Medicaid Impact Conference
Session 2010

Revisions Post Conference of February 26, 2010

ISSUE SUMMARY

Medicaid Impact Conference Issues

February 26, 2010

#	Issue	Action	Proposed Savings Date	Annualized General Revenue	Annualized Trust Fund	Annualized Total
1	Payment for Preventable Hospital Errors	Provide an estimate of savings by expanding the policy of no longer reimbursing hospitals for preventable errors to the full Medicare policy.	Pending			Pending
2	Pharmaceutical Expense Assistance	Provide an analysis of estimated savings due to reducing the appropriation for this program to the most recent FY 2010-11 estimates.	7/1/2010	(400,000)		(400,000)
3	Nursing Home/Hospice Rate Reduction	Provide the estimated savings by reducing the FY 2010-11 Nursing Home/Hospice rates by 1%. Provide a mechanism to calculate the reduction. Include impact on Hospice rates.	7/1/2010	(11,919,306)	(19,072,131)	(30,991,437)
4	Hospital Inpatient Rate Reduction	Provide the estimated savings by reducing the FY 2010-11 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction.	7/1/2010	(16,455,039)	(26,396,069)	(42,851,108)
5	Hospital Outpatient Rate Reduction	Provide the estimated savings by reducing the FY 2010-11 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction.	7/1/2010	(4,392,376)	(7,078,989)	(11,471,365)
6	HMO Rate Reduction	Provide the estimated savings by reducing the FY 2010-11 HMO Provider rates by 1%. Provide a mechanism to calculate the reduction.	9/1/2010	(10,141,266)	(16,478,131)	(26,619,397)
7	County Health Department Rates	Provide the estimated savings by reducing the FY 2010-11 County Health Department rates by 1%. Provide a mechanism to calculate the reduction.	7/1/2010	(609,232)	(984,908)	(1,594,140)
8	County Health Department Rates	Provide the estimated savings by reducing the FY 2010-11 County Health Department rates to the same level as the estimated average rate for federally qualified health centers.	7/1/2010	(22,888,967)	(36,984,136)	(59,873,103)
9	ICF/DD Rate Reduction	Provide the estimated savings by reducing the FY 2010-11 ICF-DD Provider rates by 1%. Provide a mechanism to calculate the reduction.	10/1/2010	(1,015,364)	(1,624,687)	(2,640,051)

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10	Hospice *	Savings associated with limiting hospice payments to the Medicare annual hospice aggregate amount for each facility consistent with federal policy limits by facility.	11/01/2010	(6,586,017)	(10,538,311)	(17,124,328)
11	Adult Vision Services *	Savings associated with eliminating this service based on FY 2010-11 estimate.	10/1/2010	(4,828,402)	(7,985,449)	(12,813,851)
12	Adult Hearing Services *	Savings associated with eliminating this service based on FY 2010-11 estimate.	10/1/2010	(1,026,105)	(1,650,697)	(2,676,802)
13	Adult Dental Services *	Savings associated with eliminating this service based on FY 2010-11 estimate.	10/1/2010	(8,638,959)	(14,042,489)	(22,681,448)
14	Adult Dental Services *	Savings associated with eliminating partial dentures based on the FY 2010-11 estimate.	10/1/2010	(438,658)	(713,031)	(1,151,689)
15	Adult Podiatric Services *	Savings associated with eliminating this service based on FY 2010-11 estimate.	10/1/2010	(1,376,179)	(2,211,774)	(3,587,953)
16	Adult Chiropractic Services *	Savings associated with eliminating this service based on FY 2010-11 estimate.	10/1/2010	(427,715)	(687,415)	(1,115,130)
17	Hospice Services *	Savings associated with eliminating this service based on FY 2010-11 estimate. Provide savings net of add backs such as nursing home care and hospital services.	1/1/2011	(31,855,453)	(39,649,491)	(71,504,944)
18	FHK Rate Freeze	Provide an estimate of the savings if FHK capitation rates were frozen at the June 30, 2009 level.	10/1/2010	(4,248,383)	(9,342,093)	(13,590,475)
19	Limit Medicaid Behavioral Health Overlay Services to six days per week for juvenile justice and child welfare clients *	Savings associated with limiting behavioral health overlay services for youths in juvenile justice and child welfare settings to six days a week.	1/1/2011	(1,599,041)	(1,990,277)	(3,589,318)
20	Expand Medicaid Drug Rebate Collections to Injectable Drugs	Savings associated with additional manufacturer drug rebate collection on injectable drugs.	7/1/2010	(1,268,845)	1,268,845	0
21a	Reduce MediPass Primary Care Case Management Fee **	Savings associated with reducing the per member per month case management fee for beneficiaries served through the Medicaid fee-for-service program to $1.00. Analysis should discuss any federal or state implementation issues with reducing this fee.	1/1/2011	(4,843,774)	(6,054,889)	(10,898,663)

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21b	Eliminate MediPass Primary Care Case Management Fee **	Savings associated with eliminating the per member per month case management fee for beneficiaries served through the Medicaid fee-for-service program. Analysis should discuss any federal or state implementation issues with eliminating this fee.	1/1/2011	(9,687,565))	(12,109,798)	(21,797,363)
22	Reduce Children's Medical Services (CMS) Primary Care Center Targeted Case Management Fee	Savings associated with reducing the per member per month case management fee for CMS individuals to $1.00. Analysis should discuss any federal or state implementation issues with reducing this fee.	10/1/2010	(969,994)	(1,552,092)	(2,522,086)
23	Eliminate Medicaid Eligibility for 19 & 20 Year Olds	Savings associated with eliminating Optional Medicaid coverage for children aged 19 and 20 effective January 1, 2011 due to MOE requirements for AARA stimulus funds. Analysis should include number of beneficiaries impacted as well as annualized savings and numbers impacted.	1/1/2011	(16,044,905)	(19,970,595)	(36,015,500)
24	Reduce Medicaid Eligibility for Pregnant Women to 150% of Poverty *	Savings associated with the elimination of optional Medicaid coverage for pregnant women with incomes of 150-185% of the federal poverty level effective January 1, 2011 due to MOE requirements for AARA stimulus funds. Analysis should include number of beneficiaries impacted as well as annualized savings and numbers impacted.	1/1/2011	(26,183,135)	(33,122,825)	(59,305,962)
25	Eliminate the Medicaid Breast and Cervical Cancer Treatment Program *	Savings associated with the elimination of Optional Medicaid Coverage for women currently eligible for Medicaid services due to a diagnosis of breast or cervical cancer through the Mary Brogan Breast and Cervical Cancer program administered through the DOH. Savings amounts should have an effective date of January 1, 2011 due to MOE requirements for AARA stimulus funds. Analysis should include number of beneficiaries impacted as well as annualized savings and numbers impacted.	1/1/2011	(4,796,982)	(6,528,428)	(11,325,410)

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26	Disease Management Contracts	Provide an estimate of savings if provisions of OPPAGA Research Memorandum-Options to Reduce Disease Management Program Costs-January 15, 2009 were implemented.	7/1/2010	(692,280)	(1,107,720)	(1,800,000)
27	Nursing Home Diversion	Provide an estimate of savings associated with increasing nursing home diversion slots by the number of new nursing home slots agreed upon for the FY 2010-11 estimate. Analysis should include estimated resource needs.	7/1/2010	(6,501,794)	(10,311,239)	(16,813,033)
28	Home & Community Based Services Waivers	Provide an estimate of the savings associated with consolidating the smaller waivers that operate in limited areas of the state into existing larger waivers that operate statewide. Provide a mechanism for calculating the savings. Discuss any federal approval or implementation issues in your analysis.	7/1/2010	(1,132,870)	(1,812,709)	(2,945,579)
29	Home & Community Based Services Waivers	Provide an estimate of the savings associated with aligning clients with the most cost effective waiver for which the individual has met the criteria. Provide a mechanism for calculating the savings. Discuss any federal approval or implementation issues in your analysis.	Pending			Pending
30	Home & Community Based Services Waivers	Provide an estimated average cost for an individual in a waiver, including the Medicaid state plan costs compared to the average nursing home diversion cost. Provide a mechanism for calculating the savings.	Pending			Pending
31	Reduce the Maximum Daily Number of Home Health Aide Visits from 4 to 3 *	Provide an estimate of the savings associated with reducing home health aide visits to 3 visits per day. Provide a mechanism for calculating the savings.	1/1/2011	(436,941)	(543,848)	(980,789)
32	Limit Private Duty Nursing Services	Provide an estimate of the savings associated with holding private duty nursing services to 12 continuous hours. Provide a mechanism for calculating the savings.	1/1/2011	(5,393,107)	(6,712,633)	(12,105,740)

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33	Medically Needy	Provide an estimate of savings from reducing the benefits covered under the Medically Needy program. Analysis should discuss any federal or state implementation issues and identify whether premiums could be imposed for adults as approved under the Deficit Reduction Act (DRA).	4/1/2011	(103,980,266)	(129,421,003)	(233,401,268)
34	Risk Adjusted HMO Rates Statewide	Provide an estimate of savings if risk adjusted rates were implemented for HMOs based on the FY 2010-11 estimate.	9/1/2010	195,614	195,615	391,229
35	Managed Care Expansion – MediPass ***	Provide the estimated savings by mandating MediPass recipients, excluding voluntary eligibles, transition to managed care plans in counties where there are 2 or more HMO plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.	7/1/2010	(25,389,396)	(34,241,407)	(59,630,803)
36	Managed Care Expansion – MediPass ***	Provide the estimated savings by mandating MediPass recipients, including voluntary eligibles, transition to HMOs in counties where there are 2 or more HMO plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.	7/1/2010	(42,153,627)	(56,024,498)	(98,178,125)
35a	Managed Care Expansion – MediPass ***	Provide the estimated savings by mandating MediPass recipients, excluding voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans with no capacity or in counties with less than 2 managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.	7/1/2010	(9,032,188)	(12,987,191)	(22,019,379)

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36a	Managed Care Expansion – MediPass ***	Provide the estimated savings by mandating MediPass recipients, including voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans with no capacity or in counties with less than 2 managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.	7/1/2010	(11,399,964	(16,063,829)	(27,463,793)
37	Managed Care Organizations - Medical Loss Ratios	Provide the estimated savings from the establishment of a minimum medical loss ratio of 85% for all Medicaid HMOs similar to behavioral health sciences. Analysis should discuss estimated resource needs, impacts to plan performance, and measures required to maintain plan performance.	9/1/2010	(1,230,186)	(1,981,960)	(3,212,146) Non-recurring
38	Managed Care Organizations - Fraud Detection	Provide the estimated savings by expanding efforts to monitor for potentially abusive or fraudulent corporate practices. Analysis should discuss estimated resource needs, impacts to plan performance, and measures required to maintain plan performance.	7/1/2010		718,116	718,116
39	Managed Care Organizations	Provide the estimated savings by making managed care organizations at risk for all Medicaid services, including long term care, and enrollment growth within geographic areas.	7/1/2011			Pending
40	Statewide Contracting - Medicaid HMO	Provide the estimated savings by limiting the number of Medicaid HMO providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.	Pending			Pending
41	Statewide Contracting - Pharmacy	Provide the estimated savings by limiting the number of pharmacy providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.	Pending			Pending
42	Statewide Contracting - Durable Medical Equipment	Provide the estimated savings by limiting the number of durable medical equipment providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.	Pending			Pending

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43	Statewide Contracting - Home Health Services	Provide the estimated savings by limiting the number of home health services providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.	7/1/2011			Pending
44	Statewide Contracting - Hospital Services	Provide the estimated savings by limiting the number of hospital service providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.	Pending			Pending
45	Pharmacy Reimbursement	Provide the estimated savings from lowering the Average Wholesale Price (AWP) component in the pharmacy reimbursement methodology from AWP minus 16.4% to minus 17.4%; and lowering the Wholesale Acquisition Cost (WAC) pricing component from WAC plus 4.75% to 3.75% and alternative WAC based pricing.	7/1/2010			N/A
46	Prepaid Dental Program	Provide the estimated savings from expanding the prepaid dental program statewide.	7/1/2011	(2,471,737)	(3,083,120)	(5,554,857)
47	HIV/AIDS Specialty Plan	Provide the estimated savings from expanding the specialty plan to include home and community based services.	7/1/2010			Pending
48	Nursing Home - Intermediate Care II	Provide the estimated savings from transferring Intermediate Care II clients to Assisted Living Facilities.	7/1/2010	(21,532,069)	(34,453,550)	(55,985,619)
49	ICF/DD Assessment	Provide an estimate of revenue generated by requiring an assessment of net revenue to ICF/DD facilities up to the maximum allowable amount of 5.5%. Estimate should include the amount of state funds that could be eliminated from this service and hold the providers harmless.	10/1/2010	(2,069,910)	3,363,519	
50	Nursing Home/Hospice Assessment	Provide an estimate of revenue generated by requiring an assessment of net revenue to Nursing Home/Hospice facilities up to the maximum allowable amount of 5.5%. Estimate should include the amount of state funds that could be eliminated from this service and hold the providers harmless.	7/1/2010	(32,985,961)	53,600,846	

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51	HMO Assessment	Provide an estimate of revenue generated by requiring an assessment of net revenue to managed care organizations. Include the maximum allowable amount of 5.5% and a mechanism to calculate a lower amount.	7/1/2010	(410,263,079)	410,263,079	0
52	Hospital IP Assessment Increase	Provide an estimate of revenue generated from increasing the inpatient hospital assessment by 1%. Provide a mechanism to calculate the assessment.	7/1/2010	(215,096,033)	215,096,033	0
53	Hospital OP Assessment Increase	Provide an estimate of revenue generated from increasing the outpatient hospital assessment by 1%. Provide a mechanism to calculate the assessment.	7/1/2010	(111,524,195)	111,524,195	0
54	Nursing Home County Billing	Provide an estimate of revenue generated from increasing the county contribution for nursing home and intermediate care facilities from $55 per month per person to $202.	1/1/2011	(66,682,221)	66,682,221	0
55	Kidcare	Provide estimated costs of providing dental services in accordance with the provisions of the Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009.	7/1/2010	692,125	1,504,399	2,196,524
56	Medicaid Waiver	Provide estimated savings from the approval of a waiver that would limit Medicaid expenditures to legislative appropriations. Analysis should include recommended level of funding that would be necessary to obtain such waiver.	1/1/2011			N/A
57	Medically Needy	Provide estimated savings if the agency considered "split billings" in the share of cost calculation. Please discuss any federal implementation issues.	7/1/2010	(8,131,982)	(13,012,018)	(21,144,000)
58	Medicare Special Needs Plan (SNPs)	Provide estimated savings if persons eligible for both Medicare and Medicaid (dual eligibles), were mandatorily enrolled in SNPs. Please discuss any federal or state implementation issues.	1/1/2011	(23,304,289)	(29,006,124)	(52,310,413)

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59	Expand Coverage of Disposable Incontinence Products	Provide an estimate of cost to expand coverage of disposable incontinence products for Medicaid beneficiaries 21 and under. Analysis should include the amount of funding that should be moved from the HCBS waiver for this service in APD.	1/1/2011	8,689,780	10,815,900	19,505,680
60	Statewide Implementation of Hospitalist Programs	Provide estimated savings associated with statewide expansion of the Hospitalist program. Analysis should include savings with full implementation to all hospitals and savings associated with full implementation, but exempting teaching hospitals. Analysis should discuss any federal and state implementation issues.	7/1/2011	(8,001,832)	(9,959,631)	(17,961,463)
61	Supplemental Nursing Home payments for AIDS Care.	Provides estimated savings from eliminating the supplemental payment for AIDS patients served in Nursing Homes. Analysis should include providers claiming the supplemental payment and reporting the off-set on cost reports as well as providers claiming the care cost and not reporting the off-set.	7/1/2010	(154,218)	(246,765)	(400,983)
62	Capitated Incontinence Supplies	Provide estimated savings from implementing a statewide capitated incontinence supply program. Analysis should discuss any federal or state implementation issues.	7/1/2012	(492,980)	(613,596)	(1,106,576)
63a	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associate with eliminating nursing home bed hold days or limiting to four days instead of eight. Analysis should show savings at 85 percent occupancy rates.	7/1/2010	(4,749,765)	(7,600,119)	(12,349,884)
63b	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associate with eliminating nursing home bed hold days or limiting to four days instead of eight. Analysis should show savings at 90 percent occupancy rates.	7/1/2010	(2,384,737)	(3,815,827)	(6,200,564)
64a	Eliminate/Reduce ICF-DD Bed Hold Days	Savings associate with eliminating ICF-DD bed hold days or limiting to four days instead of eight. Analysis should show savings at 85 percent occupancy rates.	10/1/2010	(67,788)	(108,467)	(176,255)

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64b	Eliminate/Reduce ICF-DD Bed Hold Days	Savings associate with eliminating ICF-DD bed hold days or limiting to four days instead of eight. Analysis should show savings at 90 percent occupancy rates.	10/1/2010	(40,673)	(65,080)	(105,753)
65	Reduce Nurse Staffing Requirements to 2.6 Hours	Savings associated with reducing required nursing staffing ratios to 2.6 hours from the current 2.9 average hours.	7/1/2010	(11,544,516)	(18,472,427)	(30,016,943)
66	Hospice	Savings associated with implementation of a federal waiver to limit Medicaid Hospice services to a maximum of 210 days	7/1/2010	(3,329,797)	(5,328,020)	(8,657,817)
67	Fraud and Abuse	Savings associated with reducing the managed care discount factor by 4.5% in Miami-Dade County due to a Fraud and Abuse Adjustment.	9/1/2010	($10,478,119)	($16,766,080)	($27,244,199)

* Savings identified for this issue may be reduced due to unforeseen shifts in behavioral or service needs. These shifts cannot be identified or anticipated at this point; therefore the potential impact to the savings is not included in the analysis provided.

