. Medically Needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.
- Section 409.975(7), F.S., MEDICALLY NEEDED ENROLLEES. This section provides that each managed care plan must accept any Medically Needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a Medically Needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee’s share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for Medically Needy patients for services provided before enrollment in the plan. Medically Needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.

#### **D. Program Goals**

The goal of the new Medically Needy program is to extend Medicaid eligibility to people who are categorically eligible for Medicaid (i.e., children and parents, persons who are elderly, blind or disabled), but who are not eligible for Medicaid due to income or assets that exceed the limits established in the Florida Medicaid State Plan. Those individuals who incur medical expenses that, when subtracted from their countable income, would reduce their income below the MNIL are currently eligible for Medicaid through the Medically Needy program on a month-to-month basis. The proposed waiver will modify the operation of the Medically Needy program to allow Medically Needy recipients to receive services through the Managed Medical Assistance (MMA) program as specified in sections 409.972(1) and 409.975(7), F.S.

The Agency seeks to continue to serve this population by providing access to continuous enrollment in Medicaid managed care, and to reduce costs by:

- a) Removing incentives for individuals to continue to incur inefficient medical costs such as accessing treatment in the emergency room rather than treatment in a less costly setting in order to qualify for eligibility.
- b) Extending eligibility to twelve month periods rather than recertifying recipients each month; and
- c) Providing coordinated and appropriate use of medically necessary services reimbursed by Medicaid for this population.



## **E. Program Objectives**

The proposed demonstration waiver seeks to improve the effectiveness of the Medically Needy program by providing access for this population to an integrated service delivery system of health care. Using a coordinated approach to care will address a number of unintended consequences of the current program and provide for opportunities for increased access to care, simplified eligibility determination and improved continuity of care delivery in the most efficient and effective setting.

As previously described, Medicaid applicants who are otherwise eligible for Medicaid, but who do not qualify due to income and assets that exceed the standard level for eligibility, cannot receive services reimbursed by Medicaid until SOC is met. Under the proposed demonstration, the Medically Needy program will:

- Provide for the enrollment of persons eligible for the Medically Needy program in managed care plans operated under the MMA program;
- Provide that individuals are responsible for payment of incurred claims (up to the SOC amount) that are used to determine eligibility,
- Improve the continuity of care for persons eligible for the Medically Needy program through the provision of up to 12 months of continuous enrollment;
- Provide for recipient payment of a premium not greater than the calculated SOC after the first month of qualifying for the program, with continued enrollment of up to 12 months, contingent on payment of the premium;
- Provide that the Agency shall pay any portion of the premium that exceeds the recipient's SOC; and
- Provide for a grace period of at least 90 days before disenrolling recipients who fail to pay their share of the premiums.

## **Specific Objectives**

The proposed objectives of the waiver will:

1. Provide incentives to providers and recipients for efficient utilization of services by providing for the ability of continuous eligibility and requiring recipient cost sharing through a premium arrangement not to exceed the current SOC amount.
2. Require eligibility determination only once each 12 months rather than meeting SOC monthly.
3. Provide recipients with a three-month grace period before they can be disenrolled from the plan for non-payment of their premiums, to ensure coordination of care.
4. Provide the managed care providers assurances that recipients are eligible for up to a 12-month period.
5. Provide recipients access to care coordination and remove the incentive for the emergency room to be a first choice of setting for medical care in order to qualify for eligibility.

## II. Program Description

### A. Medically Needy Program

The following provides a description of the Medically Needy program and the integrated health care delivery system (MMA program) through which the Medically Needy recipients will receive their Medicaid services as specified in Florida law. Please note that on August 1, 2011, the Agency submitted an amendment to Florida 1115 Medicaid Reform Waiver to implement the MMA program. A detailed description of the MMA program can be viewed at the below link. The Agency continues to work with the Centers for Medicare and Medicaid Services (Federal CMS) to obtain approval of the amendment to implement the MMA program.

[http://ahca.myflorida.com/Medicaid/statewide\\_mc/pdf/mma/Amendment\\_1\\_1115\\_Medicaid\\_Reform\\_Waiver\\_08012011.pdf](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf)

### B. Eligibility

Under this proposed waiver, the criteria for initial eligibility for the Medically Needy program would not be more restrictive than the current Florida Medicaid State Plan criteria and persons who become eligible through the proposed Medically Needy program would receive additional months of eligibility through enrollment in the MMA program, regardless of whether their incurred bills exceeded the SOC amount in the months subsequent to their original eligibility month.

Table 2 summarizes the groups eligible for the Medically Needy program.

<b>Table 2 Summary of Groups Eligible for the Medically Needy Program</b>		
<b>Group</b>	<b>Medicaid Eligibility</b>	<b>Medically Needy</b>
Infants (under age 1)	Up to 185% of FPL	Individuals not Medicaid eligible due to income or assets who are part of an assistance group with incurred medical expenses that, when subtracted from income, fall below the Medically Needy Income Limit. The MNIL is based on assistance group size: 1-\$180, 2-\$241, 3-\$303, 4-\$365, etc.(See Table 1)
Children under age 6	Up to 133% of FPL	
Children age 6 through 17	Up to 100% of FPL	
Children age 18 and 19	Dependent children age 18 or 19 and in school can be eligible if family income is below 19% of FPL (51% with earnings disregard). Current or former foster children are eligible without regard to income to age 21.	
Parents	Up to 19% of FPL (51% of FPL with earnings disregard)	
Individuals who are Aged, Blind or Disabled	Up to 75% of FPL for an individual or up to 83% of FPL for a couple.	
Childless Adults (Not Aged, Blind or Disabled)	Not eligible	Not eligible

## **Initial Eligibility**

In the month in which the household becomes eligible by incurring medical expenses sufficient to meet the SOC, the medical expenses for the balance of the month will be paid through the FFS system. The Medically Needy recipients in the household will be subsequently enrolled in the MMA program as outlined below. In any months between the household meeting the SOC and enrollment in the managed care plan, the Medically Needy recipients would only become eligible by the household incurring medical expenses sufficient to meet the SOC.

## **C. Plan Enrollment and Disenrollment**

Upon implementation of the MMA program, the Agency will transition eligible recipients in each region on a staggered basis into the managed care plans.

The Agency will carefully plan the transition of the affected Medically Needy recipients into the MMA program to preserve continuity of care. The Agency will follow a multi-layered approach in the design of the transition plan by:

- Assessing the capacity of the contracted plans to ensure continuity of care.
- Coordinating with the contracted plans and the Agency's designated choice counselor to create a staggered transition to ensure that the volume of Medically Needy recipients being transitioned occurs in an organized manner.
- Coordinating with the new contracted plans, the Agency's designated choice counseling vendor, local area office staff and advocacy groups in ensuring appropriate and timely notice to Medically Needy recipients, including developing and releasing flyers to locations and providers frequented by impacted recipients to help ensure recipients understand the changes that are occurring to the Medically Needy program.

### **1. Medically Needy Recipients:**

At the time a Medically Needy household becomes eligible by meeting the household's SOC, the eligible Medically Needy recipients will receive information about the managed care plan choices in their area. The Medically Needy recipients will be informed of their option to select a plan within 30 days of being determined eligible for Medicaid and the Medically Needy program. Twelve months of continuous Medicaid coverage is not available to Medically Needy recipients until they are enrolled in a managed care plan. Once Medically Needy recipients have made their choice, they will be able to contact the Agency or the Agency's designated choice counseling vendor to register their plan selection or complete enrollment through the online process. Recipients can also use the enrollment form to mail in their selection. If the recipient does not select a plan within the 30-day period, the Agency will assign the Medically Needy recipient to a managed care plan.

### **2. Assignment**

Each Medically Needy recipient will be given 30 days to select a managed care plan after being determined eligible for Medicaid and the Medically Needy program. Within the 30-day period, the Agency or the Agency's designated choice counseling vendor will provide information to recipients to encourage an active plan selection. Recipients who fail to choose within this timeframe will be assigned to a plan in their region.

When automatically enrolling a Medically Needy recipient into a plan, the Agency will seek to preserve an existing provider relationship by considering whether the recipient has received services from one of the primary care providers in the plan's provider network in the past.

### **3. Lock-In/Disenrollment**

Once a mandatory Medically Needy recipient has selected or been assigned to a managed care plan, the enrollee will have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, the enrollee will be locked-in for the remainder of the 12 month period and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan.

The Agency or the Agency's designee will record the managed care plan change/disenrollment reason for all Medically Needy recipients who request such a change. The Agency or the Agency's designee will be responsible for processing all enrollments and disenrollments.

For the Medically Needy recipients, failure to pay the monthly premium will result in disenrollment from the managed care plan, the Medically Needy program and Florida Medicaid. The Medically Needy recipient receives a 90-day grace period for non-payment of premium before being disenrolled from the managed care plan, the Medically Needy program and Florida Medicaid.

For Medically Needy recipients who become categorically eligible for Medicaid while enrolled in the Medically Needy program and are determined to be mandatory for participation in the MMA program the recipients will be: disenrolled from the Medically Needy program, enrolled in the MMA program, remain in their MMA plan for their Medicaid services to ensure continuity of care and not have to pay a monthly premium.

The Agency assures Federal CMS that it complies with Section 1932(a)(4) and 42 Code of Federal Regulations (CFR) 438.56, insofar as the provisions are applicable.

### **4. Re-enrollment**

In instances of a temporary loss of Medicaid and Medically Needy eligibility, which the Agency is defining as six months or less, the Agency will re-enroll the Medically Needy recipients in the same managed care plan they were enrolled in prior to the temporary loss of eligibility. The Agency believes that such re-enrollment will promote increased use of preventive services, maximize continuity of care and foster continued provider relationships.

## **D. Information and Choice**

### **1. Enrollee Choice**

Potential enrollees will have a choice of two or more managed care plans in each region. The Agency assures Federal CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice, since at least two options will be available in all demonstration regions. Recognizing the unique attributes of Florida's rural communities, the Agency will issue regional bids to ensure that individuals will have two or more plan options.

## **2. Enrollee Information**

The Agency or the Agency's designated choice counseling vendor will ensure that Medically Needy recipients are provided with full and complete information about their managed care plan options. The Agency or the Agency's designated choice counseling vendor will provide information regarding an individual's choice of managed care plans.

The Agency will develop Medically Needy enrollee education so individuals will fully understand their choices and will be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan and the data will be made available publicly. Specifically, the Agency or the Agency's designated choice counseling vendor will provide information on selecting a managed care plan.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at or near the fourth-grade reading level and available in a language other than English when 5% of the region speaks a language other than English. The Agency or the Agency's designated choice counseling vendor will also provide oral interpretation services, regardless of the language and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the Agency or the Agency's designated choice counseling vendor to obtain additional information. The Agency or the Agency's designated choice counseling vendor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours and will be staffed with staff qualified and trained to address the needs of the enrollees and potential enrollees.

The Agency assures Federal CMS that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, relating to Information Requirements.

The Agency or the Agency's designated choice counseling vendor will retain responsibility for all enrollment and disenrollment activities into managed care plans.

## **E. Benefits**

The MMA program will provide Medically Needy recipients with health care options that will allow them to better manage their health care. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit "silos" that exist today, there are statewide limits and caps on various services that have varying impact on local populations.

### **1. Customized Benefit Packages**

A major element of the MMA program is the ability of managed care plans to develop customized benefit packages targeted to specific populations. These customized benefit packages will foster enrollee choice and will enable enrollees to access the health care services they need. Additionally, it is expected that these customized benefit plans will resemble commercial insurance plans, further bridging public and private coverage.

The benefit packages may look different from traditional Medicaid in several ways. In order to provide additional or special services to the targeted population, these tailored benefit packages may vary the amount, duration and scope of some services and may contain service-specific coverage limits, such as the number of visits or dollar cost. All packages must cover mandatory Medicaid services, including medically necessary services for pregnant women and early and periodic screening and diagnosis and treatment (EPSDT) services for children under age 21, as the Agency is not seeking to waive EPSDT requirements for children enrolled in a Medicaid managed care plan. In addition, managed care plans may also cover services not currently offered under Florida Medicaid State Plan, such as adult preventative dental care. Services not included in an approved benefit package, or exceed those in an approved benefit package, will be considered non-covered services.

All benefit packages must be prior-approved by the Agency and must be at least actuarially equivalent to the services provided to the target population under the current Florida Medicaid State Plan benefit package. In addition to being actuarially equivalent to the value of traditional Medicaid services, each managed care plan's customized benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population (e.g., TANF, aged and disabled, etc.).

While one of the major principles of the Agency is to encourage innovation by allowing for the variation of amount, duration and scope, plans are not required to change benefit packages and may choose to offer a benefit package that mirrors current coverage levels. Actual benefit packages will depend on market innovation and the population the plan seeks to serve and will be reviewed annually by the Agency.

#### a. Actuarial Equivalency

The Agency will evaluate each proposed customized benefit plan for actuarial equivalence to the current Florida Medicaid State Plan. To do this, the Agency will use a Benefit Plan Evaluation Model that: 1) compares the value of the level of benefits in the proposed package to the value of the current Florida Medicaid State Plan package for the average member of the population and 2) ensures that the overall level of benefits is appropriate.

Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that, given a specified Medicaid target population and its historical utilization, the expected claim cost levels of all managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic FFS plan. The Agency will use this as the first threshold to evaluate the customized benefit package submitted by a managed care plan to ensure that the package earns the premium established by the Agency. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits.

#### b. Sufficiency

In addition to meeting the actuarial equivalence test, each managed care plans proposed customized benefit package must meet state-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. In this evaluation, the Agency will identify specific services (e.g., inpatient hospital, outpatient physician care, behavioral health, and prescription drugs) and will evaluate each

proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the managed care plan's proposed benefit level.

Thus, in order for a managed care plan to obtain Agency prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Florida Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. Recipients will have the option to choose a managed care plan with a benefit package that best fits their needs. For example, one managed care plan's benefit package may offer fewer chiropractic visits and more vision benefits than another managed care plan's benefit package. If the recipient does not need a chiropractor, but wears glasses, he/she may wish to choose a managed care plan with a benefit package that offers more vision benefits. The flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for plan enrollees.

The Agency will evaluate service utilization on an annual basis and use this information to update the benefit comparison package to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

## **2. Cost Sharing**

Under the MMA program, the contracted plans may impose cost-sharing requirements consistent with the currently approved nominal levels in the Florida Medicaid State Plan. Table 3 provides the current cost-sharing, including co-payments and co-insurances.

<b>Table 3 Co-payment/Co-insurance</b>	
<b>Services</b>	<b>Co-payment/Co-insurance</b>
Birthing Center	\$2 per day per provider
Chiropractic	\$1 per day per provider
Community Mental Health	\$2 per day per provider
Dental – Adult	5% co-insurance per procedure
FQHC	\$3 per day per provider
Home Health Agency	\$2 per day per provider
Hospital Inpatient	\$3 per admission
Hospital Outpatient	\$3 per visit
Independent Laboratory	\$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first \$300 for each non-emergent visit
Nurse Practitioner	\$2 per day per provider
Optometrist	\$2 per day per provider
Pharmacy	2.5% co-insurance up to the first \$300 for a max of \$7.50 a month
Physician and Physician Assistant	\$2 per day per provider
Podiatrist	\$2 per day per provider
Portable X-Ray	\$1 per day per provider
Rural Health Clinic	\$3 per day per provider
Non-Emergency Transportation	\$1 per trip

All individuals not exempt by federal regulation will be responsible for cost-sharing for services. The Agency will review and approve cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing will not be required for children through age 18, pregnant women (when accessing pregnancy related services), institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by Federal CMS. The Agency will also encourage managed care plans to reduce or waive cost-sharing requirements for preventive services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, pap smears and certain prescribed medication. Due to the transparency of outcomes built into the MMA program – particularly with each managed care plan’s ability to maximize the number of people who receive preventive services – managed care plans will be incentivized to remove all barriers to preventive services, including waiving cost sharing for those services. When a co-payment or co-insurance is required as part of the plan benefit structure, the provider will be responsible for collecting payments from individuals.

### **3. Medically Needy Enrollee Premiums**

Florida law requires that each managed care plan must accept any Medically Needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. In the first month of enrollment in a plan, the recipient shall not be required to pay a portion of the monthly premium. After the first month of qualifying as a Medically Needy recipient and enrolling in a plan, the recipient shall pay the managed care plan a portion of the monthly premium equal to the recipient’s share of the cost as determined by DCF. The Agency shall pay any remaining portion of the monthly premium. If the monthly premium is lower than the Medically Needy recipient’s SOC, the recipient will be responsible for paying the entire premium and the Agency will not be responsible for paying any portion of the premium to the plan. The managed care plans are not obligated to pay claims for Medically Needy recipients for services provided before enrollment in the plan. Medically Needy recipients are responsible for payment of incurred claims that are used to determine eligibility for the Medically Needy program. The managed care plans must provide a grace period of at least 90-days before recipients who fail to pay their shares of the premium are disenrolled by the Agency.

### **4. Healthy Behaviors**

As part of the procurement process in 2013, each selected managed care plan shall be required to establish a program to encourage and reward healthy behaviors. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment program.

## **F. Health Care Delivery Systems**

### **1. Managed Medical Assistance Program**

Florida’s MMA program is designed to operate statewide and will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The Medically Needy recipients through this waiver will be mandated to participate in the MMA program to receive their health care services.

The MMA program will introduce more individual choice, increase access and improve quality, efficiency and fiscal integrity while stabilizing cost. The MMA program is an integrated model to manage all care and will increase the enrollment of recipients including the Medically Needy



population in comprehensive managed care plans that are capable of coordinating all of an individual's care.

## **2. Regions**

Florida law established 11 regions throughout the State of Florida for the MMA program, and outlines the number of managed care plans authorized to provide services in each region. Table 4 provides a list of the counties by the 11 regions.

<b>Table 4 Regions for the MMA Program</b>	
<b>Region</b>	<b>Counties</b>
<b>Region 1:</b>	Escambia, Okaloosa, Santa Rosa and Walton
<b>Region 2:</b>	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
<b>Region 3:</b>	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
<b>Region 4:</b>	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
<b>Region 5:</b>	Pasco and Pinellas
<b>Region 6:</b>	Hardee, Highlands, Hillsborough, Manatee and Polk
<b>Region 7:</b>	Brevard, Orange, Osceola and Seminole
<b>Region 8:</b>	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
<b>Region 9:</b>	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
<b>Region 10:</b>	Broward
<b>Region 11:</b>	Miami-Dade and Monroe

## **3. Procurement Method**

Under the MMA program, the Agency will competitively procure the managed care plans to provide services to all eligible Medicaid recipients, including the Medically Needy population. The Agency will initiate separate but simultaneous procurements in each of the 11 regions of the state with full implementation by October 1, 2014.

The law establishes criteria for preference in reviewing Invitation to Negotiate (ITN) respondents, including

- Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body;
- Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations;
- Availability and accessibility of primary care and specialty physicians in the provider network;
- Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services;
- Commitment to quality improvement;
- Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and

- Documentation of policies for preventing fraud and abuse.

The Agency is directed to enter into five-year health plan contracts with selected managed care plans. The Agency may not renew the contracts and may extend the term of the contract only in order to cover any delays in transitioning to a new plan, but the contract may not be renewed.

#### **4. Managed Care Plans Defined**

Under the MMA program, a managed care plan is defined as an eligible plan under contract with the Agency to provide services in the Medicaid program, and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity in the state, or qualified pursuant to Florida law, that is paid a prospective per-member, per-month payment by the Agency.

An “eligible plan” is defined as a health insurer authorized under Chapter 627, F.S., an Exclusive Provider Organization authorized under Chapter 627, F.S., a Health Maintenance Organization authorized under Chapter 641, F.S., a Provider Service Network (PSN) authorized under state law, an ACO authorized under federal law, or the Children’s Medical Service (CMS) Network authorized under Florida law.

#### **5. Number of Plans per Region**

The Agency will procure a specified number of MMA plans per region. Florida law specifies a minimum and maximum number of managed care plans, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid.

Issuance of the procurement will provide for a choice of plans, as well as, market stability as the Agency will enter into five-year contracts. As noted in Table 5, there will be a minimum of two managed care plan choices in each of the 11 regions of the state. To the extent that there are fewer than two managed care plan choices in an area, the Agency will issue a procurement to obtain a second managed care plan and meet the federal requirements regarding choice until two managed care plans are available.

<b>Table 5 MMA Plans per Region</b>			
	<b>Min # of Plans</b>	<b>Max # of Plans</b>	<b>Min # of PSNs</b>
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1

Participation by the CMS Network shall be pursuant to a single, statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits but will be subject to all managed care plan contract requirements.

## **6. Plan Selection Criteria**

As part of the ITN process, the Agency will establish preference criteria for reviewing respondents as previously described. Such criteria will include, but not limited to, the Agency's evaluation of whether managed care plans: have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied will be promptly paid under state law; are organizations that are based in and perform operational functions in the state of Florida, in-house or through contractual arrangements, by staff located in this state; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

## **7. Reimbursement**

The Agency will reimburse most contracted plans on a capitated basis; however, FFS payments may be used for PSN providers for a time-limited period as authorized in State law.

Capitation rates for the capitated MMA plans will be developed in accordance with 42 CFR 438.6. The Agency will develop actuarially sound, risk-adjusted premiums. The premiums will be based on historical Medicaid expenditures including the use of encounter data, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures.

The Agency will develop risk-adjusted premium rates to pay the managed care plans. Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. The purpose of health-based risk adjustment is to provide a risk score for each individual to reflect predicted health care needs. The scores of all of the individuals enrolled in each managed care plan determine the collective risk score and the resulting premiums for that plan. The Agency will work with its contracted actuary to update and enhance risk adjustment methodologies to reflect nationally recognized models best suited for this program.

The Agency assures Federal CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary. The Federal CMS Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

The Agency may pay some or all PSNs on a FFS basis as authorized by Florida law, using historical Medicaid covered services with no variation of benefit package. The Agency will not reimburse a FFS-based PSN for services not authorized under the Florida Medicaid State Plan. PSNs may provide and directly pay for additional services through any savings earned at no cost to the state.

## **G. Accountability and Monitoring**

The Agency will follow standard state contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all state and federal requirements. The Agency will specify monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted managed care plans to enrollees. The overarching goal is to promote the health and well-being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes and promoting quality and cost-effective delivery of services.

## **1. Provider Network Requirements**

The Agency will require that all managed care plans ensure availability of services consistent with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206, that is, managed care plans will be required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected utilization of service.

In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type and regional distribution of providers in managed care plan networks. The Agency will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the managed care plans must maintain a panel of preventive and specialty care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population. Managed care plans will be required to have providers available within reasonable travel and distance standards comparable to standards established by the Agency.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as a pharmacy option, the exclusive use of mail order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate each plan's pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting managed care plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

In addition, managed care plans will be required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators and such other information as the Agency deems necessary. The provider database must be available online to both the Agency and the public and allow comparison of the availability of providers to network adequacy standards and accept and display feedback from each provider's patients.

## **2. Plan Accountability and Performance Standards**

The Agency will enhance the monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of preferred drug list on the plan's website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives

and disincentives for network providers; collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures with results published on each plan website; accreditation within one year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification to the Agency of impending birth of a child to an enrollee. The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

### **3. Grievance and Appeals**

The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for, services as required by section 1932(b)(4) of the SSA and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.
- Maintains a state-level panel to hear appeals of grievances not resolved at the plan level.
- Preserves the Medicaid fair hearing process that requires each Medicaid managed care plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:
  - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
  - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the Agency takes action without the advance notice and as required in accordance with State policy consistent with Fair Hearings. The Agency must also inform enrollees of the procedures by which benefits can be continued or reinstated, and,
  - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

### **4. Program Integrity**

The Agency assures that the Medicaid program integrity system will require each managed care plan to comply with Section 1932(d)(1) of the SSA and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The Agency will prohibit any of the managed care plans from knowingly having a relationship with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the managed care plan,

2. A person with beneficial ownership of 5% or more of the managed care plan's equity,
3. A person with an employment, consulting or other arrangement with a managed care plan for the provision of items and services that are significant and material to the managed care plan's obligations under its contract with the Agency.

The Agency's Medicaid program integrity system will oversee the activities of managed care plan enrollees, health care providers, plan networks and their representatives in order to prevent fraud or abuse, over-utilization or duplicative utilization, underutilization or inappropriate denial of services and neglect of enrollees and to recover overpayments as appropriate. The Agency will refer incidents of suspected fraud, abuse, over utilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency, including the licensing agency and the Medicaid Fraud Control Unit of the Attorney General's office.

The program integrity system will require each managed care plan to comply with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable.

The payments to each managed care plan will be required to be in compliance with 42 CFR 438.604, Data that must be certified, and 42 CFR 438.606, Source, content, and timing of certification.

## **H. Sanctions**

To ensure stability, the Agency will impose new penalties for managed care plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to three months payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another managed care plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25% of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 days' notice to the Agency before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the Agency is required to terminate all contracts with that plan in other regions.

If the Agency terminates a contract with a managed care plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medical needs, and existing provider or care relationships.

## **I. Quality Initiatives**

Improved quality and performance has been a key component of the Florida's managed care strategy and will continue to be a primary focus of the MMA program.

Quality and performance measurement will play a primary role in the selection of managed care plans during the procurement process in the MMA program. Accreditation by a nationally recognized accrediting body, the organization's record in achieving specific quality standards and the organization's documented commitment to quality improvement will be among the criteria for selection.