** The reduction or elimination of the MediPass fee may result in an unintended impact to the Managed Care Waiver and may risk the ability to mandatorily assign recipients to a health plans in counties where there is only one plan other than MediPass. Choice must be provided in order to mandatorily assign recipients to a plan.

*** The same level of funding contributions from all payers (IGTs) is assumed.

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ISSUE DETAIL

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #1

Proposal Name:	Payment for Preventable Hospital Errors
Brief Description of Proposal:	Expand Medicaid policy to no longer reimburse hospitals for preventable errors that extend inpatient hospital stays.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	The Agency has begun work on the first steps of this project through a contract with the inpatient hospital services prior authorization vendor. There are legal challenges postponing implementation. The Agency anticipates that the challenge will be resolved and a new contract in place by January 1, 2011.
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	12 months	The Agency has begun work on the first steps of this project through a contract with the inpatient hospital services prior authorization vendor. There are legal challenges postponing implementation.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	N/A	Already have a state plan amendment to no longer reimburse hospitals for preventable hospital errors. Amendment was submitted 06/30/09 and approved 09/25/09 effective 01/01/10.
IV. Will this require the Procurement Process?	Yes	Florida Medicaid reimburses hospitals an inpatient per diem rate. Florida Medicaid has tried to implement this project by considering these errors when the peer review organization approves prior authorization days. The procurement for the peer review organization is on hold due to legal challenge. Procurements can take up to six months or longer when challenged.
V. Will this proposal require an administrative rule?	Yes	The provider handbooks will have to be updated with the new policy. This process will take a minimum of four months which can be concurrent with the procurement process. The Agency will begin this process in April 2010.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	

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VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Mike Bolin
Secondary Analyst:	Princilla Jefferson
Assumptions (Data source and methodology):	Anticipated saving are contingent on additional analysis and policy changes once a new vendor is in place. Therefore, no savings calculation is available at this time.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/15/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**Pending**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:			
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

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Work Papers/Notes/Comments: **Issue #1 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Section 5001(c) of the Deficit Reduction Act of 2005 requires Medicare to identify at least two conditions that are (a) high cost and/or high volume; (b) result in the assignment of a case to a diagnosis related grouper (DRG) that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. In August 2007, Medicare published the FY2008 Inpatient Prospective Payment System (IPPS) Final Rule. The Final Rule included six conditions that when present trigger a higher payment under Medicare reimbursement methodology. For discharges after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (the condition was not present on admission to the hospital). Payment would be made under the Medicare reimbursement methodology as if the secondary diagnosis was not present.

Beginning October 1, 2007, Medicare IPPS hospitals must include present on admission indicators for the conditions identified by the Final Rule for consideration in adjusting Medicare reimbursement beginning October 1, 2008.

Florida pays hospitals on a per diem based on Medicaid allowable costs rather than on a DRG methodology. With the per diem payment methodology, the Florida Medicaid Management Information System cannot identify and exclude a specific diagnosis and the costs associated with that preventable medical error from the hospital per diem payment. The per diem rate is based on the number of covered days, not diagnoses present on a claim.

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Proposal: Issue #2

Proposal Name:	Pharmaceutical Expense Assistance Reduction
Brief Description of Proposal:	Reduce state (non-Medicaid, GR only) pharmaceutical expense assistance funding to FY 2008-2009 expenditure level
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($400,000)
Bureau(s) Responsible for Administration:	Pharmacy

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	The program is currently operational.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Anne Wells
Secondary Analyst:	Marie Donnelly
Assumptions (Data source and methodology):	Actual expenditures for this program for FY 08/09 were obtained from paid claims data.
FY Impacted by Implementation:	2010/2011
Date Analysis Completed:	January 2010

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Funding Sources:	Start Year	Additional Year	Issue #2 Cont. Annualized
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($400,000)**		**($400,000)**
General Revenue:	**($400,000)**		**($400,000)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($0)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The Pharmaceutical Expense Assistance Program was established on January 1, 2006 pursuant to section 409.9301, Florida Statutes. The purpose of the program is to pay coinsurance and deductibles for certain Medicare Part B drugs related to cancer and organ transplant for patients that are eligible for Medicaid through the Medically Needy category.

Under the Pharmaceutical Expense Assistance Program these specific drugs are paid with state funds, and individuals eligible for the program are not required to meet their Medicaid share of cost obligation prior to coverage. Further, expenditures for the drugs covered under this program do not count toward the individual's share of cost requirement for other Medicaid funded services.

Only those 652 individuals who met eligibility requirements as of January 1, 2006 were enrolled in the program. The program included Medicare eligible individuals who were also eligible under the Florida Medicaid Medically Needy program and who had been diagnosed with cancer or were organ transplant recipients. No new enrollees have been added, and through attrition, the number of individuals who accessed the program during fiscal year 2008-2009 has decreased to 71. Occasionally, individuals who have not used the benefit for some time may access the program again (i.e., recurrence of cancer).

Amounts reimbursed by the state are the Medicare deductible or copayment requirement for the specific drugs covered. After Medicare Part B reimburses the provider for the initial claim, Medicaid pays the "crossover" claim for the residual amount. The state reimbursed crossover claims for coinsurance and deductible amounts for specific cancer and anti-rejection drugs for a total of $33,616 during fiscal year 2008-2009. The proposed budget reduction would reduce the current annual funding of $450,000 to $50,000 for fiscal year 2010-2011.

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Proposal: Issue #3

Proposal Name:	Nursing Home/Hospice Rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 Nursing Home/Hospice rates by 1%. Provide a mechanism to calculate the reduction. Include impact on Hospice rates.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($30,991,437)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Long-Term Care Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #3 Cont.**

Lead Analyst:	Steve Russell
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective July 1, 2010.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/18/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($30,991,437)**		
General Revenue:	**($11,919,306)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($19,072,131)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

	Reduction
TOTAL COST	($30,991,437)
TOTAL GENERAL REVENUE	($11,919,306)
TOTAL MEDICAL CARE TRUST FUND	($19,072,131)
TOTAL REFUGEE ASSISTANCE TF	$0

Given where the NH assessments are currently authorized and structured, the industry may not be able to buy this rate reduction back. See table below for buy-back information assuming assessments of revenue up to the maximum allowable of 5.5%.

Medicaid Impact Conference Issues

February 26, 2010

Issue #3 Cont.

NURSING HOMES

		1%	Reduction
	44,335	44,335	0
SKILLED CARE CASELOAD	9,944	9,944	0
SKILLED CARE UNIT COST	$5,431.39	$5,377.08	($54.31)
SKILLED CARE TOTAL COST	$648,117,171	$641,636,202	($6,480,969)
CROSSOVER CASELOAD	369	369	0
CROSSOVER UNIT COST	$1,573.77	$1,573.77	$0.00
CROSSOVER TOTAL COST	$6,968,636	$6,968,636	$0
INTERMEDIATE CARE CASELOAD	32,654	32,654	0
INTERMEDIATE CARE UNIT COST	$5,390.69	$5,336.78	($53.91)
INTERMEDIATE CARE TOTAL COST	$2,112,331,003	$2,091,206,569	($21,124,434)
GENERAL CARE CASELOAD	1,368	1,368	0
GENERAL CARE UNIT COST	$5,368.99	$5,315.30	($53.69)
GENERAL CARE TOTAL COST	$88,137,266	$87,255,965	($881,301)
SPECIAL PAYMENTS TO NURSING HOMES	$13,518,350	$13,518,350	$0
TOTAL COST	$2,869,072,426	$2,840,585,722	($28,486,704)
TOTAL GENERAL REVENUE	$528,102,466	$517,146,480	($10,955,986)
TOTAL MEDICAL CARE TRUST FUND	$1,779,127,171	$1,761,596,453	($17,530,718)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$270,000,000	$270,000,000	$0
TOTAL GRANTS AND DONATIONS TF	$291,842,789	$291,842,789	$0

Medicaid Impact Conference Issues

February 26, 2010

HOSPICE

MEDICAID CASELOAD	17,039	17,039	0
MEDICAID UNIT COST	$1,726.04	$1,713.79	($12.25)
MEDICAID TOTAL COST	$352,919,947	$350,415,214	($2,504,733)
TOTAL COST	$352,919,947	$350,415,214	($2,504,733)
TOTAL GENERAL REVENUE	$82,882,027	$81,918,707	($963,320)
TOTAL MEDICAL CARE TRUST FUND	$217,186,935	$215,645,522	($1,541,413)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$42,000,000	$42,000,000	$0
TOTAL GRANTS AND DONATIONS TF	$10,850,985	$10,850,985	$0

Breakdown of NH cuts/buyback FY1011 (assuming max 5.5% revenue)	1% Cut
NFQA FEE COLLECTED	$349,313,863
FMAP	61.54%
TOTAL COLLECTED (FEE + MATCH)	$908,252,374
TOTAL MED SHARE	($217,286,596)
OPERATION ADD-ON REIMBUSEMENT	($96,893,157)
ADMINITRATION COST	($349,911)
HOSPICE RESTORE	($34,784,198)
TOTAL BUYBACK AVAILABLE	$558,938,512
CUTS 2, 3,4	$390,392,167
CUT 5	$81,333,369
CUT - 6 proposed reduction	**$28,486,704**
TOTAL CUT BEFORE NFQA MAX AND RATE FREEZE	$500,212,240
BUYBACK SURPLUS (DEFICIT). If there is a surplus, then will CUT/BUYBACK to zero out funds. If there is a deficit, then the deficit will be cut and no buyback.	$58,726,272
CUT/BUYBACK - MAXIMIZE NFQA	($58,726,272)
TOTAL REDUCTION AFTER NFQA MAX	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #4

Proposal Name:	Inpatient Hospital Rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10-11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($41,013,742)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009. 15% Budget Reduction, Agency Analysis 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #4 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective July 1, 2010.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/18/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($41,013,742)**		**($42,851,108)**
General Revenue:	**($15,751,154)**		**($16,455,039)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($25,203,487)**		**($26,329,775)**
Refugee Assistance Trust Fund:	**($59,101)**		**($66,294)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

	1.00%	FY1011 reduction	Annual Reduction
TOTAL COST		($41,013,742)	($42,851,108)
TOTAL GENERAL REVENUE		($15,751,154)	($16,455,039)
TOTAL MEDICAL CARE TRUST FUND		($25,203,487)	($26,329,775)
TOTAL REFUGEE ASSISTANCE TF		($59,101)	($66,294)

Medicaid Impact Conference Issues

February 26, 2010

Issue # 4 Cont.

0.6154			
HOSPITAL INPATIENT SERVICES		1%	Reduction
MEDICAID CASELOAD	1,248,847	1,248,847	0
MEDICAID UTILIZATION RATE	2.56%	2.56%	0.00%
MEDICAID ADMISSIONS PER MONTH	31,937	31,937	0
MEDICAID DAYS PER ADMISSION	5.03	5.03	0.00
MEDICAID PER DIEM	$1,651.31	$1,634.80	($16.51)
MEDICAID TOTAL COST	$3,182,691,263	$3,150,864,350	($31,826,913)
AM-SURG CASELOAD	2,806,630	2,806,630	0
AM-SURG UTILIZATION RATE	0.11%	0.11%	0.00%
AM-SURG SERVICES/MONTH	2,988	2,988	0
AM-SURG UNIT COST	$495.79	$495.79	$0.00
AM-SURG TOTAL COST	$17,777,062	$17,777,062	$0
CHILD CASELOAD	1,736,369	1,736,369	0
CHILD UTILIZATION RATE	0.04%	0.04%	0.00%
CHILD SERVICES/MONTH	775	775	0
CHILD UNIT COST	$6,600.31	$6,600.31	$0.00
CHILD TOTAL COST	$61,382,891	$61,382,891	$0
SPECIAL PAYMENTS TO HOSPITALS	$168,300	$168,300	$0
DISPROPORTIONATE SHARE	$0	$0	$0
TOTAL COST	$3,262,019,516	$3,230,192,603	($31,826,913)
TOTAL GENERAL REVENUE	$514,906,828	$502,659,745	($12,231,733)
TOTAL MEDICAL CARE TRUST FUND	$1,985,981,168	$1,966,401,338	($19,572,045)
TOTAL REFUGEE ASSISTANCE TF	$2,371,125	$2,371,125	($23,135)
TOTAL PUBLIC MEDICAL ASSIST TF	$380,320,000	$380,320,000	$0
TOTAL GRANTS AND DONATIONS TF	$354,832,535	$354,832,535	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0
TOTAL OTHER STATE FUNDS	$23,607,860	$23,607,860	$0

Medicaid Impact Conference Issues

February 26, 2010

Issue # 4 Cont.

PREPAID HEALTH PLAN				
CASELOAD	1,120,345	1,120,345	0	
UNIT COST	$198.34	$197.52	($0.82)	0.995865784
TOTAL COST	$2,666,574,740	$2,655,550,545	($11,024,195)	
CASELOAD-MENTAL HEALTH	661,258	661,258	0	
UNIT COST	$34.48	$34.48	$0.00	
TOTAL COST	$273,595,997	$273,595,997	$0	
TOTAL COST	$2,940,170,737	$2,929,146,542	($11,024,195)	($9,186,829)
TOTAL GENERAL REVENUE	$688,906,260	$684,683,165	($4,223,306)	($3,519,421)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,802,353,995	$1,795,596,054	($6,757,730)	($5,631,442)
TOTAL REFUGEE ASSISTANCE TF	$11,510,482	$11,467,323	($43,159)	($35,966)
TOTAL TOBACCO SETTLEMENT TF	$437,400,000	$437,400,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #5

Proposal Name:	Outpatient Hospital Rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10-11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($10,932,582)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Outpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009. 15% Budget Reduction, Agency Analysis 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #5 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective July 1, 2010.
FY Impacted by Implementation:	FY 10-11
Date Analysis Completed:	02/19/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($10,932,582)**		**($11,471,365)**
General Revenue:	**($4,185,971)**		**($4,392,376)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($6,721,420)**		**($7,051,689)**
Refugee Assistance Trust Fund:	**($25,191)**		**($27,300)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

	1.0%	FY1011 reduction	Annual Reduction
TOTAL COST		($10,932,582)	($11,471,365)
TOTAL GENERAL REVENUE		($4,185,971)	($4,392,376)
TOTAL MEDICAL CARE TRUST FUND		($6,721,420)	($7,051,689)
TOTAL REFUGEE ASSISTANCE TF		($25,191)	($27,300)

Medicaid Impact Conference Issues

February 26, 2010

Issue #5 Cont.

0.6154				
HOSPITAL OUTPATIENT SERVICES		1%		
MEDICAID CASELOAD	1,248,847	1,248,847		
MEDICAID UTILIZATION RATE	69.87%	69.87%		
MEDICAID SERVICES PER MONTH	872,537	872,537		
MEDICAID UNIT COST	$78.68	$77.90	($1)	
MEDICAID TOTAL COST	$823,866,778	$815,628,110	($8,238,668)	
CROSSOVER CASELOAD	437,439	437,439		
CROSSOVER UTILIZATION RATE	18.33%	18.33%		
CROSSOVER SERVICES/MONTH	80,195	80,195		
CROSSOVER UNIT COST	$137.63	$137.63		
CROSSOVER TOTAL COST	$132,450,795	$132,450,795		
SPECIAL PAYMENTS	$0	$0		
TOTAL COST	$956,317,573	$948,078,905	($8,238,668)	($8,238,668)
TOTAL GENERAL REVENUE	$176,087,436	$172,945,322	($3,153,948)	($3,153,948)
TOTAL MEDICAL CARE TRUST FUND	$587,492,576	$582,410,666	($5,070,076)	($5,070,076)
TOTAL REFUGEE ASSISTANCE TF	$1,699,876	$1,685,232	($14,644)	($14,644)
TOTAL PUBLIC MEDICAL ASSIST TF	$105,000,000	$105,000,000	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$86,037,685	$86,037,685	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Issue #5 Cont.

PREPAID HEALTH PLAN				
CASELOAD	1,120,345	1,120,345		
UNIT COST	$198.34	$198.10	($0.24)	
TOTAL COST	$2,666,574,740	$2,663,342,043		
CASELOAD-MENTAL HEALTH	661,258	661,258		
UNIT COST	$34.48	$34.48		
TOTAL COST	$273,595,997	$273,595,997		
TOTAL COST	$2,940,170,737	$2,936,938,040	($3,232,697)	($2,693,914)
TOTAL GENERAL REVENUE	$688,906,260	$687,667,894	($1,238,428)	($1,032,023)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,802,353,995	$1,800,372,320	($1,981,613)	($1,651,344)
TOTAL REFUGEE ASSISTANCE TF	$11,510,482	$11,497,826	($12,656)	($10,547)
TOTAL TOBACCO SETTLEMENT TF	$437,400,000	$437,400,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #6

Proposal Name:	HMO Rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 HMO rates by 1%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	09/01/2010
If not July 1, start date; please explain.	This will follow the HMO rate setting which is September 1.
Total Cost/(Savings)/{Revenue}:	($22,182,831)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Rates are set September 1 each year and are subject to Actuarial certification.
II. Will this proposal require a change in Florida Statute?	Yes	409.9124, F.S.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #6 Cont.**

Lead Analyst:	Jack Shi
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective September 1, 2010.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/19/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**10**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($22,182,831)**		**(26,619,397)**
General Revenue:	**($8,451,055)**		**($10,141,266)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($13,644,933)**		**($16,373,919)**
Refugee Assistance Trust Fund:	**($86,843)**		**($104,212)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

Based on the previous two years and recent discussions with the actuaries, it is unlikely that a straight rate reduction, not linked with a FFS efficiency or reduction or new policy that impacts the rates such as fraud and abuse adjustments, would be found actuarially sound for 09/01/10.
HMO rates are set September 1 each year and are subject to actuarial calculations.

	1.0%	10/11 Reduction	Annual Reduction
TOTAL COST		($22,182,831)	($26,619,397)
TOTAL GENERAL REVENUE		($8,451,055)	($10,141,266)
TOTAL OTHER STATE FUNDS		$0	$0
TOTAL MEDICAL CARE TRUST FUND		($13,644,933)	($16,373,919)
TOTAL REFUGEE ASSISTANCE TF		($86,843)	($104,212)

Medicaid Impact Conference Issues

February 26, 2010

Issue #6 Cont.

0.6154				
PREPAID HEALTH PLAN		1.0%		
CASELOAD	1,120,345	1,120,345	0	
UNIT COST	$198.34	$196.36	($1.98)	
TOTAL COST	$2,666,574,740	$2,639,955,343	($26,619,397)	
CASELOAD-MENTAL HEALTH	661,258	661,258	0	
UNIT COST	$34.48	$34.48	$0.00	
TOTAL COST	$273,595,997	$273,595,997	$0	
TOTAL COST	$2,940,170,737	$2,913,551,340	($26,619,397)	($22,182,831)
TOTAL GENERAL REVENUE	$688,906,260	$678,764,994	($10,141,266)	($8,451,055)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,802,353,995	$1,785,980,076	($16,373,919)	($13,644,933)
TOTAL REFUGEE ASSISTANCE TF	$11,510,482	$11,406,270	($104,212)	($86,843)
TOTAL TOBACCO SETTLEMENT TF	$437,400,000	$437,400,000	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #7

Proposal Name:	County Health Department Rates
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 CHD rates by 1%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($1,537,258)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #7 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective July 1, 2010.
FY Impacted by Implementation:	FY 10-11
Date Analysis Completed:	02/19/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,537,258)**		**($1,594,140)**
General Revenue:	**($587,441)**		**($609,232)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($939,969)**		**($974,837)**
Refugee Assistance Trust Fund:	**($9,848)**		**($10,071)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

	1.0%	10/11 Reduction	Annual Reduction
TOTAL COST		($1,537,258)	($1,594,140)
TOTAL GENERAL REVENUE		($587,441)	($609,232)
TOTAL MEDICAL CARE TRUST FUND		($939,969)	($974,837)
TOTAL REFUGEE ASSISTANCE TF		($9,848)	($10,071)

Medicaid Impact Conference Issues

February 26, 2010

Issue #7 Cont.

0.6154				
CLINIC SERVICES		1.0%	Reduction	
MEDICAID CASELOAD	1,248,847	1,248,847	0	
MEDICAID UTILIZATION RATE	4.68%	4.68%	0.00%	
MEDICAID SERVICES PER MONTH	58,495	58,495	0	
MEDICAID UNIT COST	$178.48	$176.70	($1.78)	
MEDICAID TOTAL COST	$125,284,718	$124,031,871	($1,252,847)	
TOTAL COST	$125,284,718	$124,031,871	($1,252,847)	
TOTAL GENERAL REVENUE	$46,873,118	$46,395,329	($478,485)	
TOTAL OTHER STATE FUNDS	$0	$0	$0	
TOTAL MEDICAL CARE TRUST FUND	$76,563,349	$75,797,026	($765,627)	
TOTAL REFUGEE ASSISTANCE TF	$873,518	$864,783	($8,735)	
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	
TOTAL GRANTS AND DONATIONS TF	$974,733	$974,733	$0	
PREPAID HEALTH PLAN				
CASELOAD	1,120,345	1,120,345	0	
UNIT COST	$198.34	$198.32	($0.025)	
TOTAL COST	$2,666,574,740	$2,666,233,447	($341,293)	
CASELOAD-MENTAL HEALTH	661,258	661,258	0	
UNIT COST	$34.48	$34.48	$0.00	
TOTAL COST	$273,595,997	$273,595,997	$0	
TOTAL COST	$2,940,170,737	$2,939,829,444	($341,293)	($284,411)
TOTAL GENERAL REVENUE	$688,906,260	$688,775,519	($130,747)	($108,956)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,802,353,995	$1,802,144,779	($209,210)	($174,342)
TOTAL REFUGEE ASSISTANCE TF	$11,510,482	$11,509,146	($1,336)	($1,113)
TOTAL HEALTH CARE TF	$437,400,000	$437,400,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #8

Proposal Name:	County Health Department Rates
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 CHD rates to the same level as the estimated average rate of FQHC rates. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($56,624,103)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX CHD Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #8 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC.
FY Impacted by Implementation:	FY 10-11
Date Analysis Completed:	02/22/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($56,624,103)**		**($59,873,103)**
General Revenue:	**($21,644,356)**		**($22,888,967)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($34,634,615)**		**($36,626,285)**
Refugee Assistance Trust Fund:	**($345,132)**		**($357,851)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

	FQHC rate	
	FY1011	Annual
TOTAL COST	($56,624,103)	($59,873,103)
TOTAL GENERAL REVENUE	($21,644,356)	($22,888,967)
TOTAL MEDICAL CARE TRUST FUND	($34,634,615)	($36,626,285)
TOTAL REFUGEE ASSISTANCE TF	($345,132)	($357,851)

Medicaid Impact Conference Issues

February 26, 2010

Issue #8 Cont.

CLINIC SERVICES	FQHC rate			
MEDICAID CASELOAD	1,248,847	1,248,847		
MEDICAID UTILIZATION RATE	4.68%	4.68%		
MEDICAID SERVICES PER MONTH	58,495	58,495		
MEDICAID UNIT COST	$178.48	$120.96	($57.53)	
MEDICAID TOTAL COST	$125,284,718	$84,905,618	($40,379,100)	
TOTAL COST	$125,284,718	$84,905,618	($40,379,100)	($40,379,100)
TOTAL GENERAL REVENUE	$46,873,118	$31,451,819	($15,421,299)	($15,421,299)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$76,563,349	$51,887,082	($24,676,267)	($24,676,267)
TOTAL REFUGEE ASSISTANCE TF	$873,518	$591,984	($281,534)	($281,534)
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$974,733	$974,733	$0	$0
PREPAID HEALTH PLAN				
CASELOAD	1,120,345	1,120,345		
UNIT COST	$198.34	$196.89	-1.45	
TOTAL COST	$2,666,574,740	$2,647,080,737	($19,494,003)	
CASELOAD-MENTAL HEALTH	661,258	661,258		
UNIT COST	$34.48	$34.48		
TOTAL COST	$273,595,997	$273,595,997		
TOTAL COST	$2,940,170,737	$2,920,676,734	($19,494,003)	($16,245,003)
TOTAL GENERAL REVENUE	$688,906,260	$681,438,592	($7,467,668)	($6,223,057)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,802,353,995	$1,790,403,977	($11,950,018)	($9,958,348)
TOTAL REFUGEE ASSISTANCE TF	$11,510,482	$11,434,165	($76,317)	($63,598)
TOTAL HEALTH CARE TF	$437,400,000	$437,400,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #9

Proposal Name:	ICF/DD rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2010-11 ICF/DD rates by 1%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	10-11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	Rate setting period is October 1.
Total Cost/(Savings)/{Revenue}:	($1,980,038)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2010.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #9 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Eddy Stephens
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Reduction of 1% effective October 1, 2010.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/19/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,980,038)**		**($2,640,051)**
General Revenue:	**($761,523)**		**($1,015,364)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,218,515)**		**($1,624,687)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

	1%	Reduction	Annual Reduction
TOTAL COST		($1,980,038)	($2,640,051)
TOTAL GENERAL REVENUE		($761,523)	($1,015,364)
TOTAL MEDICAL CARE TRUST FUND		($1,218,515)	($1,624,687)

Medicaid Impact Conference Issues

February 26, 2010

Issue #9 Cont.

0.6154				
ICF-MR COMMUNITY		1%	Reduction	Start 10/1/10
	2,005			
CASELOAD PRIVATE	1,179	1,179	0	
UNIT COST	$10,683.31	$10,576.47	($106.84)	
TOTAL COST	$151,147,429	$149,635,898	($1,511,531)	
CASELOAD CLUSTER	624	624	0	
UNIT COST	$12,169.31	$12,047.62	($121.69)	
TOTAL COST	$91,123,783	$90,212,579	($911,204)	
CASELOAD SIXBED	226	226	0	
UNIT COST	$8,013.46	$7,933.33	($80.13)	
TOTAL COST	$21,732,507	$21,515,191	($217,316)	
TOTAL COST	$264,003,719	$261,363,668	($2,640,051)	($1,980,038)
TOTAL GENERAL REVENUE	$89,481,106	$88,465,743	($1,015,364)	($761,523)
TOTAL MEDICAL CARE TRUST FUND	$162,467,889	$160,843,201	($1,624,687)	($1,218,515)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$12,054,724	$12,054,724	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #10

Proposal Name:	Savings associated with limiting hospice payments to the Medicare annual hospice aggregate amount
Brief Description of Proposal:	This proposal would apply the Medicare annual aggregate cap for hospice services to Medicaid. This means that overall aggregate payments made to a hospice would be subject to the "cap amount" which is calculated by the Medicare fiscal agent annually at the end of the hospice cap period which runs from Nov. 1 of each year through Oct. 31 of the next year. The total payments made for services furnished to Medicaid beneficiaries during this period are then compared to the "cap amount" and any payments in excess of the cap must be refunded by the hospice. The cap amount for the 2009 cap year is $ 23,014.50 per recipient.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	11/01/2010
If not July 1, start date; please explain.	This proposal is based on the Medicare cap period which runs Nov.1 of each year through Oct.31
Total Cost/(Savings)/{Revenue}:	($11,416,219)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	One year to: • Amend State Plan • Revise Hospice Coverage and Limitations Handbook and Provider General Handbook • Promulgate rules for revised handbooks • Develop process for determining amount of excess payments for each hospice and procedure for refunding excess amounts • Modify FMMIS • Provider Notification
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	State Plan amendments take a minimum of 120 days but can be made retroactive
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Hospice Coverage and Limitations Handbook and the Provider General Handbook would need to be revised. These handbooks are in rule so rule revisions would be required.

Medicaid Impact Conference Issues

February 26, 2010

Issue #10 Cont.

VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	Unknown	This proposal would require Medicaid Program Analysis to calculate the total payments for each hospice annually, then subtract the Medicare aggregate cap amount, notify the hospice of the amount of excess payments to return to the State. Would also require system programming by the fiscal agent
VIII. Is there a previous or concurrent Analysis by the Agency?	Unknown	
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Fred Roberson
Secondary Analyst:	Barbara Hengstebeck, Medicaid Services
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Analysis does not factor in room and board since Medicare does not cover.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**8**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($11,416,219)**		**($17,124,328)**
General Revenue:	**($4,390,678)**		**($6,586,017)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,025,541)**		**($10,538,311)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Issue #10 Cont.

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
Pros: This change makes Medicaid payment consistent with Medicare policy. Since this is a policy already in place for Medicare hospice recipients, hospices are already familiar with the policy and the process for calculating overpayments.

Cons: Hospice providers are currently billing Medicaid without any caps. This would be a dramatic shift in policy for hospice billing which Hospice providers would strongly oppose.

Limit Hospice to Medicare Limit				
				for 8 months
TOTAL COST	**($17,124,328)**		**($1,427,027.33)**	**($11,416,218.67)**
TOTAL GENERAL REVENUE	**($6,586,017)**		**($548,834.75)**	**($4,390,678.00)**
TOTAL MEDICAL CARE TRUST FUND	**($10,538,311)**		**($878,192.58)**	**($7,025,540.67)**
TOTAL REFUGEE ASSISTANCE TF	**$0**		**$0.00**	**$0.00**

0.6154							
HOSPICE	FY1011	Room and board	Other	Reduction		New Total	
MEDICAID CASELOAD	18,103	13,577	4,526	4,526	4,526	18,103	
MEDICAID UNIT COST	$1,563.50	$1,563.53	$1,563.41				
MEDICAID TOTAL COST	$339,648,486	$254,736,365	$84,912,121	($17,124,328)	$67,787,793	$322,524,158	
TOTAL COST	$339,648,486	$254,736,365	$84,912,121		$67,787,793	$322,524,158	($17,124,328)
TOTAL GENERAL REVENUE	$77,777,823	$45,120,621	$32,657,202		$26,071,185	$71,191,806	($6,586,017)
TOTAL MEDICAL CARE TRUST FUND	$209,019,678	$156,764,759	$52,254,919		$41,716,608	$198,481,367	($10,538,311)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0		$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$42,000,000	$42,000,000	$0		$0	$42,000,000	$0
TOTAL GRANTS AND DONATIONS TF	$10,850,985	$10,850,985	$0		$0	$10,850,985	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #11

Proposal Name:	Adult Vision Services
Brief Description of Proposal:	Eliminate Adult Vision Services (Optometry and Visual Services)
Proposed State Fiscal Year:	10/11
Proposed Start Date:	10/01/2010
If not July 1, start date; please explain.	Delay due to rule change and recipient notification per federal requirement.
Total Cost/(Savings)/{Revenue}:	($9,610,388)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alert and send letter to provider and recipients – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Rule Promulgation – 120 days • Update Optometry & Visual Services Fee Schedules-120 days • FMMIS programming to eliminate reimbursement of Optometry and Visual Services for recipient age 21 and older.
II. Will this proposal require a change in Florida Statute?	Yes	409.906 Optional Services, (17) Optometry Services and (23) Visual Services
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.340 Visual Services, 59G-4.210 Optometry Services, and 59G-5.020 Provider Requirements (Provider General Handbook).
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #11 Cont.**

Lead Analyst:	Kathryn R. Stephens
Secondary Analyst:	Medicaid Program Analysis – Tom Wallace
Assumptions (Data source and methodology):	Based on February 2010 SSEC
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	February 22, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($9,610,388)**		**($12,813,851)**
General Revenue:	**($3,621,302)**		**($4,828,402)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($5,794,459)**		**($7,725,945)**
Refugee Assistance Trust Fund:	**($194,628)**		**($259,504)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #11 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:

1. **Impact on the state:**
   - Costs savings will be realized.