Once contracts are finalized, quality oversight will exist on two levels: at the Agency and at individual managed care plans. The Agency has a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans to their enrollees. This strategy targets overall system improvement and specifies the steps the Agency will take to hold plans accountable for on-going quality:

- Coverage and authorization of services
- Systems performance
- Clinical outcome measures
- Enrollee satisfaction
- Provider satisfaction
- Provider access and timeliness of care
- Network adequacy
- Performance improvement projects
- Quality improvement indicators
- Care coordination and continuity of care
- Timeliness of handling complaints and grievances
- External quality review
- Evaluation of disease management programs

Reporting requirements by the contracted plans as a component of the quality strategy include, but are not limited to:

- Enrollment and disenrollment
- Enrollee information
- Provider network
- Encounter data
- Grievances and appeals
- Financial reporting
- Child health check-up (a.k.a., EPSDT).

The Agency assures Federal CMS that it complies with Section 1932(c) of the Act and 42 CFR 438.200, Subpart D, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions.

The Agency will develop or adopt additional performance measures in response to features of the MMA Program to promote quality of care. When possible, established measures with available benchmark data, such as HEDIS, will be preferentially selected. Managed care plans will be required to report annual audited performance measures that include both HEDIS and

HEDIS-like or Agency-defined measures and this reporting will continue under the MMA program.

Additionally, managed care plans will be required to set performance standards for their network providers and determine continued network participation based on achievement with those standards.

In an effort to improve quality of care, the Agency adopted high standards, as defined by the NCQA National Means and Percentiles, as the performance target for each of the HEDIS measures that managed care plans are required to report. The strategies adopted by the Agency aim to bring the statewide level of performance in line with that performance target. To accomplish this goal, the Agency will require the development of a strategy for managed care plans to develop corrective action plans to address deficient scores. Failure to comply with the terms of their internally developed corrective action plans or failure to improve scores to minimal levels as set by the Agency will result in monetary penalties. The Agency will also develop an incentive program to reward higher performing health plans. Such incentives may include additional auto-assignments each month and a financial incentives to encourage continual improvement.

Managed care plans must participate in the activities of the External Quality Review Organization, which include validation of performance measures, validation of performance improvement projects and reviews of compliance with standards. Managed care plans will be required to develop and document a Quality Improvement Plan (QIP) that guides the efforts that will be taken at the managed care plan level to improve quality in both clinical and non-clinical areas of operation. As part of the MMA program plan, the QIP will be required to include enrollee satisfaction and disenrollment surveys. The Agency reviews and approves the managed care plans' QIPs. Managed care plans will be required to conduct Performance Improvement Projects (PIPs) in content areas specified in contracts.

All capitated managed care plans, as well as FFS PSNs that are capitated for non-emergency transportation, must submit encounter data to the Agency that reports services provided to enrollees under the contract. Data must be reported in a Health Insurance Portability and Accountability Act (HIPAA)-compliant X12 format and must meet minimum quality standards for processing through the state's Medicaid Management Information System. Non-compliant managed care plans can be assessed a penalty for failure to submit data accurately and timely.

The Agency will utilize encounter data to conduct quality of care studies and evaluations of services provided to recipients enrolled in the MMA program. As the program is developed, the Agency will identify areas of particular interest for studies, but will include, at a minimum, studies regarding access to care, appropriateness of care and fraud and abuse. The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes, the Agency will assess a daily fine for each day of non-compliance beginning on the 31<sup>st</sup> day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90<sup>th</sup> day unless the plan comes into compliance before that date.



### **III. Program Financing**

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#### **A. Demonstration Financing and Budget Neutrality**

Florida is proposing this waiver program to extend the length of Medicaid coverage to certain Medically Needy individuals who are already eligible for Medicaid services. All individuals will be enrolled in managed care for all services. The proposed program provides that, once persons have qualified for Medically Needy status under existing Florida Medicaid State Plan provisions, they will be enrolled prospectively in their choice of one of managed care plan contracted under the Statewide Medicaid Managed Care Program in their geographical region. The enrollment can run for up to twelve months. For Medically Needy children, this is analogous to continuous eligibility in Medicaid. For adults, this is analogous to guaranteed eligibility in managed care.

After the first month of managed care enrollment, the Medically Needy program participants are expected to pay a recipient premium, equal to the lesser of a benchmark premium designed to approximate the cost of coverage, or their SOC necessary to be met for Medicaid Medically Needy eligibility. Medically Needy persons may be disenrolled for failure to pay their premiums, subject to a 90 day grace period.

The attached budget neutrality spreadsheets have been prepared using templates provided by the Centers for Medicare and Medicaid Services (CMS) for the purpose of demonstrating federal Budget Neutrality under an 1115 Waiver. The budget neutrality spreadsheets illustrate that the proposed program can be implemented in a manner that is budget neutral to the federal government, as compared to a program that could be implemented through the Florida Medicaid State Plan.

The spreadsheets include three groups of individuals based on these principles:

1. Title XIX Group: This is the existing Medically Needy group for the months they would be eligible under the existing Medically Needy program.
2. Hypothetical Group: These are additional member months, not otherwise included in the Title XIX Group. Although they are not currently, these individuals could be covered under the Florida Medicaid State Plan, absent a waiver. These member months include up to an additional 12 months for Children and up to an additional 6 months for Adults.
3. Expansion Group: These are all other additional member months to be covered under the proposed program. That is, it represents the second six months of coverage for Adults.

#### **B. Without- and With-Waiver Projections**

Recent Historical Actual Data: The attached spreadsheets include 5 years of historical experience for the current Title XIX Group noted above. This experience reflects the current program design, which includes a single month of eligibility at a time. The time period covered in the historical experience is the period from SFY 2006-2007 through SFY 2010-2011. These are the most recent 5 years for which claims data is reasonably complete. During this period caseload growth has been considerable, with average annual increases of nearly 22%. A key feature of the current program is that the covered months tend to be very high-cost months and

volatile, as they are ones in which the recipient had met his or her SOC to qualify for the Medicaid coverage.<sup>2</sup> The per-member per-month (PMPM) values are consistently over \$1,000.

No historical data are available for the Hypothetical Group or the Expansion Group.

**Bridge Period:** The Bridge Period for this budget neutrality calculation extends from the end of SFY 2010-2011 to FFY 2014–2015 (June 30, 2011–October 1, 2014), a period of 39 months. PMPM costs are assumed to remain flat between the final year of the historical period and the base year (DY0). Caseload is assumed to grow at the historical annual average of 21.6%.

**Without-Waiver Projection:** The second page of the budget neutrality spreadsheets presents the “Without Waiver” projection. It assumes the Title XIX group continues to grow at the current rate of 21.6% annually through a Base Year which is the last 12 months before the program is implemented on October 1, 2014, and through the five years of the Demonstration. PMPM costs are assumed to grow from the base period through the demonstration period at an average annual rate of 5.8%, which is the assumption underlying the President’s budget projections. If recipients met the SOC requirements for eligibility under the current program, they were placed in the Title XIX group.

The without-waiver member month projections for the Hypothetical Group are estimates of extending eligibility up to 12 months for children and up to 6 months for adults, options that are available to the Agency within the Florida Medicaid State Plan process. Historical data was analyzed to determine the number of unique recipients receiving more than one month of eligibility within a 12-month period, was used to estimate the number of months that could be authorized through the Florida Medicaid State Plan. The PMPM values are significantly lower than the PMPMs shown for the existing Title XIX group because, by definition, these months represent ones in which the recipients have *not* met SOC requirements for eligibility under the current program.

**With-Waiver Projection:** With-waiver projections were developed giving consideration to the changes in expected cost associated with bringing lower cost months into the average and applying the required enrollee premium. A global assumption is that a uniform cross-section of 10% of persons will pay their premiums throughout their enrollment in the program. Projections are then stratified into each of the three groups listed above.

Benchmark premiums have been established based on whether or not recipients have disability status, whether or not they are also eligible for Medicare, and whether they are a child or an adult. The premiums reflect an estimate of the cost of providing services and are based on the costs of existing Medically Needy individuals, after adjusting for the relationship between their claims and SOC, the fact they are covered continuously which may smooth out medical services received and claims by month as opposed to encouraging “clumping” them into a single month to meet the SOC, managed care impact, managed care administrative costs and other relevant factors.

The caseload projection for the Title XIX Group is unchanged from the with-waiver projection, because the projection number of initial (qualifying) months is not expected to change as a result of the waiver. The PMPM costs are reduced by 4% to reflect the impacts of care

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<sup>2</sup> Note: as in other States, Medically Needy recipients in Florida are allowed to collect medical receipts over a period of time in order to qualify for Medicaid – called “clumping”.

management and fewer incentives to obtain services in higher-cost settings to meet SOC criteria. This reduction is taken in DY0, and the President's average annual trend of 5.8% is used thereafter through the demonstration period.

The with-waiver projection for the Hypothetical Group is unchanged from the without-waiver projection. CMS guidance states that the State is not allowed to accrue federal savings on a Hypothetical Group even if the State has an absolute cost savings on this population.

The Expansion Group represents the set of the second 6 eligibility months for adults that cannot be provided through a State Plan Amendment. This expansion group's costs are paid for via the federal savings accrued under the Title XIX population.

Budget Neutrality Summary: The fourth page of the attached spreadsheet is a summary of with-waiver and without-waiver projections, showing that the waiver projections are budget neutral over the five year period.

## **IV. Research Hypotheses and Evaluation**

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### **A. Research Hypotheses**

The following are the research hypotheses for the proposed 1115 Research and Demonstration Waiver for the Medically Needy program.

#### **Hypothesis #1:**

The proposed Medically Needy program successfully extends Medicaid eligibility to the Medically Needy population and effectively enrolls them in a managed care plan (see Eligibility and Enrollment).

#### **Hypothesis #2:**

The proposed Medically Needy program successfully provides continuity of care to the Medically Needy eligible population (see below Continuity of Care and SOC).

#### **Hypothesis #3:**

Budget neutrality is maintained (see Budget Neutrality).

### **B. Evaluation Plan**

The goal of the new Medically Needy program is to extend Medicaid eligibility to people who are categorically eligible for Medicaid (i.e., children and parents, persons who are elderly, blind or disabled), but who are not eligible for Medicaid due to income or assets that exceed the limits established in the Florida Medicaid State Plan. Those individuals who incur medical expenses that, when subtracted from their countable income, would reduce their income or assets below the MNIL are currently eligible for Medicaid through the Medically Needy program on a month-to-month basis. The proposed program seeks to prove that, by providing for access to 12 months of continuous enrollment in Medicaid managed care and requiring premium payments from recipients, the program would remain budget neutral while improving access to care. There are three main areas of focus for the evaluation: Eligibility Expansion and Enrollment, Continuity of Care, and SOC.

#### **1. Eligibility Expansion and Enrollment**

The goals of the proposed Medically Needy program cannot be met without effectively enrolling eligible persons. The following research questions/outcome measures will provide an assessment of the effectiveness of implementation for the proposed Medically Needy program.

##### **Research Questions:**

- What is the number of Medically Needy eligible persons in Florida?
- What is the number of Medically Needy eligible persons successfully enrolled in managed care plans?
- What is the percentage of Medically Needy eligible persons enrolled?
- What is the comparison of actual versus projected enrollment and Analysis of Difference?

## **2. Continuity of Care**

In order to evaluate the effectiveness of continuity of care, it is necessary to determine whether the goal of continuity of care is met and whether the continuity of care results in the intended outcomes. The following research questions are designed to measure the effectiveness of the program at providing continuity of care as well as providing insight into the effectiveness of continued enrollment.

### **Research Questions:**

- How many enrolled Medically Needy recipients maintain eligibility for 12 months? Check for continued eligibility at 3 or 6 month intervals.
- What is the average length of enrollment in a managed care plan?
- Do Medically Needy recipients enrolled in a managed care plan actively seek care?
- How do patterns and costs of care compare to the pre-waiver Medically Needy population?

## **3. Share of Costs**

The premium payment is meant to add stability to the SOC requirement under the Medically Needy program. The premium structure should therefore encourage stability in enrollment, provide no extra costs over existing requirements and should be easily administered. The following research questions will help identify the effectiveness of the premium provisions.

### **Research Questions:**

- Do Medically Needy enrollees pay their premiums?
- What is the pattern of premium payment?
  - Percentage that pay on time
  - Percentage that pay late
  - Percentage that maintain arrearages for premium payments
- How many are disenrolled for failure to pay premium?
  - Number and percentage disenrolled for premium non-payment
  - Number and percentage disenrolled for other reasons

## **Evaluation Interim and Summary Reports**

The evaluation will include at least one interim report due annually within 90 days of the end of the first demonstration year or as specified in the Special Terms and Conditions of the waiver as approved by Federal CMS. Each annual evaluation report will detail the findings relevant to the above research questions and will include analysis of findings in the context of meeting program goals and objectives. After three years, the evaluation will include a summary report that: summarizes the results from each of the three annual evaluation reports, provides a three-year trend analysis of program strengths and weaknesses and details findings in the context of meeting program goals and objectives over the three-year period.

After five years or at the end of the evaluation period whichever occurs later, the evaluation will include a final report that summarizes the results from each of the five annual evaluation reports and the three-year trend analysis report and provides a five-year trend analysis of program strengths and weaknesses. The final report will also detail findings in the context of meeting program goals and objectives over the five-year (i.e., complete waiver) period.

## **V. Waiver and Expenditure Authorities**

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The Agency is seeking authority through the proposed 1115 Research and Demonstration Waiver to implement the Medically Needy program as specified in Florida law. In order to meet the goals and objectives of the Medically Needy program, the Agency is seeking a waiver of the following Sections of the SSA in accordance with Section 1115 of the SSA.

1. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the Agency to impose a premium.
2. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).
3. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

In addition, the Agency requests costs not otherwise matchable for this population and expanded months of coverage that do not meet Florida Medicaid State Plan criteria.

## VI. Public Process

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The Agency utilized methods to solicit public input on the 1115 Research and Demonstration Waiver for the proposed Medically Needy program as required by 42 CFR 431.408.

1. The Agency's public comment period for this waiver application began October 12, 2012, and extended to November 13, 2012.
2. The Agency provided public notice of the application, along with a link to the Agency's website and a notice in the state's Administrative Record, October 12, 2012, edition, [Vol. 38/49](#), Section VI, [12148782](#) (see Appendix). The Agency posted a Public Notice Document on its website which described the elements of the proposed 1115 Research and Demonstration Waiver for the proposed Medically Needy program, per the requirements of 42 CFR 431.408. The Agency posted public comments received during the 30-day public comment period on its website. The Agency responded to all written public comments received during the 30-day public comment period.
3. The Agency held two publicly noticed workshops, of which one included teleconferencing capability, at least 20 days prior to submitting the application to CMS. Both workshops were publicized through the state's Administrative Record and on the Agency's website, [www.AHCA.MyFlorida.com](http://www.AHCA.MyFlorida.com).
  - On October 19, 2012, the Agency held a public workshop in Ft. Lauderdale, Florida, at the Westin Ft. Lauderdale. The meeting was moderated by Medicaid Area Office 2, with David Rogers, Florida's Assistant Deputy Secretary for Medicaid Health Systems, presenting. Mr. Rogers outlined the proposed changes and opened the floor for comments. There were 15 stakeholders present and three speakers who made comments. Questions were presented and addressed by Mr. Rogers. No written comments were received at the meeting.
  - On October 23, 2012, the Agency held a public workshop in Tallahassee, Florida, at the Agency for Health Care Administration, as part of the federally mandated Medical Care Advisory Committee (MCAC) meeting. The meeting was moderated by Florida's Deputy Secretary for Medicaid, Justin Senior, and Melanie Brown-Woofter, Chief, Bureau of Health Systems Development. David Rogers, Assistant Deputy Secretary for Medicaid Health Systems, outlined the proposed changes and opened the floor for comments. There were 23 stakeholders in attendance and two speakers made public comments. Questions were presented and addressed by Mr. Rogers. One stakeholder submitted comments in writing. A call-in number was advertised in the public notice for the MCAC meeting as well as the public notice for the waiver application.
4. The Agency utilized an electronic mailing list and publicized the following email address: [FLMedicaidManagedCare@AHCA.MyFlorida.com](mailto:FLMedicaidManagedCare@AHCA.MyFlorida.com) on its website and in the public notice.

- Florida's ARNPs

Issue:

Florida ARNPs have expressed concern that they will not be able to directly participate as Medicaid providers in a managed care environment. The Agency continued to receive comments via email from ARNPs (see Appendix) through this public comment period, and the following response was provided:



Response:

As part of the Statewide Medicaid Managed Care statute, advanced registered nurse practitioner services were included as part of the required minimum benefits to be provided by participating health plans. In addition, statutory language was adopted through SB 730 during the 2012 Legislative Session clarifying that a primary care provider under the SMMC program would not be limited to physicians. Currently, ARNPs contracted with health plans are able to see patients enrolled in the Medicaid program, but the only contracted health plan network provider is the physician; the nurse practitioner works under/for the physician which will not change with implementation of the SMMC program.

- Florida Association of Health Plans

Florida Association Health Plans provided a series of suggestions regarding the program:

Issue:

Concern relating to premium collection and recommends that the Agency enter into a single statewide contract with third party administrator to handle the administrative process of collecting premiums.

Response:

Statute provides that the recipient must make payment of their premium to the health plan. The state currently has no statutory authority or funding for this recommendation.

Issue:

Concerns relating to actuarial soundness of program components including the individual nature of the determination of SOC, the 90-day grace period, and the plan risk associated with collection of the premium, and recommends that rate ranges be used for SOC, that the grace period be shortened to 30 days and that the rates be monitored on a quarterly basis.

Response:

The Agency is required to establish rates that are actuarially sound and is constrained by statute in that the agency may not execute contracts with managed care plans at payment rates not supported by the General Appropriations Act.

Issue:

Concern related to continuity of care and its impact on actuarial soundness on associated rates based on the extent of the use of out-of-network providers. Recommends that for continuity of care the managed care enrollment (choice) process include primary care provider (PCP) selection, that the agency establish strong in-network guidelines and that the state enrollment process establish a

member requirement to contact their care manager and complete a care management discussion with their assigned MCO within a specified time period.

Response:

Medically Needy individuals would go through a Choice Counseling process just as other Florida Medicaid recipients. When making a plan choice, recipients have access to information regarding the PCPs, hospitals, pharmacies and specialists participating with each plan and can make a plan choice to best fit their provider needs. As part of the MMA program, the agency is required to establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Plan contracts will include requirements for case management/care coordination programs. All recipients that request case management will be put into the case management program.

- Florida Hospital Association (FHA):

The Florida Hospital Association submitted their comments in a formal letter to the Medicaid Director.

Issue:

While supportive of the extension of eligibility for the 12 month period, FHA suggests that the program remain under the FFS model, that the premium component could put the population at financial risk, including non-payment of premiums, and that the shift to a premium approach will not prevent the recurring eligible/not eligible cycle which they assert assists under the current system.

Response

Statute directs the Agency, upon receipt of federal approval, to include the Medically Needy population in the Statewide Medicaid Managed Care program and to implement the premium outlined in this application. The program is intended to minimize disruption of care through the increased coordination of care available under a managed care arrangement, the 12 month eligibility span, and the 90-day grace period for non-payment of premiums.

Issue:

FHA expressed the desire for additional information and background detail on the premium process and its link to capitation payments, calculations used to determine estimated average SOC, and projected casemonths as represented in the public notice document.

Response:

Capitation and enrollee premium estimates provided with the waiver application are based on general program concepts as outlined in the authorizing legislation. These estimates will be refined as the Agency and CMS work through special

terms and conditions for the program, and FHA's suggestions will be taken into account as we move forward with program development. The growth in case months is driven by the proposed extension of eligibility to 12 continuous months. In SFY 2009-2010, the average number of months of eligibility experienced in a year was just under 2.5, which means that an increase to a 12-month eligibility segment produces a significant increase in case months.

Issue:

FHA expressed the desire for clarification with regards to the recipient's responsibility for incurring cost in the amount of their SOC in order to become eligible for Medicaid during that given month.

Response:

Medically Needy recipients must incur medical expenses in the amount of their SOC in order to become eligible for Medicaid during that given month. Once eligible, for the remainder of that month the recipient's medically necessary costs are reimbursable by Medicaid.

- The Florida Renal Administrators Association

The Florida Renal Administrators Association provided a series of comments regarding the program:

Issue:

The Association asked for clarification on whether the monthly premium would be a requirement for Medicaid recipients and whether the current practice of submitting SOC would be maintained.

Response:

Once enrolled in the health plan, recipients must be given a 90-day grace period by the health plan before they can disenroll for non-payment of premium. At least one premium must be paid for the recipient to remain enrolled in the health plan for a maximum of four months. While recipients are enrolled in the health plan, the health plan is responsible for their expenses. For any months in which recipients are not enrolled in the health plan, they may still receive Medicaid eligibility by incurring bills in excess of their SOC just as in the current Medically Needy program.

The initial month of Medicaid eligibility would be obtained just as in the current Medically Needy program. After that, the recipient would be enrolled in and receive all services through the health plan. While enrolled in the health plan, the recipient would not have to incur costs or track bills, but would be asked to pay a monthly premium that could not exceed the SOC amount.

5. The Agency consulted with Florida's two federally recognized tribes; the Seminole Tribe of Florida and the Miccosukee Tribe of Florida, through written correspondence on October 3, 2012, to solicit input for the proposed Medically Needy program (see

Appendix). This activity was accomplished more than 30 days prior to submitting the initial waiver request to Federal CMS, per consultation requirements outlined in Florida's Medicaid State Plan Amendment, approved April 26, 2012. No comments have been received from either tribe.

6. Contact information for questions and additional information regarding Florida's 1115 Research and Demonstration Waiver for Medically Needy is as follows:

Marie Donnelly  
Government Analyst II  
Agency for Health Care Administration  
2727 Mahan Drive MS#  
Tallahassee, FL

Phone: (850) 412-4149

Email: [Marie.Donnelly@AHCA.MyFlorida.com](mailto:Marie.Donnelly@AHCA.MyFlorida.com)

## Appendix

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### **Public Comments:**

The Agency received the following comments via email and letters during the course of the public comment period:

**Sent:** Tuesday, November 13, 2012 9:29 PM

**To:** FLMedicaidManagedCare

**Subject:** Medically Needy Waiver

To Whom It May Concern:

Please do not approve the Medicaid Medically Needy waiver for the State of Florida. This will force out nurse practitioners from being reimbursed or empanelled to care for many patients. The ones who will ultimately suffer are the patients in Florida.

Instead, find some way to force the State of Florida to change their rules, thereby allowing Nurse Practitioners to practice to the full extent of our education and training.

Sincerely,

Paulette Perlowin, ARNP

**Sent:** Tuesday, November 13, 2012 6:49 PM

**To:** FLMedicaidManagedCare

**Subject:** medically needy rules

To ACHA

I am a nurse practitioner medicaid provider. I understand the new rules will not allow me to be paid by the medically needy program and i do have some patients on the medically needy program. There are very few providers available for this. I work with patients to help them deal with the underlying causes as well as with medications for chronic disease. Treating these patients in an effective way takes time, and nurse practitioners spend the time to make a positive difference. Thanks Elizabeth Markovich

**Sent:** Tuesday, November 13, 2012 6:02 PM

**To:** FLMedicaidManagedCare

**Subject:** opposed

Please accept this communication as position statement from one of many NP's in FL who are opposed to the medically needed waiver.

While there may be administrative issues that require attention, this population of patients rely upon ARNP's for access to quality care.

Ernestly,

Elise Hazzard, ARNP-BC

**Sent:** Saturday, November 10, 2012 6:34 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Florida's Share of Cost?

What a terrible Medicaid program for the needy. Just awful.

**Sent:** Wednesday, November 07, 2012 2:06 PM  
**To:** FLMedicaidManagedCare  
**Subject:** The program will move all „Medically Needy individuals into the Managed Care program that is also under consideration for a waiver.

The program will move all „Medically Needy individuals into the Managed Care program that is also under consideration for a waiver.

The Medically Needy (also called Share of Cost) program is the component of Medicaid that provides short-term coverage to patients who are over the income limit for regular Medicaid but have catastrophic medical expenses and are otherwise Medicaid-eligible. Under the Medically Needy program today, once a patient's total medical bills for the month „paid or unpaid - add up to an amount that approaches monthly family income, Medicaid coverage kicks in for the rest of that month. (That process is known as meeting Share of Cost for the month.) Among those who must rely on the program on an ongoing basis are dialysis patients, organ transplant recipients, and children with complex medical needs. (Press release FLCHAIN Oct 18,2012) Patient Access to Nurse Practitioners will be reduced with the New Waiver. Medically needy patients are especially vulnerable. Presently a Nurse Practitioner may be directly empanelled and reimbursed under the Medicaid-fee-for-service program. However according to AHCA this practice will have to stop because of the state's restrictive Nurse Practice Act. Under the new waiver, and because of the state's restrictive Nurse Practice Act, Nurse Practitioners will no longer be able to directly empanel as providers with HMOs. Instead, they will have to be empanelled as a provider under the license of a physician contracted with the particular HMO plan. Similarly, Nurse Practitioners will no longer be directly reimbursed for their services and instead payment will go to the physician. This policy will limit access to care for patients by making it harder for Nurse Practitioners to provide care and stay in business. Many Nurse Practitioners have expressed concern that they will have to close their clinics because of this policy. The waiver should be denied until access to full scope Nurse Practitioner care can be guaranteed.