Cons:

2. **Impact on Recipients:**
   - Elimination of Vision Services for adult recipients will terminate all financial assistance for diagnostic tests, visual exams, and treatments for diseases/conditions of the eye.
   - Elimination of Vision Services for adult recipients will also terminate all financial assistance for the purchase of corrective lenses and eyeglass frames.
   - Without access to vision services a visually impaired adult's independence is severely limited and their personal safety and well-being is compromised.
3. **Impact on Providers:**
   - Elimination of Vision Services will result in loss of reimbursement to all enrolled Optometry and Visual Services providers who render services to recipients age 21 and older.
4. **Impact on the state:**
   - The elimination of vision services to adult recipients is expected to generate a flurry of e-mails, phone calls and letters from concerned recipients, family members and providers.

Description	# Eligibles	GR	MCTF	Other Trust	Total
ADULT DENTAL SERVICES	787,829	$8,638,959	$13,823,233	$219,256	$22,681,448
ADULT DENTAL SERVICES CROSSOVER					
ADULT HEARING SERVICES	787,829	$1,026,105	$1,641,874	$8,823	$2,676,802
ADULT HEARING SERVICES CROSSOVER					
ADULT VISUAL SERVICES	787,829	$4,729,276	$7,567,334	$259,504	$12,556,114
ADULT VISUAL SERVICES CROSSOVER	787,829	$99,126	$158,611	$0	$257,737
Total		$14,493,466	$23,191,052	$487,583	$38,172,101

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #12

Proposal Name:	Adult Hearing Services
Brief Description of Proposal:	Eliminate adult hearing services
Proposed State Fiscal Year:	10/11
Proposed Start Date:	10/01/2010
If not July 1, start date; please explain.	Delay due to rule change and recipient notification per federal requirement.
Total Cost/(Savings)/{Revenue}:	($2,007,602)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alerts and send provider and recipient letters – 90 days • Publish Medicaid Provider Bulletin 90 days • Rule Promulgation – 120+ days • Update Hearing Services Fee Schedule – 90 days • FMMIS programming to eliminate reimbursement of Hearing Services for recipients age 21 and older- 90 days
II. Will this proposal require a change in Florida Statute?	Yes	409.906 Optional Services
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.110 Hearing Services and 549G-5.020 Provider Requirements (Provider General Handbook)
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #12 Cont.**

Lead Analyst:	Kathryn R. Stephens
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	Based on February 2010 SSEC
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	February 23, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,007,602)**		**($2,676,802)**
General Revenue:	**($769,579)**		**($1,026,105)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,231,406)**		**($1,641,874)**
Refugee Assistance Trust Fund:	**($6,617)**		**($8,823)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #12 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:

1. Impact on the state:

- Costs savings will be realized.

Cons:

2. Impact on Recipients:

- Adult recipients with external hearing aids and those who have been implanted hearing devices would no longer have the financial assistance needed to maintain their medically needed prosthetic device.

- Without access to hearing devices and services a hearing-impaired adult's independence is limited and their personal safety and well-being is compromised.

3. Impact on Providers:

- Elimination of Hearing Services will result in loss of reimbursement to all enrolled Hearing services providers, who render services to adult recipients.

4. Impact on state:

- The elimination of services to adult recipients is expected to generate a flurry of e-mails, phone calls and letters from providers, recipients and their family members, and other concerned parties.

Description	# Eligibles	GR	MCTF	Other Trust	Total
ADULT DENTAL SERVICES	787,829	$8,638,959	$13,823,233	$219,256	$22,681,448
ADULT DENTAL SERVICES CROSSOVER					
ADULT HEARING SERVICES	787,829	$1,026,105	$1,641,874	$8,823	$2,676,802
ADULT HEARING SERVICES CROSSOVER					
ADULT VISUAL SERVICES	787,829	$4,729,276	$7,567,334	$259,504	$12,556,114
ADULT VISUAL SERVICES CROSSOVER	787,829	$99,126	$158,611	$0	$257,737
Total		$14,493,466	$23,191,052	$487,583	$38,172,101

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #13

Proposal Name:	Elimination of Adult Dental Services
Brief Description of Proposal:	Discontinuing the Adult Dental Services Program.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	Delay due to rule change and recipient notification per federal requirement.
Total Cost/(Savings)/{Revenue}:	($17,011,086)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	• Publish Provider Alert and mail provider and recipient letters • Rule Promulgation: 120 days • FMMIS programming to capture changes in reimbursement methodology for recipients age 21 and over. • Revisions to State Plan: 90 days.
II. Will this proposal require a change in Florida Statute?	Yes	409.906 (1) (b) optional services.
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing rule, 59G-4.060, would require amendment.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #13 Cont.**

Lead Analyst:	Mary Cerasoli
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Based on February 2010 SSEC. Program Analysis pulled the data from claims submitted for dental services provided to all eligible Medicaid recipients age 21 and above.
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	2/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($17,011,086)**		**($22,681,448)**
General Revenue:	**($6,479,219)**		**($8,638,959)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($10,367,425)**		**($13,823,233)**
Refugee Assistance Trust Fund:	**($164,442)**		**($219,256)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #13 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

If adult dental services are eliminated from the Medicaid dental program:

- Medicaid recipients age 21 and above will not be able to get the needed dental services in order to maintain proper nutrition and health. This could lead to more serious and expensive to treat conditions;
- Providers will not be able to provide dental services to recipients age 21 and over;
- Most Medicaid recipients cannot afford dental treatment, so they will not seek treatment until it is an emergency. Emergency department services are expensive and will provide limited solutions to the patient's dental problem.
- The State will save money.

If adult dental services are not eliminated:

Providers will be able to continue to provide much needed dental services to maintain proper nutrition and health.

Medicaid Services expects there to be no implementation obstacles.

Description	# Eligibles	GR	MCTF	Other Trust	Total
ADULT DENTAL SERVICES	787,829	$8,638,959	$13,823,233	$219,256	$22,681,448
ADULT DENTAL SERVICES CROSSOVER					
ADULT HEARING SERVICES	787,829	$1,026,105	$1,641,874	$8,823	$2,676,802
ADULT HEARING SERVICES CROSSOVER					
ADULT VISUAL SERVICES	787,829	$4,729,276	$7,567,334	$259,504	$12,556,114
ADULT VISUAL SERVICES CROSSOVER	787,829	$99,126	$158,611	$0	$257,737
Total		$14,493,466	$23,191,052	$487,583	$38,172,101

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #14

Proposal Name:	Adult Partial Denture Services
Brief Description of Proposal:	Eliminate the provision for partials for recipients age 21 and above.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	Delay due to recipient notification per Federal requirements
Total Cost/(Savings)/{Revenue}:	($863,767)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services, Program Analysis, Contract Management

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	• Publish RV Banner and mail provider and recipient letters – 60 days • Rule Promulgation -120 days • FMMIS programming to capture changes in reimbursement methodology for recipients age 21 and over. • Revisions to State Plan 90 days.
II. Will this proposal require a change in Florida Statute?	Yes	409.906 (1) (b) optional services.
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing rule would require amendments.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
VIV. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #14 Cont.**

Lead Analyst:	Mary Cerasoli
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Based on February 2010 SSEC. 1,987 Medicaid recipients age 21 and above received partials in 07/08. Program Analysis pulled the data according to partial denture procedure codes and the number of adults that received a partial.
FY Impacted by Implementation:	2010/2011
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($863,767)**		**($1,151,689)**
General Revenue:	**(328,994)**		**($438,658)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($526,424)**		**($701,898)**
Refugee Assistance Trust Fund:	**($8,350)**		**($11,133)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

If partials are eliminated from the Medicaid dental program;

- Medicaid recipients age 21 and above will not be able to get partial dentures in order to maintain proper nutrition and health;
- The providers will not be able to provide partials or partial denture-related services to recipients age 21 and over;
- Most Medicaid recipients cannot afford to pay for cleanings, and for adults, Medicaid does not cover that service. Cleanings are important to maintain good oral hygiene and to prevent the failure of teeth to which partials are attached.
- Recipients may insist that the dentist provide a partial even though the recipient cannot afford cleanings or fillings to bring the mouth up to optimum health before a partial is made. In some cases, it may be a matter of months before the remaining teeth fail and the dentist has to remove the decayed or diseased teeth to seat full dentures.
- The State will save money should funding be discontinued for Medicaid covered partials.

Cut Partial dentures
FY 10-11

	Annualized	9 Months
TOTAL COST	($1,151,689)	(863,767)
TOTAL GENERAL REVENUE	($438,658)	(328,994)
TOTAL MEDICAL CARE TRUST FUND	($701,898)	(526,424)
TOTAL REFUGEE ASSISTANCE TF	($11,133)	(8,350)
Recipients	1,987	

Medicaid Impact Conference Issues

February 26, 2010

Issue #14 Cont.

ADULT DENTAL	Total	Partial dentures
DENTAL SERVICES CASELOAD	787,829	787,829
DENTAL SERVICES UTILIZATION RATE	4.40%	0.22%
DENTAL SERVICES PER MONTH	34,630	1,758
DENTAL SERVICES UNIT COST	$54.58	$54.58
DENTAL SERVICES TOTAL COST	$22,681,448	$1,151,689
CROSSOVER CASELOAD	2,806,630	
CROSSOVER UTILIZATION RATE	0.00%	
CROSSOVER SERVICES/MONTH	0	
CROSSOVER UNIT COST	$0.00	
CROSSOVER COST	$0	
TOTAL COST	$22,681,448	$1,151,689
TOTAL GENERAL REVENUE	$8,638,959	$438,658
TOTAL MEDICAL CARE TRUST FUND	$13,823,233	$701,898
TOTAL REFUGEE ASSISTANCE TF	$219,256	$11,133
TOTAL TOBACCO SETTLEMENT TF	$0	
TOTAL GRANTS AND DONATIONS TF	$0	

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #15

Proposal Name:	Adult Podiatric Services
Brief Description of Proposal:	Elimination of Podiatry Services for Adults
Proposed State Fiscal Year:	10/11
Proposed Start Date: 01/01/2011	10/01/2010
If not July 1, start date; please explain.	Delay due to recipient notification per Federal requirements
Total Cost/(Savings)/{Revenue}:	($2,690,965)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alert and send provider and recipient letters – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Rule promulgation 120 days • Update Podiatry Services Fee Schedule – 120 days • FMMIS programming to eliminate reimbursement of Podiatry Services for recipients age 21 and older – 90 days or greater
II. Will this proposal require a change in Florida Statute?	Yes	409.906 Optional Services, (19) Podiatry Services
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.220 Podiatry Services and 59G-5.020 Provider Requirements (Provider General Handbook)
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #15 Cont.**

Lead Analyst:	Kathryn R. Stephens
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Based on February 2010 SSEC. An estimated 18,498 are adults using this service.
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	February 24, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,690,965)**		**($3,587,953)**
General Revenue:	**($1,032,134)**		**($1,376,179)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,651,523)**		**($2,202,031)**
Refugee Assistance Trust Fund:	**($7,307)**		**($9,743)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #15 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:

1. Impact on the state:

- Costs savings will be realized if Podiatry Services for adult recipients ages 21 and older are eliminated.

Cons:

2. Impact on Recipients:

- Eliminating Podiatry Services for adult recipients will terminate access to specialty medical services for conditions involving the lower legs and feet, (i.e., those conditions secondary to poor circulation and Diabetes). This could lead to more serious and expensive to treat conditions.

3. Impact on Providers:

- The elimination of the Podiatry Services Program will result in loss of reimbursement to all enrolled Podiatrists who treat Medicaid recipients age 21 and older.

4. Impact on the state:

- The elimination of Podiatry Services to adult recipients is expected to generate a flurry of e-mails, phone calls and letters from concerned recipients, family members and providers.

	TOTAL	GR	MCTF	RATF
Podiatrist (adults + children)	$4,238,023	$1,624,431	$2,602,084	$11,508
Adults (annualized)	$3,587,953	$1,376,179	$2,202,031	$9,743
Adults (9 months - FY1011)	$2,690,965	$1,032,134	$1,651,523	$7,307

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #16

Proposal Name:	Adult Chiropractic Services
Brief Description of Proposal:	Eliminate Adult Chiropractic Services
Proposed State Fiscal Year:	10/11
Proposed Start Date:	10/01/2010
If not July 1, start date; please explain.	Delay due to recipient notification per Federal requirements
Total Cost/(Savings)/{Revenue}:	($836,348)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alerts and mail provider and recipient letters – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Rule Promulgation – 120 days • Promulgate Chiropractic Services Fee Schedule – 120 days • FMMIS programming to eliminate reimbursement of Chiropractic Services for recipients age 21 and older – 90 days
II. Will this proposal require a change in Florida Statute?	No	409.906 Optional Services (7) re: Chiropractic Services does not specify age of recipients served
III. Will this proposal require a State Plan Amendment?	Yes	Optional Groups Other Than The Medically Needy (24), Attachment 2.2-A, page 23d
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.040 Chiropractic Services and 59G-5.020 Provider Requirements
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #16 Cont.**

Lead Analyst:	Kathryn R. Stephens
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Based on February 2010 SSEC. An estimated 6,183 adults will use this service.
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	February 4, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($836,348)**		**($1,115,130)**
General Revenue:	**($320,786)**		**($427,715)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($513,290)**		**($684,387)**
Refugee Assistance Trust Fund:	**($2,271)**		**($3,028)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #16 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:

Impact on the state:

Costs savings will be realized if Chiropractic Services for adult recipients ages 21 and older are eliminated.

Cons:

Impact on Recipients:

Eliminating Chiropractic Services for adult recipients will reduce Medicaid recipients' treatment options for musculoskeletal conditions and related pain.

Impact on Providers:

The elimination of the Chiropractic Services Program will result in loss of reimbursement to all enrolled Chiropractors who treat Medicaid recipients age 21 and older.

Cons:

The elimination of services to adult recipients is expected to generate a flurry of e-mails, phone calls and letters from concerned recipients, family members and providers.

	TOTAL	GR	MCTF	RATF
Chiropractor (adults + children)	$1,587,492	$608,102	$975,079	$4,311
Adults (annualized)	$1,115,130	$427,715	$684,387	$3,028
Adults (9 months - FY1011)	$836,348	$320,786	$513,290	$2,271

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #17

Proposal Name:	Hospice Services
Brief Description of Proposal:	Eliminate Hospice as a covered service. Provide savings net of add back for nursing home care.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Maintenance of stimulus funds. Also delay due to rule change and recipient notification per federal requirement.
Total Cost/(Savings)/{Revenue}:	($35,752,472)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	One year to: • Amend State Plan • Revise Medicaid Provider General Handbook and repeal Hospice Coverage and Limitations Handbook • Promulgate rules for revised Provider General Handbook and repealed Hospice C&L Handbook • Modify Florida Medicaid Management Information System • Provider notification • Recipient notification
II. Will this proposal require a change in Florida Statute?	No	Hospice is an optional service. Ch. 409.906 is permissive so it does not need to be changed.
III. Will this proposal require a State Plan Amendment?	Yes	Minimum of 90 days for approval. State Plan Amendments can be retroactive.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Hospice handbook is in rule and will need to be repealed. This takes a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #17 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Barbara Hengstebeck, Medicaid Services
Assumptions (Data source and methodology):	Based on February 2010 SSEC.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/18/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($35,752,472)**		**($71,504,944)**
General Revenue:	**($15,927,726)**		**($31,855,453)**
Administrative Trust Fund:	**($19,824,746)**		**($39,649,491)**
Medical Health Care Trust Fund:	**($0)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros: In the past ten years, Medicaid expenditures for the Hospice program have increased dramatically - from $65 million in FY 1999-2000 to $321 million in FY 2009/2010. Hospice is an optional Medicaid service.

Cons: Elimination of Hospice services may actually cost Medicaid more in hospital, emergency room, pharmacy and other areas if the recipient continues to pursue curative treatment. Also – Hospice expenditures include nursing home room and board payments to the nursing home. This room and board rate is 95% of what Medicaid would have to pay the nursing home for the same recipient, so cutting hospice could result in an increase in nursing home costs.