Please ask them to deny the waiver because patient access to Nurse Practitioners will be in jeopardy. Twenty percent of PCPs in Medicaid are Nurse Practitioners.

Thank you for your consideration

**Sent:** Wednesday, October 31, 2012 7:58 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Deny Medically Needy Waiver

Please DENY or vote NO for the Medically Needy Waiver! This is bad business for patients, ARNPs, and our community!

Kelly Kevitt, MSN, ARNP, FNP-BC

Sent: Wednesday, October 31, 2012 4:33 AM

To: FLMedicaidManagedCare  
Subject: Waiver limits access to care

Presently a Nurse Practitioner may be directly empanelled and reimbursed under the Medicaid-fee-for-service program. However according to AHCA this practice will have to stop because of the state's restrictive Nurse Practice Act. Under the new waiver, and because of the state's restrictive Nurse Practice Act, Nurse Practitioners will no longer be able to directly empanelled as providers with HMOs. Instead, they will have to be empanelled as a provider under the license of a physician contracted with the particular HMO plan. Similarly, Nurse Practitioners will no longer be directly reimbursed for their services and instead payment will go to the physician. This policy will limit access to care for patients by making it harder for Nurse Practitioners to provide care and stay in business. Many Nurse Practitioners have expressed concern that they will have to close their clinics because of this policy. The waiver should be denied until access to full scope Nurse Practitioner care can be guaranteed. As stated here this waiver is a bad idea and bad for Floridians. Please act in the interest of all Floridians and not just the physicians and politicians! Dr. Jody Heriot CRNA

**Sent:** Tuesday, October 30, 2012 3:31 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Medicaid Waiver

I am a nurse practitioner, certified nurse midwife, in Martin County.  
I am opposed to the plan to not include ARNPs such as myself in the Medicaid waiver. We are an integral part of health care and adding this restriction is in fact restraint of trade that does not serve patient well and delays care.

Cassandra Garcia

**Sent:** Tuesday, October 30, 2012 12:09 PM  
**To:** FLMedicaidManagedCare

I cheerfully provide quality care to many Medicaid patients. The Florida Medicaid HMO programs that exclude Nurse Practitioner's from,being reimbursed is not in the best interest in the people of Florida. This policy will limit access to care for patients by making it harder for Nurse Practitioners to provide care and stay in business. Many Nurse Practitioners have expressed concern that they will have to close their clinics because of this policy. The waiver should be denied until access to full scope Nurse Practitioner care can be guaranteed.

Carolyn Zaumeyer, MSN, ARNP

**Sent:** Tuesday, October 30, 2012 9:58 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Changes to the Medicaid Waiver

This will limit access to care for many patients and will increase the cost of the care. Please make changes to allow Nurse Practitioners to provide primary care to these patients.

Jan Heidel, MSN, NP-C

**Sent:** Monday, October 29, 2012 10:51 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically Needy Waiver - Requesting a stay to this rule.

The proposed rule change for Medically needy patients for Nurse Practitioners will affect my own practice and will in turn pushed me to lay off my Medical Assistants staff in the office. This rule will make my patients suffer due to reduced access to care that the proposed rule changes will cause.

I am proposing that the rule remains as it is, with expansion authorizing HMOs to open up their panel to Nurse Practitioners without any hindrance. The policy if implemented will swell up the unemployment line with scores of Medical Assistants and office staff laid off. The patient access to care will be jeopardized, the Nurse Practitioners are the bulk of providers for the Medicaid patients.

Thanks in advance for your rethinking on the proposed policy.

Alade Babatunde Afolabi, FNP-C, DNP

**Sent:** Monday, October 29, 2012 7:45 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Deny Medically Needy Waiver

The Medically Needy waiver is not in the best interests of the patients as it will severely restrict their access to care by nurse practitioners, who historically are the most willing providers for the underserved. Please deny this waiver, as it impedes nurse practitioners from practicing in their full scope. Your consideration is greatly appreciated,

Marcia J. Huszagh, ARNP, FNP-C

-----Original Message-----

**Sent:** Monday, October 29, 2012 12:52 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Nurse Practitioners caring for Medicaid Patients

As an ARNP in Florida, I urge you to reconsider the medical waiver and deny this until access to full scope Nurse Practitioner care can be guaranteed. I believe we will be moving backwards in the medical care of the medically needy if this waiver is passed. As healthcare moves forward, we need to expand the role of NP's, not restrict the role.

Lesley Bowlus, ARNP-C

**Sent:** Sunday, October 28, 2012 7:35 PM  
**To:** FLMedicaidManagedCare  
**Subject:** NP Access

Allowing nurse practitioners to practice fully is in the best interest of patient care. In addition, it is necessary for the Nurse Practitioners to be directly reimbursed for their services instead of payment going to the physician. This policy will limit access to care for patients by making it harder for Nurse Practitioners to provide care and stay in business. Terry Pye



**Sent:** Sunday, October 28, 2012 11:51 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically Needy and Nurse Practitioners

By moving all "Medically Needy" individuals into "Managed Care" programs, it will restrict patients ability to find providers by decreasing the number of nurse practitioners to provide care. In the area that I am employed, more physician providers are not accepting "Managed Care" Medicaid patients. These patients are turning to nurse practitioner run clinics as their providers. By removing ARNP's from the option, you will see more misuse of the local emergency departments which will increase costs. If Florida is serious about cutting healthcare costs, the state must work with ARNP's to provide solutions not put up more road blocks.

Rita Smith Pruette, ARNP, MSN

**Sent:** Sunday, October 28, 2012 11:42 AM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically Needy Waiver

As a providing Nurse Practitioner in Florida, I'm writing to ask that you please reconsider this waiver.

Nurse Practitioners in Florida are twenty percent of the primary care access for Medicaid patients. This waiver will severely limit medical access for those patients. This limitation will be felt in our emergency rooms and hospitals since these patients will no longer have continuity of care at their medical provider's offices. This waiver will also increase medical cost as these patients medical conditions become out of control and they develop co-morbid medical conditions as a result.

Please think of not only our Florida medical patients but of the cost to Florida as well.

Joella Hall ARNP

**Sent:** Sunday, October 28, 2012 8:54 AM  
**To:** FLMedicaidManagedCare  
**Subject:** waiver

Please deny the "Medically Needy Waiver." This will greatly decrease patients access to medical care to those who most require it.  
Thanks,

Jill Garrett ARNP

**Sent:** Saturday, October 27, 2012 6:46 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically needy waiver

Please deny the Medical needy waiver for Florida Medicaid patients. Because of this waiver we as Nurse Practitioners will be unable to provide the medical services they require Thank you,  
Jane Dacri ARNP

**Sent:** Saturday, October 27, 2012 4:50 PM  
**To:** FLMedicaidManagedCare  
**Subject:** "Medically Needy"

It has come to my attention that another proposed waiver to Florida's Medicaid program has been proposed. This program will move all "Medically Needy" individuals into the Managed Care program that is also under consideration for a waiver.  
This is bad for patient access to care. Please deny the waiver.

*Max Holliday ARNP-C*

**Sent:** Saturday, October 27, 2012 4:25 PM  
**To:** FLMedicaidManagedCare  
**Subject:** New waiver restricts nurse practitioners from serving the medically needy

This proposed waiver HMO program is going to restrict the medically needy in their access to care. Vote against the Waiver. Many medically needy are receiving quality, cost effective care in NP run clinics. If this waiver is passed these patients will have to seek new providers and their care will become more expensive; not better quality. Medicaid can save millions by NOT passing this waiver and continuing to provide access to care by NPs. Don't pass this waiver!!!

Ruth Antonowich, MS, RN FNP student graduating in Dec 2012.

**Sent:** Saturday, October 27, 2012 4:16 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Medicaid Waiver

I am a board certified nurse practitioner in private practice and have legitimate concerns about the potential damage that will occur if NP's are not allowed to care for this population under proposed Medicaid waiver policies.  
I currently provide both primary care and psychiatric care to Medicaid patients in Volusia County and have done so for over 12 Years. I have had to discharge many of my medically needy patients due to their insurance switching to managed care. I am not against managed care. I would just like to continue to provide care to this population. If Medicaid Gold recognizes me as an effective medical provider then I feel it should be mandated that the HMO's do the same. Otherwise, I will no longer be able to provide services to this population. You are setting up just another barrier for the citizens of Florida who need it the most.  
Finally, the 20% of NP's that are designated as current Medicaid providers are billing directly. The other 80% are billing under the physician which means you are actually spending more on those services. I thought the goal for the Medicaid waiver was to increase access and decrease costs. Without NP's providing care independently, YOU WILL NOT SEE THAT HAPPEN!

Marifrances Gullo, ARNP-BC

**Sent:** Saturday, October 27, 2012 3:39 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically Needy Waiver Request

Please deny the Florida Medicaid waiver because patient access to Nurse Practitioners will be in jeopardy. Twenty percent of PCPs in Medicaid are Nurse Practitioners.

Patricia I. Wahrenberger, DNP-DCC, FNP-BC

**Sent:** Saturday, October 27, 2012 3:07 PM  
**To:** FLMedicaidManagedCare  
**Subject:**

Please DENY the medically Needy Waiver!!!

Christy Kuhn, RN, BSN, CCRN, PCCN

**Sent:** Saturday, October 27, 2012 2:58 PM  
**To:** FLMedicaidManagedCare  
**Subject:** deny the wavier

Deny the wavier and keep nurse practitioners providing care to the recipients.

Tracey Novak

**Sent:** Saturday, October 27, 2012 2:57 PM  
**To:** FLMedicaidManagedCare  
**Subject:** nurse practitioners

Please tell me cutting nurse practitioners out of the medicaid program is going to help Florida... Patients needs access to nurse practitioners.

**Sent:** Saturday, October 27, 2012 2:51 PM  
**To:** FLMedicaidManagedCare  
**Subject:** Medically Needy Waiver

Dear Sir/Madam,

Patient Access to Nurse Practitioners will be reduced with the New Medically Needy Waiver. Medically needy patients are especially vulnerable. Presently a Nurse Practitioner may be directly empanelled and reimbursed under the Medicaid-fee-for-service program. However this practice will have to stop because of the state's restrictive Nurse Practice Act. Under the new waiver, and because of the state's restrictive Nurse Practice Act, Nurse Practitioners will no longer be able to directly empanel as providers with HMOs. Instead, they will have to be empanelled as a provider under the license of a physician contracted with the particular HMO plan. Similarly, Nurse Practitioners will no longer be directly reimbursed for their services and instead payment will go to the physician. This policy will limit access to care for patients by making it harder for Nurse Practitioners to provide care and stay in business. Many Nurse Practitioners have expressed concern that they will have to close their clinics because of this policy. For these reasons, I do not support the waiver

Susan Lynch MSN NP-C

**Public Notice:**

The Agency posted the following public notice in the Florida Administrative Register, October 12, 2012, edition, [Vol. 38/49](#), Section VI, [12148782](#):

## Notice of Meeting/Workshop Hearing

### AGENCY FOR HEALTH CARE ADMINISTRATION

#### Medicaid

The Agency for Health Care Administration announces a public meeting to which all persons are invited.

DATE AND TIME: October 19, 2012, 2:00 p.m. - 5:00 p.m.

PLACE: The Westin Ft. Lauderdale, 400 Corporate Drive, Ft. Lauderdale, Florida 33334,

Phone: (954)772-1331

DATE AND TIME: October 23, 2012, 1:00 p.m. -3:00 p.m.

PLACE: Medical Care Advisory Committee Meeting, Agency for Health Care Administration, 2727 Mahan Drive

Building 3, Conference Room A, Tallahassee, Florida 32308, Call-In Information (Listen Only): 1-888-670-3525.

When prompted, enter the participant pass code: 4265177105

GENERAL SUBJECT MATTER TO BE CONSIDERED: During the 2011 legislative session, the Florida Legislature passed House Bills 7107 and 7109, and Governor Scott signed the bill into law June 2, 2011. The Legislature continued the Medically Needy program and directed the Agency for Health Care Administration (Agency) to seek federal waiver authority to enroll Medically Needy recipients into their choice of managed care plans, and to change the program to provide additional months of coverage, to implement a premium that would not exceed the share of cost, and to provide care coordination and utilization management to achieve more cost-effective services.

The Agency will hold two public meetings on separate dates and in different areas of the state to solicit verbal and written comments from all interested stakeholders. The dates and times are noted above. The Agency's website, AHCA.MyFlorida.com, will provide email and postal addresses for submission of comments, and a link to the Federal CMS website. All interested stakeholders will be able to provide and review comments by the public for a minimum of 30 days prior to the submission of the waiver application to Federal CMS. To view the full public notice document which includes a comprehensive description of the proposed 1115 Research and Demonstration Waiver for Florida's Medically Needy program use the following link:

[http://ahca.myflorida.com/Medicaid/statewide\\_mc/pdf/mma/Public\\_Notice.pdf](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Public_Notice.pdf). A copy of the

agenda may be obtained by contacting: Robin Ingram at (850)412-4017 or by email at

[Robin.Ingram@ahca.myflorida.com](mailto:Robin.Ingram@ahca.myflorida.com). Pursuant to the provisions of the Americans with

Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 7 days before the workshop/meeting by contacting: Robin Ingram at (850)412-4017 or by email at

[Robin.Ingram@ahca.myflorida.com](mailto:Robin.Ingram@ahca.myflorida.com). If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).



[www.fahp.net](http://www.fahp.net)    200 West College Ave, Suite 104, Tallahassee, Florida 32301    (850) 386-2904

October 24, 2012

Statewide Medicaid Managed Care Program  
Office of the Deputy Secretary for Medicaid  
Agency for Health Care Administration  
2727 Mahan Drive, MS #8  
Tallahassee, FL 32308

Dear Deputy Secretary Senior:

I provided oral testimony on behalf of the member plans of the Florida Association of Health Plans (FAHP) at the public workshop held in Ft. Lauderdale on October 19, 2012. Through this submission, FAHP also offers formal written comments for your consideration in developing the 1115 waiver application for the Medically Needy Program for submission to the Centers for Medicare and Medicaid Services (CMS).

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## **Proposed 1115 Research and Demonstration Waiver Florida's Medically Needy Program**

### **Medically Needy (MN) Waiver**

- The premise of the managed care MN program is to provide more efficient health care through continuous 12 month coverage, in exchange for the recipient paying their share of cost (SOC) through a premium
- MN recipients have a 90 day grace period in which to pay their premium before being disenrolled
- The MCO should be responsible for providing care and payment of premiums should be the responsibility of the state
  - Today MN participants are not required to pay the entire SOC; rather they have to document incurred bills (paid or unpaid) that equal or exceed the SOC and then full Medicaid coverage is activated for that month.
  - The MN population is high risk. These are very sick individuals with low incomes. They are unlikely to pay premiums which would be unaffordable. In the event of non-payment the program, as designed, is actuarially unsound.
    1. Uncollectable premium will result in MCO bad debt.
    2. Administrative expenses in attempting to obtain premium payment would be substantial.
    3. Rates that assume unrealistic levels of premium payment would be actuarially unsound.

- Utilizing the MCO as a debt collector will impact the effectiveness of care management. The Premium collection process could create a barrier between the MCO and member; the member may not take the MCO care manager call fearing that it is a collection call
- Variable rates for each member will add complexity to the process and minimum rate ranges are desirable

## **Issue Detail**

### **1. Managed Care Organization Premium Collection**

Premium collection is not typically handled by the MCO for the Medicaid population. Medically Needy Medicaid recipients are, necessarily, very sick. These are the individuals for whom the care management provided by an MCO will be most beneficial. Through care management, care gaps will be identified and closed, non-health related socio-economic issues such as food and housing insecurity will be identified and referrals made, and support services will be put in place. The premium collection process could create a barrier between the MCO and member, turning the care manager into a bill collector in the eyes of the member. The member may refuse to take a call from their care manager who is calling to coordinate care, under the misguided belief it is a collection call for unpaid premiums.

It is recommended that the Agency enter into a single statewide contract with a Third Party Administrator (TPA) to handle the administrative process of collecting premiums, record keeping and maintaining files. This is similar to the process used by the Florida Healthy Kids Corporation (FHKC) where a TPA is used to collect monthly premiums from families and reports nonpayment of premiums to the enrollment broker or Agency to update enrollment their files. This is consistent with the overall program goals and objectives

### **2. Premium Amount and Share of Cost**

The recipient's share of cost (SOC) is calculated by the Department of Children and Families (DCF). The varied premium amount for each member is calculated by AHCA and is another complicating factor to the premium collection process. Enrollment files to MCOs and associated PMPM rates will have the additional complexity of accommodating variable rates for each member. It is recommended that at a minimum, rate ranges be used for the SOC calculation as this would simplify the process.

### **3. Premium, AHCA not responsible for SOC premium amount**

The waiver application, page 11, removes AHCA's responsibility for any of the unpaid SOC premium due to the MCO. The Medically Needy population is a high risk for payment default, given they have already exceeded monthly income expense amounts. The premium collection responsibility creates an additional risk for the MCOs without historical information of the effectiveness of an MCO to collect premiums from this group. In the Fall 2012 Report on Florida's Long-Range Financial Outlook (as adopted by the Legislative Budget Commission), the following was noted: *"The possibility that Medically Needy recipients might not pay premiums while remaining enrolled and receiving services for 90 days creates a risk. The risk has a cost continuum starting at zero, when assuming all premiums are paid, up to a loss by the managed care plans of an estimated (\$97.8 million) per year, when assuming no premiums are paid. While the loss would technically be borne by the managed care plans, it is indeterminate the extent to which the state may require plans to bear this risk and the extent to which the federal*

*government will provide waiver authority for the new Medically Needy program.”* The waiver does not articulate what latitude the MCO has if premiums are not collected. We would recommend that AHCA contract with a TPA, as noted in Issue 1 above. If, however, AHCA requires the MCO to collect the SOC, rates must account for and assume an appropriate level of bad debt since all SOC will not be recoverable from members.

#### **4. Enrollment process Continuity of Care out of network**

Members in this population can be expected to have a higher rate of established relationship with provider organizations related to their disease conditions. In addition, it is expected that the population will be a higher consumer of more specialized services and specialists. It will be important to tie the MCO selection to the current providers providing treatment to the member.

The choice counselors will help guide the member on the enrollment process. In order to avoid continuity of care delays and issues, we recommend that the enrollment process include PCP selection with relevant PCP information made available to the MCO during the enrollment file exchange. Additionally, it is recommended that strong in-network guidelines be established to support actuarial soundness of associated rates by reducing the use of costly out of network usage for continuity of care.

#### **5. High Risk Population**

The Medically Needy Waiver population is a high risk population with high-cost medical conditions, requiring additional care management. Accurately identifying these recipients in the enrollment files for immediate outreach to manage care will be critical. We recommend that the state enrollment process establish a member requirement to contact their care manager and complete a care management discussion with their assigned MCO within a specified time period. Timely care coordination and utilization management is critical to achieve more cost-effective services.

#### **6. Disenrollment, 90-day grace period**

Medically Needy recipients are responsible for payment of their share of cost of the monthly premium. Plans must provide a grace period of 90 days before disenrolling a recipient for nonpayment of premium. With the 90 day grace period, we can expect that some people will learn quickly of this provision and essentially pay premiums quarterly. We believe the 90 day grace period is too long and does not encourage responsible payment of premiums. By way of comparison, the Florida Healthy Kids program provides for a 30 day advance payment and includes penalties or waiting periods of 30 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums (s. 624.91(5), F.S.). We recommend shortening the 90 day grace period prior to disenrollment to encourage responsible payment of premiums.

#### **7. Medically Needy Premiums/Rates**

The Waiver states that “enrollees are expected to pay on average \$118 per month that will never exceed any individual’s SOC”. This average is estimated based on an increase in case months and a total per capita monthly cost that is expected to drop from just over \$1,000 to approximately \$450. Premium benchmarks will be developed by the AHCA actuaries and will be based on historical experience of the Medically Needy and other similar populations. We are concerned that the premium rates established may not be actuarially sound as this high risk population has never been managed. AHCA has made the assumption that by providing 12 months continuous eligibility, requiring premium

payment from the recipient and continuity of care the program would remain budget neutral. At a minimum, we recommend that the rates be monitored quarterly.

### **Recommendations**

- AHCA should contract with a single statewide TPA to handle the administrative process of collecting premiums, record keeping, and maintaining files. (FHK currently uses a TPA for this function and spends \$22 million annually.)
- The collection of the SOC premium payment should be outside of the MCO PMPM and, at a minimum, rate ranges should be used for the SOC calculation to simplify the process.
- If AHCA requires the MCO to collect the SOC, include an allowance for bad-debt write-off since not all SOC will be recoverable from members.
- Include PCP selection in the enrollment process. Forward PCP information to the MCO during the enrollment file exchange.
- Establish strong in-network guidelines to support actuarial soundness of associated rates by reducing the use of costly out of network usage for continuity of care.
- Establish a member requirement to contact the care manager and complete a care management discussion with the assigned MCO within a specified time period to ensure timely care coordination and utilization management.
- At a minimum, monitor rates on a quarterly basis.
- Shorten the 90 day grace period prior to disenrollment to encourage responsible payment of premiums.
- AHCA should engage in discussions with:
  1. Michelle Robleto regarding her experience with Florida's high risk pool
  2. Rich Robleto regarding Florida Healthy Kids experience with premium collection
  3. Other states such as Hawaii and Pennsylvania with experience with similar programs

We appreciate the opportunity to provide comments and trust that you will seriously consider our concerns and recommendations in developing the waiver application.

Sincerely,



Michael Garner, Ph.D.  
President and CEO

Attachments (3)



## Attachment 1

### Statutory Language

409.972 Mandatory and voluntary enrollment.

(1) Persons eligible for the program known as “medically needy” pursuant to s. 409.904(2) shall enroll in managed care plans. Medically needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.

409.975 Managed care plan accountability.

(7) **MEDICALLY NEEDED ENROLLEES.**—Each managed care plan must accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee’s share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for medically needy patients for services provided before enrollment in the plan. Medically needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.

## Attachment 2

# Medically Needy Program – Managed Care Waiver

### *Initial Eligibility*

- In the month in which the household becomes eligible by incurring medical expenses sufficient to meet the SOC, the medical expenses for the balance of the month will be paid through the FFS system.
- Medically Needy recipients are responsible for payment of incurred claims that are used to determine eligibility for the Medically Needy program.
- At the time a Medically Needy household becomes eligible by meeting the household's SOC, the eligible Medically Needy recipients will receive information about the managed care plan choices in their area.
- The Medically Needy recipients will be informed of their option to select a plan within **30 days** of being determined eligible for Medicaid and the Medically Needy program. Twelve months of continuous Medicaid coverage is not available to Medically Needy recipients until they are enrolled in a managed care plan.
- In any months between the household meeting the SOC and enrollment in the managed care plan, the Medically Needy recipients would only become eligible by the household incurring medical expenses sufficient to meet the SOC.

### *Managed Care Plan Premium*

- In the first month of enrollment in a plan, the recipient shall not be required to pay a portion of the monthly premium.
- After the first month of qualifying as a Medically Needy recipient and enrolling in a plan and contingent upon Federal CMS approval, the recipient shall pay the managed care plan a portion of the monthly premium equal to the recipient's share of the cost as determined by DCF. The Agency shall pay any remaining portion of the monthly premium.
- If the monthly premium is lower than the Medically Needy recipient's SOC, the recipient will be responsible for paying the entire premium and the Agency will not be responsible for paying any portion of the premium to the plan.
- The managed care plans are not obligated to pay claims for Medically Needy recipients for services provided before enrollment in the plan.
- The managed care plans must provide a grace period of at least 90-days before recipients who fail to pay their shares of the premium are disenrolled by the Agency.

### *Managed Care Enrollment*

- 30 Days to Choose
  - Each Medically Needy recipient will be given 30 days to select a managed care plan after being determined eligible for Medicaid and the Medically Needy program.
  - Recipients who fail to choose within this timeframe will be assigned to a plan in their region.
- 90 Days to Change
  - Once a mandatory Medically Needy recipient has selected or been assigned to a managed care plan, the enrollee will have 90 days in which to voluntarily disenroll and select another managed care plan.
- After 90 Days Lock-In
  - After 90 days, the enrollee will be locked-in for the remainder of the 12 month period and no further changes may be made until the next open enrollment period, except for cause.

## Attachment 3

### Draft Example

**Example #1 – Situation:** A family of two whose gross income is \$1,068 per month and whose net countable income (after allowable disregards of income and deductions) is \$404 per month. The Medically Needy Income Limit for this family is \$241 and the share of cost (SOC) is \$163. Application for benefits is made during the same month in which expenses greater than the SOC are incurred.

Family Size	Net Countable Income	Medically Needy Income Limit (Monthly)	Share of Cost (SOC)
2	\$404	\$241	\$163

In April, the mother in this family, who is not otherwise eligible for Medicaid, applies for eligibility and submits bills for her incurred medical expenses that exceed the \$163 SOC as of April 10. Her child is categorically eligible and the mother is the only Medically Needy member of the household. She is determined eligible for Medicaid beginning April 10, and allowable medical expenses incurred on or after April 10 are paid by the Medicaid fee-for-service program.