Obstacle: Hospice is a popular program with families of patients who have received hospice services and the general public. In many communities, the hospice is a not-for-profit organization and is considered a community service. The Hospice provider association (Florida Hospices and Palliative Care Association) will strongly oppose elimination of this program. Other opponents may include advocacy groups, patient rights groups, AARP and the general public.

Medicaid Impact Conference Issues

February 26, 2010

Issue #17 Cont.

Eliminate Hospice and transfer Nursing Home recipients to Nursing Home Program		
	Start 1/1/11	Net reduction
TOTAL COST	($35,752,472)	($71,504,944)
TOTAL GENERAL REVENUE	($15,927,727)	($31,855,453)
TOTAL MEDICAL CARE TRUST FUND	($19,824,746)	($39,649,491)
TOTAL REFUGEE ASSISTANCE TF	$0	$0

	0.5545					
HOSPICE	FY1011	Room and board	Other		NET	**Begin 01/01/11**
MEDICAID CASELOAD	18,103	13,577	4,526	13,577		
MEDICAID UNIT COST	$1,563.50	$1,563.53	$1,563.41	$1,645.82		
MEDICAID TOTAL COST	$339,648,486	$254,736,365	$84,912,121	$268,143,542	($71,504,944)	
TOTAL COST	$339,648,486	$254,736,365	$84,912,121	$268,143,542	($71,504,944)	($35,752,472)
TOTAL GENERAL REVENUE	$98,462,416	$60,634,066	$37,828,350	$66,606,963	($31,855,453)	($15,927,726)
TOTAL MEDICAL CARE TRUST FUND	$188,335,085	$141,251,314	$47,083,771	$148,685,594	($39,649,491)	($19,824,746)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0	$0	$0	$0
TOTAL HEALTH CARE TF	$42,000,000	$42,000,000	$0	$42,000,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$10,850,985	$10,850,985	$0	$10,850,985	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #18

Proposal Name:	FHK Rate Freeze
Brief Description of Proposal:	Estimate of savings if Florida Healthy Kids Corporation capitation rates were frozen at the June 30, 2009 level.
Proposed State Fiscal Year: 00/00	SFY 10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	FHKC health plan contracts on 10/1 – 9/30 contract year
Total Cost/(Savings)/{Revenue}:	($10,192,857)
Bureau(s) Responsible for Administration:	Medicaid Services (manages contract with Florida Healthy Kids Corporation)

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Y	Implementation 10/1/10. FHKC's managed care contracts (and rates) for health plan services are based on an October 1 – September 30 cycle so the effective date of any rate freeze would mean that FHKC would not approve any rate increases for the next health plan contract year, effective 10/1/10.
II. Will this proposal require a change in Florida Statute?	N	Statute change not necessary.
III. Will this proposal require a State Plan Amendment?	N	State Plan Amendment not necessary.
IV. Will this require the Procurement Process?	N	No procurement would be necessary if a rate freeze goes into effect unless holding the average PMPM rates frozen at the current average PMPM results in some rates that cannot be actuarially justified, and a current insurer could not continue at that rate. In those cases, FHKC would have to procure a new plan for that county. Additionally, FHKC can non-renew any or all contracts after receipt of Plan rate adjustment requests (due April 1st). FHKC may re-procure with or without a rate freeze. FHKC has until June 1st to give notice of non-renewal to the health plans for a 10/1 effective date.
V. Will this proposal require an administrative rule?	N	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	N	
VII. Will this proposal require additional staffing?	N	
VIII. Is there a previous or concurrent Analysis by the Agency?	N	
IX. Is this proposal included in the current Governors recommendations?	N	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #18 Cont.**

Lead Analyst:	Greg Bracko
Secondary Analyst:	Gail Hansen
Assumptions (Data source and methodology):	Based on January 20 Kidcare SSEC.
FY Impacted by Implementation:	10/11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($10,192,857)**		**($13,590,475)**
General Revenue:	**($3,186,287)**		**($4,248,383)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,006,570)**		**($9,342,093)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #18 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
If rates due to rate freeze cannot be actuarially justified then health plans could not continue at that rate.

Assumptions:								
Program implementation date 10/1/2010.								
Projected Florida Healthy Kids		205,667						
Title XXI Federal Medical Assistance blended rate				68.74%				
Program component.		Avg. Monthly caseload		$PMPM	Total	Federal	State	
Florida Healthy Kids								
-Results from January 29, 2010 SSEC			205,667					
Medical				$114.21	$281,870,737			
Dental				$11.10	$27,394,844			
Cost				$125.31	$309,265,581	$212,589,161	$96,676,421	
Florida Healthy Kids								
-Adjusted to remove inflation			205,667					
Medical				$110.08	$271,677,880			
Dental				$11.10	$27,394,844			
Cost				$121.18	$299,072,725	$205,582,591	$93,490,134	
Total Decrease			205,667					
Medical				($4.13)	($10,192,857)			
Dental				$0	$0			
Total Savings				($4.13)	($10,192,857)	($7,006,570)	($3,186,287)	

Medicaid Impact Conference Issues

February 26, 2010

					Health Care Services (68500000)				
					Children's Special Health Care Trust Fund (68500100)				
					(1000-2) General Revenue (State)			($3,186,287)	
					(2474-3) Medical Care Trust Fund			($7,006,570)	
							Total	($10,192,857)	
Footnotes									
1. There were two rate increases consensed at the January 29, 2010 SSEC: one to recognize inflation at the									
annual contract renewal at October 1, 2010 and one for compliance with CHIPRA choice requirements at									
January 1, 2011. Since the CHIPRA choice requirements are mandatory, this rate freeze analysis only									
removes the inflation rate increase.									
2. The source of the original per member per month cost is the January 29, 2010, SSEC, SFY 10-11.									
3. The Dental per member per month cost is also addressed in Impact Conference item #65.									

The following comments were provided to appropriations staff after the Impact conference of 02/26/2010.

1. *A proposed new issue title and description of action for item 18.*

Proposed Issue #18: Rate Adjustment Limitation

Proposed Action: Provide an estimate of the savings if medical and dental trend increases were removed from Healthy Kids rate adjustments effective October 1, 2010.

2. *Draft proviso language to implement this item if it is chosen.*

Proposed Proviso language: Funds in specific appropriation XX reflect a reduction from GR and MTF to the annual rate adjustments for the Florida Healthy Kids Corporation health and dental plan contracts for the 2010-2011 contract year.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #19

Proposal Name:	New Service Limits for Medicaid Behavioral Health Overlay Services
Brief Description of Proposal:	Savings associated with limiting behavioral health overlay services for youth in juvenile justice and child welfare settings to six days a week.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Medicaid would follow the rules promulgation process to revise the policy handbook governing this service.
Total Cost/(Savings)/{Revenue}:	($1,794,659)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	This change would require a revision to the Community Behavioral Health Services Coverage and Limitations Handbook. As the bundled rate for this service does not cover ancillary services such as medication management, Medicaid would also need to restrict the providers from billing for any other mental health treatment service on the seventh day. Upon legislative approval, the time line for implementation is estimated to be six to nine months. To promulgate the revised limits, Medicaid would have to follow the standard Rule Promulgation procedures which take a minimum of 120 days. In addition, audits and reimbursement rules for the affected procedure codes would have to be changed in the Florida Medicaid Management Information System to reflect the new service limits. Finally, BHOS providers would have to be notified of the new changes.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Revise and promulgate Behavioral Health Services Handbook
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	An analysis of this proposed service limit was developed in January 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #19 Cont.**

Lead Analyst:	Leah Kulakowski
Secondary Analyst:	Bill Hardin
Assumptions (Data source and methodology):	Medicaid calculated the total paid claims amounts for BHOS recipients for SFY 07/08, and then subtracted one-seventh.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	January 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,794,659)**		**($3,589,318)**
General Revenue:	**($790,521)**		**($1,599,041)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($995,138)**		**($1,990,277)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #19 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): Behavioral health overlay services are mental health and substance abuse services for children and adolescents who reside in residential settings that are under contract with Child Welfare privatized providers or the Department of Juvenile Justice. This proposal would reduce the number of days per week that providers can be reimbursed for this service from 7 days per week to 6 days per week.

The initial response to this proposal will likely be complaints from providers, and behavioral health care lobbyists. The Agency proposed this reduction last session and providers expressed concerns about the fiscal impact that this would have on their facilities as it would amount to a cut of 14% in allowed reimbursements. They would also argue that the children need the services daily. These same interested parties would likely challenge any new rule promulgation to create the proposed service limits. A rule challenge would delay implementation.

If these new service limits create undue hardships on providers, the Department of Children and Families and the Department of Juvenile Justice may be compelled to renegotiate their contracts and increase their expenditures to these providers. With no availability of Federal financial participation, 100% of this increased funding would come from DCF and DJJ budgets, and ultimately from state General Revenue.

Another option would be to implement prior authorization of this service. The Agency is concerned that the service is being over-utilized and previous attempts to manage this service have been met with opposition from providers. The Agency believes that by implementing prior authorization, children who really need the service would receive it and those who do not need it would not.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #20

Proposal Name:	Expand Medicaid Drug Rebate Collections to Injectable Drugs
Brief Description of Proposal:	Savings associated with additional manufacturer drug rebate collection on injectable drugs reimbursed through physician services claims.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	{$1,649,565} Net savings of $0
Bureau(s) Responsible for Administration:	Medicaid Pharmacy/Medicaid Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	CSR to build system functionality to identify claims for which rebates can be collected is currently in the queue for implementation. Due to routine lag time in rebate invoicing and collection process, only two quarters of revenue will be realized in fiscal year 10/11.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #20 Cont.**

Lead Analyst:	Anne Wells
Secondary Analyst:	Marie Donnelly
Assumptions (Data source and methodology):	Rebate collection estimates from Unisys (rebate collection vendor).
FY Impacted by Implementation:	10/11
Date Analysis Completed:	October 2009

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**12**
Total (Savings) Cost of Proposal:	**($0)**		**($0)**
General Revenue:	**($634,423)**		**($1,268,845)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($1,015,142)**		**($2,030,284)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**$1,649,565**		**$3,299,129**
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #20 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

There are two ways to potentially increase rebate revenue:

Current Condition	System or Process Enhancement Required	Potential Additional Rebate Revenue
NDC not validated to J-code submitted on claim	Implement J-code to NDC validation in claim system edits	$539,069.81 annually
NDC not submitted on Medicare crossover claims	Require NDC for payment on crossover claims; subject to NDC validation	$2,760,059.62 annually
Total		$3,299,129.43 annually*

CSR is currently in queue and programming is partially completed in preparation for implementation. Upon completion, NDC and units reimbursed data can be submitted to the rebate invoicing and collection vendor.

The Agency is currently working on this issue.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #21a

Proposal Name:	**Reduce MediPass Primary Care Case Management Fee**
Brief Description of Proposal:	Reduce the MediPass primary care case management fee for beneficiaries served through the Medicaid fee-for-service program to $1.00 or eliminate the fee for beneficiaries served through the MediPass Program. Issue 21a will specifically address the reduction of the primary care case management fee to $1.00 and impacts the following programs: MediPass, CMS Network, Healthy Start Coordinated Care Systems, Provider Service Networks and Minority Physician Networks. This reduction also applies to Pediatric Emergency Room Diversion Program however the Agency does not currently have any contractors under this program.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	A minimum of six months will be needed to implement this proposal. The 1915(b) waiver will need to be amended including a recalculation of cost effectiveness. MediPass provider agreements, PSN and MPN contracts and CMS Network agreements will need to be amended. Modifications to the Medicaid fiscal agent system will have to be made. In addition, a review of the MediPass provider network will have to be complete to assure adequacy in all 62 counties of operation.
Total Cost/(Savings)/{Revenue}:	($5,449,332)
Bureau(s) Responsible for Administration:	Health Systems Development

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	A minimum of six months will be needed to implement. The 1915(b) waiver will need to be amended including a recalculation of cost effectiveness. MediPass provider agreements, PSN and MPN contracts and CMS Network agreements will need to be amended. Modifications to the Medicaid fiscal agent system will have to be made. In addition, a review of the MediPass provider network will have to be complete to assure adequacy in all 62 counties of operation.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	

Issue #21a Cont.

IV. Will this require the Procurement Process?	No	However, the Agency would need to amend the following contracts and/or agreements with providers: • MediPass, • CMS Network, • Healthy Start Coordinated Care Systems, • Provider Service Networks and • Minority Physician Networks
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The Agency will need to amend the 1915(b) Managed Care Waiver including cost-effectiveness to reflect the reduction of $1.00 PMPM case management fee to each of the programs listed above in brief description of proposal. Federal CMS has two 90 day period to approve the amendment once submitted.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This issue was reviewed/evaluated by the Agency in 2008. Legislation was passed in 2008 which reduced the primary care case management fee from $3.00 to $2.00 for the following programs: MediPass, CMS Network, Healthy Start Coordinated Care Systems, Provider Service Networks, Minority Physician Networks and Pediatric Emergency Room Diversion Program. The Agency amended contracts, amended the 1915(b) Managed Care waiver and modified the Medicaid fiscal agent system.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #21a Cont.**

Lead Analyst:	Tracy Hurd
Secondary Analyst:	Linda Macdonald
Assumptions (Data source and methodology):	This analysis needs to be calculated by Program Analysis using the enrollment information for 5 programs currently operational (MediPass, CMS Network, Healthy Start, Provider Service Networks, Minority Physician Networks). The fiscal analysis needs to be conducted as follows: determine cost of current MediPass PMPM at $2.00 PMPM compared to cost of PMPM at $1.00 PMPM based on current enrollment for the fiscal year.
FY Impacted by Implementation:	FY2010-2011
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($5,449,332)**		**($10,898,663)**
General Revenue:	**($2,421,887)**		**($4,843,774)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($3,014,448)**		**($6,028,896)**
Refugee Assistance Trust Fund:	**($12,996)**		**($25,993)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #21a Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

A reduction in the primary care case management fee will have a direct impact on the six programs listed below:

- MediPass,
- Children's Medical Services Network,
- Provider Service Networks,
- Healthy Start Coordinated Care System,
- Minority Physician Networks, and
- Pediatric Emergency Room Diversion.

A reduction in the case management fee could result in fewer providers who are willing to participate in these programs that provide services to some of Florida's most vulnerable beneficiaries. If network adequacy is not sufficient, or if no participating network providers remain, this may result in the elimination of the program. If the programs listed above were eliminated due to inadequate networks, the result would be more Medicaid beneficiaries being placed in the completely unmanaged fee for service environment which would result in increased cost to Medicaid.

In addition to the amendments to the 1915(b) waiver and amendments to the MediPass, PSN, MPN and CMS network contracts/agreements, the Medicaid Summary of Services Publication will need to be revised and the payment rate information in the Florida fiscal agent system will need to be updated to ensure a reduced payment to $1.00 per member per month for enrollees in each of the programs listed above.

Important Note*:** Federal regulations [Section 1915(b)(1) of SSA] allow states to implement primary care case management systems which restricts the provider from (or through) whom an individual (Medicaid managed care eligible) can obtain medical care services (other than in emergency circumstances), ***if such restriction does not substantially impair access to such services of adequate quality where medically necessary.

If the MediPass Program is no longer a choice due to an inadequate provider network, this change would impact the state's ability to mandatorily assign recipients in counties where only one managed care option exists. Federal regulations require the state to offer a choice of at least two managed care options (PCCM, managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan) to all mandatory managed care eligibles. If the state can no longer offer a choice of two managed care options, the state would ***no longer have federal waiver authority to implement mandatory assignment*** in those areas. This means the enrollees in the one remaining managed care option (i.e. HMO, FFS PSN, Capitated PSN or MPN) would have to be immediately offered the option to disenroll from their currently assigned managed care option into FFS. The Agency would not be able to mandatorily assign new eligibles to the one remaining managed care option (only voluntary enrollments could be processed). This would result in an increased enrollment in the FFS system and increased cost to Medicaid.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue # 21a Cont.**

TOTAL COST	($10,898,663)	($5,449,332)
TOTAL GENERAL REVENUE	($4,843,774)	($2,421,887)
TOTAL MEDICAL CARE TRUST FUND	($6,028,896)	($3,014,448)
TOTAL REFUGEE ASSISTANCE TF	($25,993)	($12,997)
TOTAL COST	($10,898,663)	($5,449,332)

MEDIPASS SERVICES

MEDICAID CASELOAD	1,170,517	1,170,517	0
MEDICAID UTILIZATION RATE	77.59%	77.59%	0.00%
MEDICAID SERVICES PER MONTH	908,225	908,225	0
MEDICAID UNIT COST	$2.00	$1.00	($1.00)
MEDICAID TOTAL COST	$21,797,363	$10,898,700	($10,898,663)
TOTAL COST	$21,797,363	$10,898,700	($10,898,663)
TOTAL GENERAL REVENUE	$8,362,800	$4,181,643	($4,181,157)
TOTAL MEDICAL CARE TRUST FUND	$13,382,576	$6,691,063	($6,691,513)
TOTAL REFUGEE ASSISTANCE TF	$51,987	$25,994	($25,993)
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #21b

Proposal Name:	**Eliminate MediPass Primary Care Case Management Fee**
Brief Description of Proposal:	Savings associated with elimination of the per member per month case management fee for beneficiaries served through the Medicaid primary care case management programs (PCCMs). The following programs would be impacted by this change: MediPass, CMS Network, Healthy Start Coordinated Care Systems, Provider Service Networks and Minority Physician Networks. This change also applies to Pediatric Emergency Room Diversion Program however the Agency currently does not have any contractors under this program.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	A minimum of six months will be needed to implement this proposal. The 1915(b) waiver will need to be amended including a recalculation of cost effectiveness. MediPass provider agreements, PSN and MPN contracts and CMS Network agreements will need to be amended. Modifications to the Medicaid fiscal agent system will have to be made. In addition, a review of the MediPass provider network will have to be complete to assure adequacy in all 62 counties of operation.
Total Cost/(Savings)/{Revenue}:	($10,898,682)
Bureau(s) Responsible for Administration:	Health Systems Development

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	A minimum of six months will be needed to implement. The 1915(b) waiver will need to be amended including a recalculation of cost effectiveness. MediPass provider agreements, PSN and MPN contracts and CMS Network agreements will need to be amended. Modifications to the Medicaid fiscal agent system will have to be made. In addition, a review of the MediPass provider network will have to be complete to assure adequacy in all 62 counties of operation.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	

Issue #21b Cont.

IV. Will this require the Procurement Process?	No	However, the Agency would need to amend the following contracts and/or agreements with providers: • MediPass, • CMS Network, • Healthy Start Coordinated Care Systems, • Provider Service Networks and • Minority Physician Networks
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The Agency will need to amend the 1915(b) Managed Care Waiver to eliminate the PMPM to each of the programs listed above. Federal CMS has two 90 day period to review and approve the amendment once submitted.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This issue was reviewed/evaluated by the Agency in 2008. Legislation was passed in 2008 which reduced the primary care case management fee from $3.00 to $2.00 for the following programs: MediPass, CMS Network, Healthy Start Coordinated Care Systems, Provider Service Networks, Minority Physician Networks and Pediatric Emergency Room Diversion Program. The Agency amended contracts, amended the 1915(b) Managed Care waiver and modified the Medicaid fiscal agent system.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #21b Cont.**

Lead Analyst:	Tracy Hurd
Secondary Analyst:	Linda Macdonald
Assumptions (Data source and methodology):	This analysis needs to be calculated by Program Analysis using the enrollment information for 5 programs currently operational (MediPass, CMS Network, Healthy Start, Provider Service Networks, Minority Physician Networks). The fiscal analysis needs to be conducted as follows: determine cost of current MediPass PMPM at $2.00 PMPM compared to cost of PMPM at $0.00 PMPM based on current enrollment for the fiscal year.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($10,898,682)**		**($21,797,363)**
General Revenue:	**($4,843,783)**		**($9,687,565)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($6,028,906)**		**($12,057,811)**
Refugee Assistance Trust Fund:	**($25,994)**		**($51,987)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #21b Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The elimination of the primary care case management fee will have a direct impact on six programs listed below:

- MediPass,
- Children's Medical Services Network,
- Provider Service Networks,
- Healthy Start Coordinated Care System,
- Minority Physician Networks, and
- Pediatric Emergency Room Diversion.

A reduction in the case management fee could result in fewer providers who are willing to participate in these programs that provide services to some of Florida's most vulnerable beneficiaries. If network adequacy is not sufficient, or if no participating network providers remain, this may result in the elimination of the program. If the programs listed above were eliminated due to inadequate networks, the result would be more Medicaid beneficiaries being placed in the completely unmanaged fee for service environment which would result in increased cost to Medicaid.

In addition to the amendments to the 1915(b) waiver and amendments to the MediPass, PSN, MPN and CMS network contracts, the Medicaid Summary of Services Publication will need to be revised and the payment rate information in the Florida fiscal agent system will need to be updated to ensure a zero payment per member per month for enrollees in each of the programs listed above.

Important Note*:** Federal regulations [Section 1915(b)(1) of SSA] allows states to implement primary care case management systems which restricts the provider from (or through) whom an individual (Medicaid managed care eligible) can obtain medical care services (other than in emergency circumstances), ***if such restriction does not substantially impair access to such services of adequate quality where medically necessary.

- With the elimination of the case management fee, the MediPass and Children's Medical Services Network may no longer be considered a primary case management program (PCCM) by the federal government. The Agency has contacted federal CMS to obtain guidance on this issue.

Issue #21b Cont.

- If the MediPass Program is no longer considered a PCCM or cannot continue to operate due to an inadequate provider network, this change would impact the state's ability to mandatorily assign recipients in counties where only one managed care option operates. Federal regulations require the state to offer a choice of at least two managed care options (PCCM, managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan) to all mandatory managed care eligibles. If the state can no longer offer a choice of two managed care options, the state would ***no longer have federal waiver authority to implement mandatory assignment*** in those areas. This means the enrollees in the one remaining managed care option (i.e. HMO, FFS PSN, Capitated PSN or MPN) would have to be immediately offered the option to disenroll from their currently assigned managed care option into FFS. The Agency would not be able to mandatorily assign new eligibles to a managed care option (only voluntary enrollments could be processed). This would result in an increased enrollment in the FFS system and increased cost to Medicaid.

TOTAL COST	($21,797,363)	($10,898,682)
TOTAL GENERAL REVENUE	($9,687,565)	($4,843,783)
TOTAL MEDICAL CARE TRUST FUND	($12,057,811)	($6,028,906)
TOTAL REFUGEE ASSISTANCE TF	($51,987)	($25,994)
TOTAL COST	($21,797,363)	($10,898,682)

MEDIPASS SERVICES

MEDICAID CASELOAD	1,170,517	1,170,517	0
MEDICAID UTILIZATION RATE	77.59%	77.59%	0.00%
MEDICAID SERVICES PER MONTH	908,225	908,225	0
MEDICAID UNIT COST	$2.00	$1.00	($1.00)
MEDICAID TOTAL COST	$21,797,363	$10,898,700	($10,898,663)
TOTAL COST	$21,797,363	$10,898,700	($10,898,663)
TOTAL GENERAL REVENUE	$8,362,800	$4,181,643	($4,181,157)
TOTAL MEDICAL CARE TRUST FUND	$13,382,576	$6,691,063	($6,691,513)
TOTAL REFUGEE ASSISTANCE TF	$51,987	$25,994	($25,993)
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #22

Proposal Name:	Eliminate the Children's Medical Services (CMS) Primary Care Center Targeted Case Management (TCM) Reimbursement Fee
Brief Description of Proposal:	Eliminate CMS Primary Care Center TCM Reimbursement Fee
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	Rule/Handbook Promulgation
Total Cost/(Savings)/{Revenue}:	($1,891,564)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		October 1, 2010 (estimate) • Disenrollment of providers by MCM in the Florida Medicaid Management Information System • Promulgate rule (minimum of 128 days) • Handbook revisions • Provider notification
II. Will this proposal require a change in Florida Statute?	No	A Stat Plan Amendment.
III. Will this proposal require a State Plan Amendment?	Yes	An SPA must be completed to stipulate provider requirements. Once submitted, the Centers for Medicare and Medicaid Services have 90 days to request additional information, deny, or approve the proposal.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	In the proposed Child Health Services Targeted Case Management Handbook/Proposed Rule 56G 8.200.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency's FY 2010-11 Schedule VIIIB
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #22 Cont.**

Lead Analyst:	Gail Underwood
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims data for Targeted Case Management for CMS population.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,891,564)**		**($2,522,086)**
General Revenue:	**($727,495)**		**($969,994)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,164,069)**		**($1,552,092)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #22 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
IMPACT:

Comments:

- Many eligible children (0-21) who are currently receiving targeted case management (TCM) through the Primary Care Centers are MediPass enrolled children and are receiving case management services through this plan.
- The same children are receiving nursing case management services through a state-employed Department of Health, Children's Medical Services (Title V agency) nurse case manager.
- Currently CMS/Primary Care Centers are receiving reimbursement of $9.25 per 15-minute unit for targeted case management services.
- This proposal would eliminate procedure code T1017SE. This would eliminate the potential for duplicate billing by MediPass or Title V providers.
- The proposal would not require a change in statute.

Primary Care Centers will have the opportunity to make comments during the administrative rule hearing process and may oppose losing this source of reimbursement.

	annualized	9 months
TOTAL COST	-$2,522,086	-$1,891,564
TOTAL GENERAL REVENUE	-$969,994	-$727,495
TOTAL MEDICAL CARE TRUST FUND	-$1,552,092	-$1,164,069
TOTAL REFUGEE ASSISTANCE TF	0	$0

The following comments were provided from DOH – CMS to the appropriations staff after the Impact conference of 02/26/2010

Medicaid Impact Conference, February 26, 2010

FOLLOW-UP: Issue #22, Eliminate or Reduce the Children's Medical Services Primary Care Center Targeted Case Management (TCM) Reimbursement Fee to $1.00

Background

Case management services assist individuals eligible under the Medicaid state plan in gaining access to needed medical, social, educational, and other services. It does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

The Deficit Reduction Act (DRA) of 2005 added section 1915(g)(2)(B) to the Social Security Act, defining "targeted case management services" (TCM) as case management services that are furnished to a particular defined target group or in any defined locations without

regard to requirements related to statewide provision of services, or comparability of services. A state can "target" case management services to specific classes of individuals, or to individuals who reside in specified area of the state (or both).

Activities that meet the definition for case management services and under the approved State plan cannot be claimed as administrative activities directly related to the proper and efficient administration of the Medicaid State plan. Some examples include Medicaid eligibility determinations and redeterminations, Medicaid intake processing; Medicaid preadmission screening for inpatient care, prior authorization for Medicaid services, utilization review, and Medicaid outreach. (CMS-2237-IFC, p. 70)

There is no duplication in the provision of case management services for children in Children's Medical Services (CMS) primary care networks with CMS administrative claiming. Administrative claiming relates only to CMS FTEs and not to contracts. The primary care contractors do not receive administrative claiming. The primary care contracts bill TCM for those children who are not case managed by state FTEs. Some primary care contractors also support medical foster care staff through TCM. The elimination of TCM would cut that as well.

While some may see the MediPass management fee as duplicative of targeted case management, it is not because they support different functions. The MediPass PCCM management fee is for the physician to manage the medical care and the physician may serve as a gatekeeper. TCM is used to coordinate services outside of the physician's office and to perform certain reminder functions for the patients such as primary and specialty care appointments. Providers of case management services, including targeted case management services, are prohibited from serving as gatekeepers under Medicaid.

> *"Individuals participating in a managed care plan receive case management services as an integral part of the managed care services. This case management is for the purpose of managing the medical services provided by or through the plan and does not extend to helping an individual gain access to social, educational, and other services the individual may need. Thus, an individual receiving services through a managed care plan may also receive case management or targeted case management services when the individual is eligible for those services*." (CMS-2237-IFC, p. 51).

Potential Impacts

It is unclear if the proposal would be to eliminate TCM and rely on the MediPass management fee to support the TCM functions.

- There may be a federal issue with assigning a MediPass provider to perform both medical case management and targeted case management. Federal law and rule specify that providers of case management services, including targeted case management services, are prohibited from serving as gatekeepers under Medicaid. The recipient of the primary care case management fee, however, may serve as a gatekeeper.
- Children with special health care needs in the primary care programs, including those in medical foster care, would not receive TCM services if the funding is reduced to $1.00 or eliminated. These functions cannot be supported through other means without funding.
- Case management facilitates access to services that have been authorized by the primary care provider, which also helps to reduce inappropriate use of services, such as emergency room for non-emergent conditions.
- Most importantly, elimination of TCM would have a negative impact on the development of a medical home model for children with special health care needs. Care coordination is a cornerstone of medical home. Staff assists the primary care physician to assure that the child is accessing services that are included in the child's treatment plan.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #23

Proposal Name:	Eliminate Medicaid Eligibility for 19 & 20 Year Olds
Brief Description of Proposal:	Savings associated with eliminating Optional Medicaid coverage for children aged 19 and 20 effective January 1, 2011 due to MOE requirements for ARRA stimulus funds. Analysis should include number of beneficiaries impacted as well as annualized savings and numbers impacted.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Delayed implementation due to ARRA maintenance of effort requirement for stimulus funding.
Total Cost/(Savings)/{Revenue}:	($18,007,750)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		The following steps are needed to implement this provision by January 1, 2011. 1. Legislation to mandate elimination of coverage becomes law May 2010. 2. DCF programs their automated eligibility system (368 hours – includes analysis, design, coding, testing, and implementation); ready to install by early December 2010. 3. The Agency makes FMMIS changes, ready to install by end of December 2010 for January 2011 effective date. 4. DCF completes reviews of all affected recipients to determine if eligible for other Medicaid category (such as disability group). Process will be handled as part of the ex parte review conducted based on information contained in the existing record at the time adverse action is taken. Adverse action will be taken between November 20 and December 20, 2010. 5. DCF submits proposed State Plan Amendment to the Agency by 10/1/2010 and the Agency submits to CMS for approval for 1/1/2011 effective date. 6. DCF develop and promulgate administrative rule change and policy by early December for January 1, 2011 implementation. Process will start no later than July 2010.

Medicaid Impact Conference Issues

February 26, 2010

Issue #23 Cont.

I. Anticipated implementation time line and process.		7. DCF sends adequate, advance termination notices to affected recipients in December for December 31 termination.
II. Will this proposal require a change in Florida Statute?	Yes	The following statutes would require revision: 409.903 (3) and (4); 409.904(2)(b) to eliminate coverage of the optional coverage of 19 and 20 year olds.
III. Will this proposal require a State Plan Amendment?	Yes	DCF would submit the requested changes to the Agency to submit to CMS to eliminate the coverage for 19 and 20 year olds in the groups where the State is able to eliminate coverage of 19 and 20 year-olds. This process takes at least 90 days. NOTE: There are children aged 19-20 in the mandatory SSI coverage group who would still have to be covered, and if the optional MEDS-AD coverage were to be continued, these children would be covered there as well. DCF has been asked to confirm that there is no mandatory coverage for the 19 and 20 year olds for child in care.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	DCF would have to amend 65A-1. It would take at least 4 months for the rule amendment process.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #23 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Martha Crabb
Assumptions (Data source and methodology):	Medicaid claims data for eligible population.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($18,007,750)**		**($36,015,500)**
General Revenue:	**($8,022,453)**		**($16,044,905)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($9,985,297)**		**($19,970,595)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #23 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): DCF will have to make the necessary system changes in their automated eligibility determination system (FLORIDA), as well as update their policy manual and training for their field staff. The affected children include children who had been in Foster Care at the age of 18, and children in low-income families who likely have no other means to access health care accept through Medicaid. It could increase the cost of uncompensated inpatient hospital care as well increase emergency room visits for these individuals.