DCF notifies AHCA in April that she has met the SOC. AHCA informs her about the managed care plan choices in her area and her option to select a plan within 30 days or she will be assigned a plan. She selects a plan in May and AHCA will enroll her in the MCO beginning in June. AHCA determines that the benchmark payment amount for the family coverage is \$262 (for one adult). She is not assessed a premium for June. June is the first month of a twelve month enrollment period. In June, she will be advised that she is responsible for paying a premium of \$163 per month (her SOC amount) for July and for each subsequent month to the MCO. If she pays the premium, she will receive continuous eligibility through May. If she fails to pay her premium for July, she will receive a notice that she has a 90 day grace period and will be disenrolled on September 31. If she pays the premium for July but subsequently fails to pay the premiums due, she will be disenrolled after 90 days beginning with the month for which no premium payment is made.

The MCO would be paid \$262, the benchmark amount in the first month and \$99 in subsequent months, which is the benchmark amount minus the premium (SOC) amount payable by the family.

Month	Premium (PMPM)	State	SOC
June 2012	\$262	\$262	
July	\$262	\$99	\$163
August	\$262	\$99	\$163
September	\$262	\$99	\$163
October	\$262	\$99	\$163
November	\$262	\$99	\$163
December	\$262	\$99	\$163
January 2013	\$262	\$99	\$163
February	\$262	\$99	\$163
March	\$262	\$99	\$163
April	\$262	\$99	\$163
May	\$262	\$99	\$163

October 30, 2012

Mr. Justin Senior  
Deputy Secretary for Medicaid  
Agency for Health Care Administration  
2727 Mahan Drive  
Bldg. 3, Mail Stop # 8  
Tallahassee, FL 32308

Dear Mr. Senior:

On October 23, 2012, the Florida Agency for Health Care Administration (the Agency) conducted a public hearing on a proposed MEDS AD 1115 Research and Demonstration waiver. This waiver addresses Florida's intent to use a managed care approach for the state's Medically Needy Program and impose a premium requirement on enrolled individuals. The Florida Hospital Association (FHA) is concerned about several of the core policy changes included in this proposal.

FHA recognizes that the current monthly eligibility process is complex and time-consuming for both the patient and the state eligibility determination system. Extending the eligibility period to twelve months, providing continuous eligibility and allowing "costs not otherwise matchable" during that period would greatly enhance continuity of care, quality, patient satisfaction and reduce the administrative burden. Therefore, we support this portion of the proposal. We believe this policy could be implemented under the current fee-for-service model, negating the need to convert this population to mandatory Medicaid managed care.

The waiver proposal, however, links this extension of the eligibility period with the introduction of a monthly premium for Medically Needy eligible individuals, and FHA has concerns about this policy change. Individuals in this eligibility group are already at risk because of their poor health condition, and this policy change puts them at significant financial risk as well. The Medically Needy populations are generally individuals with incomes below 150% of the federal poverty level who have short-term, costly illnesses, or are individuals with chronic conditions who incur high medical costs. Failure to provide continued access through the Medically Needy Program will cause an increase in poor health outcomes and increased hospitalizations. We do not believe the premium approach will prevent the recurring eligible/not eligible cycle which currently exists for Medically Needy patients. Even though the policy allows a grace period of 90 days for non-payment, the enrollee will be subjected to additional stress from collection efforts, and for very low income enrollees, the premium requirement will limit resources needed for activities of daily living. The 90-day grace period and no premium requirement in the first month of eligibility may actually encourage "gaming" of the eligibility period. As proposed, it is highly likely that this premium requirement could push vulnerable populations into further poverty status and disrupt the continuity of their health care.

Additionally, there are several other issues which this waiver proposal does not appear to adequately address. These issues include:

1. Lack of clarity regarding the premium payment process and how it is linked with the capitation calculation and payment processes.
2. No documentation on how the estimated average share of cost (SOC) is calculated. The stated SOC appears to be low compared to documentation included in the previous submission to CMS dated April 26, 2012. It would be helpful for the SOC to be displayed in terms of eligibility groups so the range of SOC would be apparent.
3. Case months are projected to grow by 300%; however, no calculation or documentation is provided to support this estimate.
4. Statements in the proposal are confusing and need further clarification. On page 2, under the description of the current program, it states, "On the date the SOC is met, the Medically Needy individuals in the assistance group become eligible for fee-for-service (FFS) Medicaid for the balance of the month and medically necessary expenses are reimbursed by Medicaid." On page 11, the proposal states "Medically Needy recipients are responsible for payment of incurred claims that are used to determine eligibility for the Medically Needy program." Clarification is needed regarding whether Medicaid is responsible for paying the balance of a claim when the initial eligibility is established on a claim which is larger than the SOC.

We recognize the current Medically Needy Program is not a perfect solution to this critical problem, but it has served as a high-risk pool and safety net for hundreds of thousands of chronically ill Floridians. FHA believes this proposal is not adequate to preserve access to care and will result in poor health outcomes for those who cannot afford to pay a premium for their health care.

Sincerely,



Paul Belcher  
Senior Vice President

cc: David Rogers, Assistant Deputy Secretary  
for Medicaid Health System



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**Florida**

**Renal Administrators Association**

AGENCY FOR HEALTH  
CARE ADMINISTRATION

<b><u>Delray Beach Office</u></b> Bob Winston 2655 W. Atlantic Avenue Delray Beach, FL 33445 Tel. 954.448.8482 eFax. 866.913.5518	<b><u>Sarasota Office</u></b> Candy Magiera 1921 Waldemere St., Suite 107 Sarasota, FL 34239 Tel. 941.917.6444 X 408 Fax. 941.917.6448	<b><u>Naples Office</u></b> Laureen Marino 1750 SW Health Parkway Naples, FL 34109 Tel. 239.594.8780	<b><u>Orlando Office</u></b> Brenda Tilley 203 Ernestine Street Orlando, FL 32801 Tel. 407.843.6110 X302
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October 30, 2012

Elizabeth Dudek, Secretary  
Agency for Health Care Administration  
2727 Mahan Drive, Building A  
Tallahassee, FL 32308

Dear Ms Dudek,

The Florida Renal Coalition is seeking clarification on the proposed statewide Medicaid managed care program's federal authority request regarding changes to the premiums and cost sharing for Medicaid beneficiaries. We also want to emphasize how important the Medically Needy program is for Medicaid beneficiaries with kidney failure who require life maintenance dialysis treatments and access medical insurance.

Regarding the Premium Option for the Medically Needy population, the request to the Centers for Medicare and Medicaid Services (CMS) states that Florida is:  
"Seeking 1115 authority to require a premium not to exceed the share of cost after the first month of qualifying as a medically needy recipient and enrolling in a plan. The recipient would pay a portion of the monthly premium equal to the enrollee's share of the cost."

If approved, would the monthly premium be an option or a requirement for Medicaid beneficiaries to continue their medically needy status? If this is approved, will Medicaid beneficiaries be allowed to continue to submit medical bills as their share of cost in lieu of paying a monthly premium? Will the current practice of submitting share of costs be maintained, or will beneficiaries have to show that their share of costs were paid in full prior to submitting their medical qualifying expenses?

We are concerned that a premium "equal to the enrollee's share of the cost" would be unaffordable and unrealistic for most Medicaid beneficiaries. Medicaid beneficiaries currently are required to "incur" medical charges that exceed their share of cost to open their Medicaid for the month. The ability to "incur" expenses assures that beneficiaries are not required to "pay" the charges before receiving coverage. Share of cost for most exceed \$850 - \$1,000 per month. If individuals are





# Florida Renal Administrators Association

required to pay this amount as a premium, they will not be able to start or maintain coverage. Dialysis patients may no longer be able to rely on Medicaid Medically Needy for the first three months prior to Medicare coverage, or on an ongoing basis, without paying the majority of their income in premiums. **A sliding scale based on income would be a better option if a premium is implemented.**

We also wish to express concern about the \$10 premium which would be required as a condition of eligibility for beneficiaries to be enrolled in a Medicaid managed care program. The burden of administering the premium, monitoring payments, collecting payments and possibly back payments if beneficiaries get behind on their payments seems to counteract any cost savings that would be achieved by implementing the premium, and could be a financial burden for Medicaid program as well as the beneficiaries.

Thank you for your assistance in answering these questions we have about the proposed new requirements and taking our concerns under consideration.

Sincerely,

A handwritten signature in cursive script that reads "Bob Winston".

Bob Winston, President  
Florida Renal Administrators Association

C: File

5 year historical

	SFY07 (7/1/06-6/30/07)	SFY08 (7/1/07-6/30/08)	SFY09 (7/1/08-6/30/09)	SFY10 (7/1/09-6/30/10)	SFY11 (7/1/10-6/30/11)	5-YEARS
<b>Title XIX</b>						
<b>TOTAL EXPENDITURES</b>						
Eligible Member Months	344,153	371,612	444,346	615,083	753,430	2,528,624
Total Cost per Eligible	\$ 1,152.78	\$ 1,121.17	\$ 1,121.37	\$ 1,070.73	\$ 1,094.31	
Total Expenditure	\$ 396,731,289	\$ 416,640,886	\$ 498,277,228	\$ 658,589,914	\$ 824,485,740	\$ 2,794,725,056
<b>TREND RATES</b>			<u>ANNUAL CHANGE</u>			<u>5-YEAR AVERAGE</u>
Eligible Member Months		8.0%	19.6%	38.4%	22.5%	21.6%
Total Cost per Eligible		-2.7%	0.0%	-4.5%	2.2%	-1.3%
Total Expenditure		5.0%	19.6%	32.2%	25.2%	20.1%
<b>Disabled</b>						
<b>TOTAL EXPENDITURES</b>						
Eligible Member Months	1				1	
Total Cost per Eligible	\$ 1.00				\$ 1.00	
Total Expenditure	\$ 1				\$ 1	
<b>TREND RATES</b>			<u>ANNUAL CHANGE</u>			<u>5-YEAR AVERAGE</u>
Eligible Member Months						0.0%
Total Cost per Eligible						0.0%
Total Expenditure						0.0%
<b>Eligible for LTC</b>						
<b>TOTAL EXPENDITURES</b>						
Eligible Member Months	1				1	
Total Cost per Eligible	\$ 1.00				\$ 1.00	
Total Expenditure	\$ 1				\$ 1	
<b>TREND RATES</b>			<u>ANNUAL CHANGE</u>			<u>5-YEAR AVERAGE</u>
Eligible Member Months						0.0%
Total Cost per Eligible						0.0%
Total Expenditure						0.0%
<b>HCBS waiver 1</b>						
<b>TOTAL EXPENDITURES</b>						
Eligible Member Months	1				1	
Total Cost per Eligible	\$ 1.00				\$ 1.00	
Total Expenditure	\$ 1				\$ 1	
<b>TREND RATES</b>			<u>ANNUAL CHANGE</u>			<u>5-YEAR AVERAGE</u>
Eligible Member Months						0.0%
Total Cost per Eligible						0.0%
Total Expenditure						0.0%
<b>Remaining HCBS Waivers</b>						
<b>TOTAL EXPENDITURES</b>						
Eligible Member Months	1				1	
Total Cost per Eligible	\$ 1.00				\$ 1.00	
Total Expenditure	\$ 1				\$ 1	
<b>TREND RATES</b>			<u>ANNUAL CHANGE</u>			<u>5-YEAR AVERAGE</u>
Eligible Member Months						0.0%
Total Cost per Eligible						0.0%
Total Expenditure						0.0%



## HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION										
2											
3											
4	MEDICAID POPULATIONS										
5	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
6	GROUP	RATE 1	OF AGING	DY 00 (Oct 13 - Sep 14)	RATE 2	DY 01 (Oct 14 - Sep 15)	DY 02 (Oct 15 - Sep 16)	DY 03 (Oct 16 - Sep 17)	DY 04 (Oct 17 - Sep 18)	DY 05 (Oct 18 - Sep 19)	WOW
7	<u>Title XIX</u>										
8	Eligible Member Months	21.6%	39	1,422,581	21.6%	1,729,859	2,103,508	2,557,866	3,110,365	3,782,204	
9	PMPM Cost	0.0%	39	\$ 1,094.31	5.8%	\$ 1,157.78	\$ 1,224.93	\$ 1,295.98	\$ 1,371.15	\$ 1,450.68	
10	Total Expenditure			\$ 1,556,744,702		\$ 2,002,795,682	\$ 2,576,650,115	\$ 3,314,942,904	\$ 4,264,776,693	\$ 5,486,767,111	\$ 17,645,932,505
11											
12	<u>Disabled</u>										
13	Eligible Member Months	0.0%	39	1	0.0%	1	1	1	1	1	
14	PMPM Cost	0.0%	39	\$ 1.00	0.0%	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	
15	Total Expenditure					\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
16											
17	<u>Eligible for LTC</u>										
18	Eligible Member Months	0.0%	39	1	0.0%	1	1	1	1	1	
19	PMPM Cost	0.0%	39	\$ 1.00	0.0%	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	
20	Total Expenditure					\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
21											
22	<u>HCBS Waivers (State plan eligibles)</u>					Percent State plan:					80%
23	Eligible Member Months	0.0%	39	1	0.0%	1	1	1	1	1	
24	PMPM Cost	0.0%	39	\$ 1.00	0.0%	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	
25	Total Expenditure					\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
26											
27											
28	HYPOTHETICAL GROUPS										
29	<u>Group 1</u>										
30	Eligible Member Months			1,296,580	21.6%	1,576,642	2,054,814	2,498,654	3,038,363	3,694,650	
31	PMPM Cost			\$ 83.19	5.80%	\$ 88.01	\$ 115.95	\$ 122.68	\$ 129.79	\$ 137.32	
32	Total Expenditure			\$ 107,858,573		\$ 138,763,075	\$ 238,258,230	\$ 306,525,884	\$ 394,354,132	\$ 507,347,633	\$ 1,585,248,954
33											
34	<u>Group 2</u>										
35	Eligible Member Months										
36	PMPM Cost										
37	Total Expenditure					\$ -					\$ -
38											
39	<u>Group 3</u>										
40	Eligible Member Months					-	-	-	-	-	
41	PMPM Cost										
42	Total Expenditure					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
43											
44											
45											
46											
47											
48											
49											
50											
51											
52											
53											
54											
55											
56	NOTES										
57	"Base Year" is the year immediately prior to the planned first year of the demonstration.										
58	"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.										
59	"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, "Months of Aging" will be 12.										
60	"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.										

**DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

**MEDICAID POPULATIONS**

ELIGIBILITY GROUP	DY 00 (Oct 13-Sep 14)	DEMO TREND RATE	DEMONSTRATION YEARS (DY)						TOTAL WW
	DY 01 (Oct 14 - Sep 15)		DY 02 (Oct 15 - Sep 16)	DY 03 (Oct 16 - Sep 17)	DY 04 (Oct 17 - Sep 18)	DY 05 (Oct 18 - Sep 19)			
Title XIX									
Eligible Member									
Months	1,422,581	21.6%	1,729,859	2,103,508	2,557,866	3,110,365	3,782,204		
PMPM Cost	\$ 1,050.54	5.8%	\$ 1,111.47	\$ 1,175.94	\$ 1,244.14	\$ 1,316.30	\$ 1,392.65		
Total									
Expenditure			\$ 1,922,685,931	\$ 2,473,599,256	\$ 3,182,343,142	\$ 4,094,173,184	\$ 5,267,285,836	\$ 16,940,087,348	
Disabled									
Eligible Member									
Months	1	0.0%	1	1	1	1	1		
PMPM Cost	\$ 1.00		\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00		
Total									
Expenditure			\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5	
Eligible for LTC									
Eligible Member									
Months	1	0.0%	1	1	1	1	1		
PMPM Cost	\$ 1.00		\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00		
Total									
Expenditure			\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5	
HCBS Waivers (State plan eligibles)									
Eligible Member									
Months	1	0.0%	1	1	1	1	1		
PMPM Cost	\$ 1.00		\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00	\$ 1.00		
Total									
Expenditure			\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5	

**HYPOTHETICAL GROUPS**

<b>Group 1</b>								
Eligible Member								
Months		21.6%	1,576,642	2,054,814	2,498,654	3,038,363	3,694,650	
PMPM Cost		5.8%	\$ 88.01	\$ 115.95	\$ 122.68	\$ 129.79	\$ 137.32	
Total Expenditure			\$ 138,763,075	\$ 238,258,230	\$ 306,525,884	\$ 394,354,132	\$ 507,347,633	\$ 1,585,248,954
<b>Group 2</b>								
Eligible Member								
Months			-	-				
PMPM Cost		0.0%	\$ -	\$ -				
Total Expenditure			\$ -	\$ -				\$ -
<b>Group 3</b>								
Eligible Member								
Months			-	-	-	-	-	
PMPM Cost								
Total Expenditure			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**NEW GROUPS AND EXPENDITURE CATEGORIES**

<b>New Group 1</b>								
Eligible Member								
Months	77,542	21.60%	94,292	322,379	392,012	476,687	579,651	
PMPM Cost	\$ 338.74	5.8%	\$ 358.38	\$ 340.83	\$ 360.60	\$ 381.51	\$ 403.64	
Total Expenditure	\$ 26,266,509		\$ 33,792,599	\$ 109,875,812	\$ 141,358,309	\$ 181,861,423	\$ 233,969,813	\$ 700,857,956

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Title XIX	\$ 2,002,795,682	\$ 2,576,650,115	\$ 3,314,942,904	\$ 4,264,776,693	\$ 5,486,767,111	\$ 17,645,932,505
Disabled	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
Eligible for LTC	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
HCBS Waivers (State plan eligibles)	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
<b>TOTAL</b>	<b>\$ 2,002,795,685</b>	<b>\$ 2,576,650,118</b>	<b>\$ 3,314,942,907</b>	<b>\$ 4,264,776,696</b>	<b>\$ 5,486,767,114</b>	<b>\$ 17,645,932,520</b>

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Title XIX	\$ 1,922,685,931	\$ 2,473,599,256	\$ 3,182,343,142	\$ 4,094,173,184	\$ 5,267,285,836	\$ 16,940,087,348
Disabled	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
Eligible for LTC	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
HCBS Waivers (State plan eligibles)	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1	\$ 5
Excess Spending From Hypotheticals						\$ -
New Group 1	\$ 33,792,599	\$ 109,875,812	\$ 141,358,309	\$ 181,861,423	\$ 233,969,813	\$ 700,857,956
New Group 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
New Group 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Transition Payments SFY 2012 Pools						
<b>TOTAL</b>	<b>\$ 1,956,478,533</b>	<b>\$ 2,583,475,071</b>	<b>\$ 3,323,701,454</b>	<b>\$ 4,276,034,610</b>	<b>\$ 5,501,255,652</b>	<b>\$ 17,640,945,320</b>
<b>VARIANCE</b>	<b>\$ 46,317,152</b>	<b>\$ (6,824,953)</b>	<b>\$ (8,758,547)</b>	<b>\$ (11,257,914)</b>	<b>\$ (14,488,538)</b>	<b>\$ 4,987,201</b>

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Group 1	\$ 138,763,075	\$ 238,258,230	\$ 306,525,884	\$ 394,354,132	\$ 507,347,633	\$ 1,585,248,954
Group 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 4	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ 138,763,075</b>	<b>\$ 238,258,230</b>	<b>\$ 306,525,884</b>	<b>\$ 394,354,132</b>	<b>\$ 507,347,633</b>	<b>\$ 1,585,248,954</b>

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Group 1	\$ 138,763,075	\$ 238,258,230	\$ 306,525,884	\$ 394,354,132	\$ 507,347,633	\$ 1,585,248,954
Group 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 4	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Group 5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ 138,763,075</b>	<b>\$ 238,258,230</b>	<b>\$ 306,525,884</b>	<b>\$ 394,354,132</b>	<b>\$ 507,347,633</b>	<b>\$ 1,585,248,954</b>
<b>HYPOTHETICALS VARIANCE</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

October 3, 2012

Ms. Cassandra Osceola  
Health Director  
Miccosukee Tribe of Florida  
P.O. Box 440021, Tamiami Station  
Miami, FL 33144

Dear Ms. Osceola:

We are writing to consult with the Miccosukee Tribe of Florida, 30 days prior to submitting a Section 1115 Research and Demonstration Waiver application to the Centers for Medicare and Medicaid Services (Federal CMS).

Under Florida's currently approved State Plan Amendment (SPA) 2012-006, notice of changes in the Medicaid program which are anticipated to have direct impact on the federally recognized tribes in Florida must be sent 30 days prior to submission of an initial waiver, waiver amendment, or SPA. The proposed Medically Needy Waiver is not anticipated to have a direct impact on the federally recognized tribes in Florida at this time. However, in the spirit of our collaboration with the Miccosukee Tribe of Florida, this notice and invitation to comment is provided.

In order to implement provisions of Florida law enacted in 2011 related to Florida Medicaid's Medically Needy program, the Agency for Health Care Administration (Agency) is directed to seek federal waiver authority to change the current Medically Needy program as follows: provide additional months of coverage; implement a premium recipients will be required to pay as a condition of maintaining eligibility that would not exceed the recipient's share of cost; and provide care coordination and utilization management to achieve more cost-effective services.

#### Description of Current and Proposed Medically Needy Programs

Currently, eligibility for the Medically Needy program is determined month-to-month. Recipients are deemed eligible from the date their incurred medical bills meet or exceed their share of cost amounts, through the end of that same month. The current Medically Needy program is authorized through the Florida Medicaid State Plan. The request for authority to implement the proposed Medically Needy program will be submitted as an initial Section 1115 Research and Demonstration Waiver. If approved by Federal CMS, the proposed change will give Medically Needy recipients additional months of Medicaid eligibility, with services coordinated through statewide Medicaid managed care organizations who may collect a premium that cannot exceed the share of cost.

Under the proposed Medically Needy program, the criteria for initial eligibility would not be more restrictive than the current Florida State Plan criteria, and persons eligible through the proposed



Medically Needy program would receive additional months of eligibility, regardless of whether their incurred bills exceed their share of cost amount in the months subsequent to their original eligibility month. At the time of eligibility determination for Medicaid and the proposed Medically Needy program, eligible Medically Needy recipients will receive information about the managed care plan choices in their area. The recipients will be informed of their option to select an authorized managed care plan within 30 days of eligibility for Medicaid and the proposed Medically Needy program. If the recipient does not select a plan within the 30-day period, the Agency will assign the individual to a managed care plan. Medicaid coverage will not be available to Medically Needy recipients until they are enrolled in a managed care plan. Payment of at least part of the premium will be a condition of maintaining eligibility for the full 12 additional months of coverage; however, enrollees will receive a 90-day grace period of coverage before being dis-enrolled for non-payment.

The Public Notice Document for the proposed Medically Needy Waiver will be posted by October 11, 2012, on the following Medically Needy program website: [http://ahca.myflorida.com/Medicaid/statewide\\_mc/](http://ahca.myflorida.com/Medicaid/statewide_mc/). The website will also provide the public with an opportunity to provide meaningful input and review other public comments, as well as information on the two public hearings to be held in different areas of the state on October 19 and October 23, 2012.

We welcome your comments on the proposed Medically Needy program. If at any time you would like to discuss the proposed Section 1115 Research and Demonstration waiver for the Medically Needy program, please contact Linda Macdonald at (850) 412-4031, or email [Linda.Macdonald@ahca.myflorida.com](mailto:Linda.Macdonald@ahca.myflorida.com).

Sincerely,

  
Justin M. Senior  
Deputy Secretary for Medicaid

JMS/lam

Cc: Denise Ward, Support Services Coordinator, Miccosukee Health Clinic



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

October 3, 2012

Ms. Connie Whidden  
Health Director  
Seminole Tribe of Florida  
3006 Josie Billie Avenue  
Hollywood, FL 33024

Dear Ms. Whidden:

We are writing to consult with the Seminole Tribe of Florida, 30 days prior to submitting a Section 1115 Research and Demonstration Waiver application to the Centers for Medicare and Medicaid Services (Federal CMS).

Under Florida's currently approved State Plan Amendment (SPA) 2012-006, notice of changes in the Medicaid program which are anticipated to have direct impact on the federally recognized tribes in Florida must be sent 30 days prior to submission of an initial waiver, waiver amendment, or SPA. The proposed Medically Needy Waiver is not anticipated to have a direct impact on the federally recognized tribes in Florida at this time. However, in the spirit of our collaboration with the Seminole Tribe of Florida, this notice and invitation to comment is provided.

In order to implement provisions of Florida law enacted in 2011 related to Florida Medicaid's Medically Needy program, the Agency for Health Care Administration (Agency) is directed to seek federal waiver authority to change the current Medically Needy program as follows: provide additional months of coverage; implement a premium recipients will be required to pay as a condition of maintaining eligibility that would not exceed the recipient's share of cost; and provide care coordination and utilization management to achieve more cost-effective services.

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Under the proposed Medically Needy program, the criteria for initial eligibility would not be more restrictive than the current Florida State Plan criteria, and persons eligible through the proposed



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[http://ahca.myflorida.com/Medicaid/statewide\\_mc/](http://ahca.myflorida.com/Medicaid/statewide_mc/). The website will also provide the public with an opportunity to provide meaningful input and review other public comments as well as information on the two public hearings to be held in different areas of the state on October 19 and October 23, 2012.

We welcome your comments on the proposed Medically Needy program. If at any time you would like to discuss the proposed Section 1115 Research and Demonstration waiver for the Medically Needy program, please contact Linda Macdonald at (850) 412-4031, or email [Linda.Macdonald@ahca.myflorida.com](mailto:Linda.Macdonald@ahca.myflorida.com).

Sincerely,

  
Justin M. Senior  
Deputy Secretary for Medicaid

JMS/lam

Cc: Kathy Wilson, Eligibility & Utilization Services Program Manager