Eliminate Optional coverage for 18 and 19 year old	
Start January 1,2011	
	All Optional 18 and 19 Year old
Caseload	(16,149)
PMPM	$185.85
Total Reduction	($18,007,750)
GR	($8,022,453)
MCTF	($9,985,297)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #24

Proposal Name:	Reduce Medicaid Eligibility for Pregnant Women to 150% of Poverty
Brief Description of Proposal:	Savings associated with the elimination of optional Medicaid coverage for pregnant women with incomes of 150-185% of the federal poverty level effective January 1, 2011 due to MOE requirements for ARRA stimulus funds. Analysis should include number of beneficiaries impacted as well as annualized savings and numbers impacted.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Delayed implementation due to American Reinvestment and Recovery Act (ARRA) maintenance of effort requirement for stimulus funding
Total Cost/(Savings)/{Revenue}:	($29,652,980)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		The following steps are needed to implement this provision by January 1, 2011. 1. Legislation to mandate elimination of coverage becomes law May 2010. 2. DCF programs their automated eligibility system (224 hours – includes analysis, design, coding, testing, and implementation); ready to install by early December 2010. 3. The Agency makes FMMIS changes, ready to install by end of December 2010 for January 2011 effective date. 4. DCF completes reviews of all affected recipients to determine if eligible for other Medicaid category (such as disability group). Process can begin in July 2010, needs to be completed by mid-December 2010. (Disability determinations make take 90 days of state processing time; more if client delay involved in gathering medical evidence.) 5. DCF submits proposed State Plan Amendment to the Agency by 10/1/2010 and the Agency submits to CMS for approval for 1/1/2011 effective date. 6. DCF develop and promulgate administrative rule change and policy by early December for January 1, 2011 implementation. Process will start no later than July 2010.

Issue #24 Cont.

I. Anticipated implementation time line and process.		7 DCF sends adequate, advance termination notices to affected recipients in December for December 31 termination.
II. Will this proposal require a change in Florida Statute?	Yes	409.903 (5), F.S. needs to be amended to remove reference to coverage of pregnant women up to 185% of the FPL.
III. Will this proposal require a State Plan Amendment?	Yes	The income limit for the poverty level pregnant women group would have to be changed in the State Plan. (DCF makes the change, the Agency submits it to CMS for approval.). The process takes at least 90 days.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	DCF would need to amend 65A-1 to reduce the income limit from 185% of the FPL to 150% of the FPL (3-4 months to amend the rule). It takes at least 4 months for a rule change.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This proposal has been presented and reviewed several times. In 2002, a proposal was reviewed to reduce the income limit to 150% of the FPL for pregnant women under Medicaid and submit an SCHIP waiver to cover pregnant women under SCHIP from 150% - 200% of the FPL (CMS indicated the proposal could not be approved). In 2004, the Florida Legislature amended 409.903 (5), F.S. to reduce the income limit for pregnant women to 150% of the FPL effective 7/1/2005. In the 2005 session, the Legislature restored the income limit to 185% of the FPL prior to July 1, 2005. OPPAGA conducted a study and produced a report January 2005 related to the negative outcomes for babies born to mothers who did not have access to prenatal care and the likelihood of significant increased costs to Medicaid for the care of low birth weight infants.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #24 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Martha Crabb
Assumptions (Data source and methodology):	Medicaid claims data for pregnant women.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	2/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($29,652,980)**		**($59,305,960)**
General Revenue:	**($13,091,567)**		**($26,183,135)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($16,294,667)**		**($32,589,333)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($266,746)**		**($533,492)**
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #24 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): Reducing the Medicaid income limit for pregnant women reduces access to prenatal care for the pregnant women who cannot qualify for Medicaid. Lack of prenatal care increases the need for neo-natal intensive care for problem births, costs that are likely to be borne by Medicaid or MediKids. It would increase the uncompensated care provided by hospitals for delivery, emergency room and inpatient care.

Eliminate Pregnant Women above 150% of FPL
Begin January 1,2011

	Pregnant Women above 150% of FPL
Caseload	2,898
PMPM	$852.69
TOTAL COST	$29,652,980
TOTAL COST	($29,652,980)
TOTAL GENERAL REVENUE	($13,091,567)
TOTAL MEDICAL CARE TRUST FUND	($16,294,667)
TOTAL REFUGEE ASSISTANCE TF	$0
TOTAL PUBLIC MEDICAL ASSIST TF	$0
TOTAL OTHER STATE FUNDS	$0
TOTAL GRANTS & DONATIONS TF	($266,746)
TOTAL TOBACCO SETTLEMENT TF	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #25

Proposal Name:	Eliminate the Breast and Cervical Cancer Treatment Program (BCCP)
Brief Description of Proposal:	Eliminate the Medicaid Breast and Cervical Cancer Treatment Program
Proposed State Fiscal Year:	10/11
Proposed Start Date:	01/01/2011
If not July 1, start date; please explain.	Delayed implementation due to American Reinvestment and Recovery Act (ARRA) maintenance of effort requirement for stimulus funding
Total Cost/(Savings)/{Revenue}:	($5,662,705)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alerts and mail letters to notify providers of – 60 days • Coordinate efforts with Department of Children and Families for the notification and disenrollment of all women currently in Medicaid under eligibility category MB C (Mary Brogan Breast and Cervical Cancer Treatment Program) – 60 days • FMMIS programming to eliminate eligibility category MB C – 60 days or greater
II. Will this proposal require a change in Florida Statute?	Yes	409.904 (9) Optional Payments for Eligible Persons
III. Will this proposal require a State Plan Amendment?	Yes	This takes a minimum of 90 days
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-5.020 Provider Requirements
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	N/A	
IX. Is this proposal included in the current Governors recommendations?	N/A	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #25 Cont.**

Lead Analyst:	Kathryn R. Stephens
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims data.
FY Impacted by Implementation:	2010-2011
Date Analysis Completed:	February 24, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($5,662,705)**		**($11,325,410)**
General Revenue:	**($2,398,491)**		**($4,796,982)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($2,985,335)**		**($5,970,670)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($278,872)**		**($557,744)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($7)**		**($14)**

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #25 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:

Impact on the state:

Costs savings will be realized if Breast and Cervical Cancer Treatment Program (BCCP) is eliminated.

Cons:

Impact on Recipients:

Eliminating funding for life-saving breast and/or cervical cancer treatment services will greatly impact the lives and well-being of women currently receiving treatment.

Eliminating funding for the Breast and Cervical Cancer Treatment Program will reduce the amount of medical care for under and uninsured women diagnosed with breast and/or cervical cancer.

The elimination of services to women who are enrolled in Medicaid solely breast and/or cervical cancer treatment is expected to generate a flurry of e-mails, letters and phone calls from recipients, family members, providers, and concerned citizens.

Women who are terminated from the Breast and Cervical Cancer Treatment Program before completing their medically necessary cancer treatment may develop metastatic cancer and die prematurely.

Impact on Providers:

Women enrolled in the Breast and Cervical Cancer Treatment Program can access all medically necessary state plan services, so the elimination of the Breast and Cervical Cancer Treatment Program will result in loss of reimbursement for all providers who may render state plan Medicaid services to women enrolled under the MB C category of eligibility.

Medicaid Impact Conference Issues

February 26, 2010

Issue #25 Cont.

Cut Pregnant Women and children from Medically Needy and Breast and Cervical cancer from the E&D program			
Starting January 1,2011			
	E&D		
TOTAL COST	($5,662,705)	($11,325,410)	
TOTAL GENERAL REVENUE	($2,398,491)	($4,796,982)	
TOTAL MEDICAL CARE TRUST FUND	($2,985,335)	($5,970,670)	
TOTAL OTHER STATE FUNDS	($7)	($14)	
TOTAL GRANTS & DONATIONS TF	($278,872)	($557,744)	

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #26

Proposal Name:	**Disease Management Contracts**
Brief Description of Proposal:	Determine the estimated savings if provisions of OPPAGA Research Memorandum – Options to Reduce Disease Management (DM) Program Costs – January 15, 2009 were implemented. OPPAGA recommendations are as follows: **Option 1:** Reduce the Pfizer and AIDS Health Contracts by 4% to 10% **Option 2:** Reduce the Pfizer contract by eliminating the incentive payment **Option 3:** Reduce the Pfizer contract by establishing a flat per member per month rate for managing all disease states. **Option 4**: Reduce the Pfizer contract by decreasing or eliminating payment for locating and enrolling aged and disabled beneficiaries.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	**Option 1** The Agency will need to amend current Pfizer and AHF DM contracts and amend the 1915(b) Managed Care Waiver to reflect the reductions minimum of two moths to implement. **Option 2** The Agency would need to amend the current Pfizer DM contract and amend the 1915(b) Managed Care Waiver to reflect the reductions. Minimum of two months to implement. **Option 3** The Agency may need to re-procure the Pfizer DM contract as this provision was not included in the procurement documents or subsequent contract. Minimum of one year to implement. **Option 4** The Agency may need to re-procure the Pfizer DM contract as this provision was not included in the procurement documents or subsequent contract. Minimum of one year to implement. The 1915(b) Managed Care waiver will need to be amended to update the programmatic section and cost-effectiveness of the waiver. The Medicaid fiscal agent system will need to be modified.
Total Cost/(Savings)/{Revenue}:	($1,800,000) Option 2
Bureau(s) Responsible for Administration:	Health Systems Development

Issue #26 Cont.

Key Elements:	Yes;No;N/A	Explanation and Time Frame
I. Anticipated implementation time line and process.	Yes	**Option 1** The Agency will need to amend current Pfizer and AHF DM contracts and amend the 1915(b) Managed Care Waiver to reflect the reductions. Minimum of two moths to implement. **Option 2** The Agency would need to amend the current Pfizer DM contract and amend the 1915(b) Managed Care Waiver to reflect the reductions. Minimum of two months to implement. **Option 3** The Agency may need to re-procure the Pfizer DM contract as this provision was not included in the procurement documents or subsequent contract. Agency will need to amend the 1915(b) Managed Care Waiver to reflect the reductions. Minimum of one year to implement. **Option 4** The Agency may need to re-procure the Pfizer DM contract as this provision was not included in the procurement documents or subsequent contract. Agency will need to amend the 1915(b) Managed Care Waiver to reflect the reductions. Minimum of one year to implement. The Medicaid fiscal agent system will need to be modified. ***Note***: Federal CMS has two 90 day periods to review and approve the amendment once submitted.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	

Issue #26 Cont.

IV. Will this require the Procurement Process?	Yes	The current Pfizer DM contract is scheduled to end 12/31/2010. Option 1 and 2 could be implemented via a contract amendment as the contract contains provisions for payment based on availability of funds. Option 3 and 4 of the OPPAGA report may require re-procurement as the PMPM for each disease state and the payment for recipients on the eligibility list but not yet enrolled was included in the procurement documents and subsequent contract.
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The Agency will need to amend the 1915(b) Managed Care Waiver to reflect the reductions that would be experienced if any of the Options 1-4 were implemented as recommended by OPPAGA, including revising the cost effectiveness calculations. Federal CMS has two 90 day periods to review and approve the amendment once submitted. The Agency would not be able to implement this change without federal approval.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This issue was reviewed /evaluated previously based upon the directive to estimate savings as a result of the OPPAGA Research Memorandum – Options to Reduce Disease Management Program Costs during the 2009 Legislative Session. As a result, during the HIV/AIDS procurement process in 2009, Option 2, 3 and 4 of the OPPAGA Memorandum were implemented for HIV/AIDS disease management. Also in the Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis: **Issue #26 Cont.**

Lead Analyst:	Tracy Hurd
Secondary Analyst:	Linda Macdonald
Assumptions (Data source and methodology):	**Option 1 - Reduce total contract amount remaining for Pfizer ($17,998,986 for calendar year 2010) by 4% and by 10%** - Pfizer contract amount = $17,998,976.50 (Jan 1, 2010 – Dec 31, 2010) 4% reduction = $709,959.06 Calculated as 4% of $17,998,976.50 10% reduction = $1,799,897.65 Calculated as 10% of $17,998,976.50 *Need to re-calculate reduction for applicable months of FY2010-11 (September-December 2010 only). **Reduce total contract amount remaining for AHF ($15M) by 4% and by 10%.** AIDS Health Care contract amount = $15,000,000.00 (Sept 1-2009- Aug 31, 2011) 4% reduction = $600,000.00 Calculated as 4% of $15,000,000.00 10% reduction = $1,500,000.00 Calculated as 10% of $15,000,000.00 *Need to calculate reduction for applicable months of FY2010-11 (September-December 2010 only). Also, need to re-calculate based on remaining contract amount as the $15M is for entire Sept. 2009- Aug 2011 contract period. **Option 2 – Eliminate the Pfizer incentive payment**. (assumption - eliminate entire $1.8M available) Savings = $1.8 million **Option 3 – Establishment of the $90 PMPM rate per disease state as recommended.** ***No savings as the option could not be implemented in FY2010-11 as the timeline for procurement is one year** If we do not need to re-procure: Savings of $3,648,205.88 This calculation is based upon Pfizer enrollment for the period of January 1, 2009 – December 31, 2009 taking into account the disease state managed and the varying payments per disease state that were applied. A total of $14,089,735.88 was paid at varying payment levels. Using the same enrollment figures but projecting payments based upon a $90.00 per member per month payment, the Agency would have paid $10,441,530.00 (a savings of $3,648,205.88). *Need to calculate for applicable months of FY2010-11, savings will not apply to entire FY, savings will apply to July-December only. Reduce from below to 90.00 PMPM Sickle Cell 191.00 PMPM Renal Disease 191.00 PMPM CHF 152.00 PMPM

Issue #26 Cont.

Assumptions (Data source and methodology):	COPD 138.00 PMPM Diabetes 104.00 PMPM Asthma 102.00 PMPM Hypertension 88.00 PMPM **Option 4 – Reduce or eliminate the payment for locating and enrolling aged and disabled beneficiaries.** ***No savings as the option could not be implemented in FY2010-11 as the timeline for procurement is one year** If we do not need to re-procure: Savings of $5,479,181.94 if eliminated or a lesser amount, if reduced. This calculation is based upon the aged and disabled population identified as being eligible for enrollment in Pfizer for the period of January 1, 2009 – December 31, 2009. Monthly invoicing data was used to identify the number of beneficiaries by disease state that were being located by the vendor. The monthly data was then summed to arrive at the total number of recipients (by disease state) for whom a payment was made. The recipient totals were then multiplied by the disease state specific rate resulting in the total amount paid of $5,479,181.94. If the payment related to locating/enrolling of this population were to be eliminated, a savings of $5,479,181.94 would be realized. *Need to re-calculate based on applicable months of FY 2010-2011, July- December only and not entire FY.
FY Impacted by Implementation:	
Date Analysis Completed:	

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,800,000)**		
General Revenue:	**($692,280)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($1,107,720)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #26 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Option 1 – Reduce the Pfizer and AIDS Healthcare (AHF) DM contracts by 4% to 10% - a reduction in total contract amount may result in the vendor terminating the contract or the vendor reducing enrollment and providing services to fewer recipients. The Pfizer contract is scheduled to conclude December 31, 2010 and has a not to exceed amount of $17,998,986 in total contract remaining for calendar year 2010. The AHF contract is scheduled to conclude August 31, 2011 and has a not to exceed amount of $15M in total contract remaining.

Option 2 – Reduce the Pfizer contract by eliminating the opportunity to earn incentive payments – The $1.8M incentive payment is not included in funding for direct patient services, but is held in reserve if outcome benchmarks are determined to have been met. No incentive payment has been made to date. The elimination of the incentive payment would not directly impact the number of enrollees served or services provided but may impact the subcontracting arrangements between Pfizer and its subcontractor who provides the telephonic case management services (McKesson). If the telephonic case management subcontract is terminated, Pfizer would have to identify a new subcontractor in order for the telephonic case management services to be provided. This could result in a disruption of services to the enrollees.

Option 3 – Reduce the Pfizer contract by establishing a flat PMPM for managing all disease states. Operationally, a consistent PMPM payment would be simpler to manage. However, the recommendation of $90 PMPM would result in a reduction in the total contract amount for Pfizer of more than 10% which may impact the number of recipients enrolled and services provided through the program.

Option 4 – Reduce the Pfizer contract by decreasing or eliminating payment for locating and enrolling aged and disabled beneficiaries. This option would also result in a larger than 10% reduction in the total contract amount which may impact the amount of services or the number of recipients who could be enrolled in the program. This option has been implemented effective September 1, 2009 for the HIV/AIDS disease management program without impact to the enrolled recipients.

Proposed strategies:
Recommend selecting one option to implement for the Pfizer DM program. Implementing multiple options would result in a reduction of total contract amount greater than 10% and may adversely impact enrolled recipients.

The Pfizer contract is scheduled to conclude December 31, 2010. Option 1 would have limited savings as the option would require a minimum of two months to implement and would therefore apply to only 4 months of the contract term. Options 3 and 4 could not be implemented prior to the end of the calendar year due to timeline for re-procurement.

Recommend implementing Option 2 for the Pfizer DM contract.

Note: Option 2, Option 3 and Option 4 were implemented in the procurement for the HIV/AIDS DM program and included in the current HIV/AIDS DM contract.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #27

Proposal Name:	**Nursing Home Diversion**
Brief Description of Proposal:	Provide an estimate of savings associated with increasing nursing home diversion slots by the 90 new nursing home slots monthly or 1,080 on an annual basis for FY 2010-11.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	N/A
Total Cost/(Savings)/{Revenue}:	($8,986,174)
Bureau(s) Responsible for Administration:	Medicaid Services, and Medicaid Program Analysis

Key Elements:	**Yes; No; N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**Yes**	Please see information below
II. Will this proposal require a change in Florida Statute?	**No**	
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**No**	
V. Will this proposal require an administrative rule?	**No**	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes**	Waiver amendments take approximately ninety days to complete. The amendment will request a retroactive effective date of July 1, 2010 so the implementation of the amendment will comply with the statute's effective date.
VII. Will this proposal require additional staffing?	**Yes**	The Governor's proposed budget includes a recommendation for additional CARES staff. However, this staffing as requested to manage the current Nursing Home Diversion appropriation and a steady increase in demand for CARES assessments overall. If Nursing Home Diversion slots are increased, then additional CARES staff will be necessary in order for CARES to manage all nursing home preadmission screening activities, which includes the review of new referrals and updated assessments, nursing home bed reviews, and waiver recertification. This increase in CARES staff would be in addition to what is already included in the Governor's proposed budget.
VIII. Is there a previous or concurrent Analysis by the Agency?	**Yes**	Medicaid Impact Conference dated March 16, 2009.
IX. Is this proposal included in the current Governors recommendations?	**No**	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #27 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Keith Young, Medicaid Services
Assumptions (Data source and methodology):	Based on February 2010 SSEC.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($8,986,174)**		**($16,813,033)**
General Revenue:	**($3,531,179)**		**($6,501,794)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($5,454,995)**		**($10,311,239)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros:
The new enrollment opportunities will expand elder's options to avoid nursing home placement and reduce Medicaid costs by avoiding more costly nursing facility care. The addition of Nursing Home Diversion slots will assist in rebalancing our state's long-term care expenditures away from institutionalization.

Implementation Concerns:
Without more CARES positions beyond the Governor's SFY 2010-11 budget recommendations, CARES may not be able to keep up with the increased demand for assessments, and the projected savings may not be realized. CARES projects the need for an additional 4.5 FTE positions for each 1,000 additional nursing home diversion slots in order to meet the demand for the increased assessments. See Administrative CARES cost below. The Total Savings above accounts for the additional costs of 4.5 CARES FTEs.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #27 Cont.**

Increase Nursing Home Diversion By 90 a month							
Number of slots				1080			
	Nursing Home Diversion	Nursing Home cost	Other services	Net Savings		DOEA Admin (4.5 FTEs per 1000 slots)	Net savings after admin CARES
TOTAL COST	$10,891,255	($18,921,321)	($1,219,858)	($9,249,924)		$263,750	($8,986,174)
TOTAL GENERAL REVENUE	$4,188,776	($7,391,146)	($394,746)	($3,597,116)		$65,937	($3,531,179)
TOTAL MEDICAL CARE TRUST FUND	$6,702,479	($11,530,175)	($825,112)	($5,652,808)		$197,812	($5,454,995)

Annualized Net savings after admin CARES
($16,813,033)
($6,501,794)
($10,311,239)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #28

Proposal Name:	Consolidate small HCBS waivers serving senior adults into larger programs (Channeling waiver, Adult Day Health Care waiver, Alzheimer's Disease waiver)
Brief Description of Proposal:	The primary goal of this proposal is to streamline the Medicaid home and community based services (HCBS) waiver system of care. There are currently 6 HCBS waivers in Florida providing services to elders which offer similar services.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($2,945,579)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Implement consolidation process July 1, 2010. Finish consolidation no later than July 1, 2011.
II. Will this proposal require a change in Florida Statute?	Yes	Yes for Channeling and Adult Day Health Care waivers. The Alzheimer's Disease waiver is set to sunset on July 1, 2010. Special legislative language for the Alzheimer's Disease waiver might be necessary to specify how Medicaid recipients and funding should transfer to other waiver programs, based on the result of options counseling and recipient choice over a specified period.
III. Will this proposal require a State Plan Amendment?	No	Optional services not included in State Plan
IV. Will this require the Procurement Process?	No	Contracts are currently held by DOEA. Consolidation activities in the field can be handled by existing support services structure and mechanisms.
V. Will this proposal require an administrative rule?	Yes	Any existing rules that address the consolidated programs will need to be altered to remove references.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Existing waivers will need to be closed out, requiring a 'transition plan' that is submitted to CMS regarding program termination
VII. Will this proposal require additional staffing?	No	Existing staff will handle Federal compliance and reporting; and field operations will continue with little or no impact
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency Cost Efficiencies presentation, January 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #28 Cont.**

Lead Analyst:	Karen Chang
Secondary Analyst:	Patrick Rhodes, Medicaid Services; DOEA staff
Assumptions (Data source and methodology):	Assumed half will choose diversion and half will choose ADA. Assumed that the statewide ADA average care plan is 30% higher than the average ADA care plan due to dementia.
FY Impacted by Implementation:	2010/11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,945,579)**		
General Revenue:	**($1,132,870)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($1,812,709)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #28 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

By phasing out the smaller waivers that are only available in limited areas of the state, the Agency hopes to reduce the administrative burden on state agencies and create a system of care that is easier for Medicaid recipients to navigate. Individuals in the consolidated waiver programs will be given the opportunity to choose another comparable waiver program. Existing state employees who will be able increase their focus on quality improvement strategies for the remaining programs.

Pro: Simplify maze of services available to elderly Medicaid recipients and allow existing staff to concentrate on improving quality and utilization. Reduce administrative burden on agency staff. Individuals in smaller programs with a limited offering of services may gain access to an increased number of services.

Con: For the Alzheimer's Disease waiver, it appears that DOEA's General Revenue funded Alzheimer's program is also being eliminated (source: Governor's FY 2010/2011 budget recommendations under "Elder Affairs; Services to Elders Program; Home and Community Services", Nonrecurring Expenditures and Schedule VIIIB Reductions - Operating). This might give the appearance that the State is completely eliminating supports for individuals with dementias and their caregivers/families. Most of these small programs impact South/Central Florida and have a limited geographic impact, which could lead to high population areas appearing to lose a significant number of services even though there will be no net reduction in available services through remaining programs.

Industry Concerns: Certain providers in the smaller waivers, such as case management agencies, will lose a guaranteed reimbursement pool, as recipients will have other provider choices. However, providers in these smaller programs are also service providers in the existing larger waivers programs that will continue. Current enrollees could continue to receive services through the same providers even after switching programs.

Implementation obstacles: Savings will not likely be immediate. CMS will require that a transition plan be submitted and approved before implementation. Recipients will need options counseling, which depending on program size, could take 6 to 9 months, then upon selecting a new program will need to go through the enrollment process. Upon completion of the transition plan, the program will be formally shut down through a waiver amendment submitted to CMS. Although certain individuals may transfer from programs with higher average per person costs to programs with lower per person costs, this will likely not result in immediate savings, as these individuals will likely maintain the same level of services. When they leave the program, however, future enrollees will likely have service costs in line with the average cost in the program due to improved utilization management and oversight in the consolidated programs.

The following analysis was done by DOEA in conjunction with AHCA.

Alzheimer's Waiver

Average Care Plan Costs	18,876.00
Number of Enrollees	270
Total Costs	5,096,520.00
Appropriation	5,020,209.00

	Clients	Avg Est Cost	Annual Costs
NH Diversion	135	$18,432	$2,488,320
ADA	135	$11,357	$1,533,168
Total			$4,021,488
Total Appropriation			$5,020,209
Savings for FY 2010-2011			$998,721
Total GR Savings for FY 2010-2011			$384,108

Assumption is that the Statewide ADA average care plan will be 30% higher than average ADA care plan due to dementia

Assumptions is that half will choose Diversion and half will choose ADA

Medicaid Impact Conference Issues

February 26, 2010

Issue #28 Cont.

Channeling Waiver

Average Care Plan Costs	$11,400
Number of Enrollees	1,400
Total Costs	$15,960,000
Appropriation	$14,700,762

	Clients	Avg Est Cost	Annual Costs
Channeling Est Expenditures	1,400	$11,400	$15,960,000
Transitioned to ADA	1,400	$11,052	$15,472,800
Total Appropriation Channeling			$14,700,762

Total GR Savings for FY 2010-2011	$0

It is the Department's assessment is that no savings could be generated by collapsing Channeling into ADA because the average cost/client for ADA in Miami/Dade is very close to the Channeling capitation amount.

Medicaid Impact Conference Issues

February 26, 2010

Adult Day Health Care Waiver

Average Care Plan Costs	17,604.00	
Number of Enrollees		28
Total Costs	492,912.00	
Appropriation	1,946,858.00	

	Clients	Avg Est Cost	Annual Costs
Adult Day Health	28	17,604.00	$492,912
ADA	28	11,508.00	$322,224
Total Appropriation Channeling			$1,946,858
Savings for FY 2010-2011			$1,624,634
Total GR Savings for FY 2010-2011			$748,762

The Department's assessment is that this program could be eliminated and all clients transition into the ADA and all costs could be absorbed through attrition in the program. This is possible since only 28 clients are currently being served in this program today.

Total Cost Savings for Item 28 Medicaid Impact Conference	
Savings for Alzheimer's	$998,721
Savings for ADHC Waiver	$1,946,858
Total	$2,945,579
Total GR	$1,132,870
Total MCTF	$1,812,709

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #29

Proposal Name:	Aligning waiver enrollees with most cost effective waiver program for which the individual meets enrollment criteria.
Brief Description of Proposal:	Provide an estimate of the savings associated with aligning clients with the most cost effective waiver for which the individual has met the criteria.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	N/A
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	N/A
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Implementation of this provision would violate Federal law. Federal law requires that an individual must be given the option of freely choosing between all available programs that can meet their needs.
II. Will this proposal require a change in Florida Statute?	N/A	
III. Will this proposal require a State Plan Amendment?	N/A	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	N/A	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	N/A	CMS would not approve this modification to existing programs as it would violate Federal laws regarding choice.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #29 Cont.**

Lead Analyst:	Karen Chang
Secondary Analyst:	Patrick Rhodes, Medicaid Services
Assumptions (Data source and methodology):	Medicaid does not have the acuity level of clients to align them with the most cost effective waiver.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**N/A**		
General Revenue:	**N/A**		
Administrative Trust Fund:	**N/A**		
Medical Health Care Trust Fund:	**N/A**		
Refugee Assistance Trust Fund:	**N/A**		
Tobacco Settlement Trust fund:	**N/A**		
Grants and Donation Trust Fund:	**N/A**		
Public Medical Assistance Trust Fund:	**N/A**		
Other State Funds:	**N/A**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #29 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pro: None.

Con: Implementation of this provision would violate Federal law. As long as there are two or more Medicaid waiver programs in a given service area that can meet an individual's needs and for which the individual qualifies, Federal law requires that an individual must be given the option of freely choosing between all available programs. The State may not direct or dictate the individual's choice of program – regardless of cost implications – if the program is available and the individual meets the program's enrollment criteria. Individuals do not have to consider fiscal impacts to the State when choosing between available programs. The only exceptions to this are as follows:

1. Only one program is available in that area, or the individual only qualifies for one program. In those instances choice is limited to receiving services from the one available program or not receiving services.
2. If there is insufficient funding for a preferred program, an individual may have to select another comparable program if they meet the enrollment criteria. Enrollment in a program may be closed due to insufficient resources or reaching a maximum approved enrollment cap, in which case the program is not available as a choice.

Industry Concerns: None

Implementation obstacles: Federal law prohibits limiting an individual's choice between programs that can meet their needs.

<u>Examples:</u>

Currently the Alzheimer's Disease waiver program's enrollment is closed. However, individuals that qualify for the Alzheimer's Disease waiver may choose between the following programs for service delivery: Channeling waiver (in Broward and Miami-Dade counties), Nursing Home Diversion waiver, Assisted Living for the Elderly waiver, and Aged and Disabled Adult waiver.

Individuals (ages 18 to 59) in the Traumatic Brain Injury/Spinal Cord Injury waiver may also be served by the Aged and Disabled Adult waiver.

Individuals over the age of 18 in any of the four Developmental Disabilities waivers, Familial Dysautonomia waiver, and Model waiver may also be served by the Aged and Disabled Adult waiver if they choose.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #30

Proposal Name:	Home and Community-Based Services Waivers
Brief Description of Proposal:	Provide an estimated average cost for an individual in a waiver, including the Medicaid state plan costs compared to the average nursing home diversion cost. Provide a mechanism for calculating the savings.
Proposed State Fiscal Year:	10/11
Proposed Start Date:	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services, Medicaid Program Analysis

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	N/A	
III. Will this proposal require a State Plan Amendment?	N/A	
IV. Will this require the Procurement Process?	N/A	
V. Will this proposal require an administrative rule?	N/A	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	N/A	
VII. Will this proposal require additional staffing?	N/A	
VIII. Is there a previous or concurrent Analysis by the Agency?	N/A	
IX. Is this proposal included in the current Governors recommendations?	N/A	This appears to be asking for a comparison of costs between waivers. This would compare average Nursing Home Diversion waiver costs to a fee-for-service waiver, such as the Aged and Disabled Adult (A/DA) waiver and State Plan services received by individuals in the A/DA waiver, presumably to determine which waiver is more cost effective over-all.

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #30 Cont.**

Lead Analyst:	Karen Chang
Secondary Analyst:	Wendy Smith
Assumptions (Data source and methodology):	Pending due to release of OPPAGA report on this issue. PMPM costs for waivers are listed in table on next page. In March 2010, OPPAGA is scheduled to release a report on the Nursing Home Diversion waiver, the Aged and Disabled Adult waiver, and the Assisted Living for the Elderly waiver, which will include a comparison of services and costs for each waiver.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**N/A**		
General Revenue:	**N/A**		
Administrative Trust Fund:	**N/A**		
Medical Health Care Trust Fund:	**N/A**		
Refugee Assistance Trust Fund:	**N/A**		
Tobacco Settlement Trust fund:	**N/A**		
Grants and Donation Trust Fund:	**N/A**		
Public Medical Assistance Trust Fund:	**N/A**		
Other State Funds:	**N/A**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #30 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The contracted Nursing Home Diversion managed care organizations are at full risk for all Medicaid acute and long term care services for their enrollees, including nursing home services. Since enrollees in Nursing Home Diversion are dually eligible (Medicaid and Medicare), Nursing Home Diversion managed care organizations are also responsible for Medicare co-payments and deductibles. If the Nursing Home Diversion waiver program were to be compared to a fee-for-service waiver program such as the Aged and Disabled Adult waiver program or the Assisted Living for the Elderly waiver program, a comparable population of dually eligible enrollees aged 65 and over who spent time in the community as well as in the nursing home would need to be included.

In March 2010, OPPAGA is scheduled to release a report on the Nursing Home Diversion waiver, the Aged and Disabled Adult waiver, and the Assisted Living for the Elderly waiver, which will include a comparison of services and costs for each waiver.

PMPM for total cost for individuals in various waivers		
FY0809		
Tab	Waiver	PMPM
DOEA	Aged and Disabled DOEA	$962.84
CF	Cystic Fibrosis	$2,193.79
ADC	Adult Day Care	$1,330.53
ALZ	Alzheimer's	$1,234.45
Model	Model	$19,886.80
Aids	AIDS	$1,215.70
TBS	Traumatic Brain Injury	$3,543.01
DS	Developmental Disabled	$3,172.10
FD	Familial Dysautonomia	$1,119.94
Chal	Channeling	$1,213.43
ALF	ALF	$1,204.71
CYF	Aged and Disabled DYF	$1,876.48
AGOUT	Aged and Disabled Aging Out	$20,677.90
NH	Nursing Homes	$4,419.45
NHD	Nursing Home Diversion	$1,541.13
PACE	PACE	$1,679.16

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #31

Proposal Name:	Reduce the Maximum Daily Number of Home Health Aide Visits from 4 to 3.
Brief Description of Proposal:	Provide estimate of savings if there is a reduction in the number of aide visits.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	This will require a state plan amendment, rule promulgation, and a system edit in FMMIS decreasing the maximum number of visits allowed.
Total Cost/(Savings)/{Revenue}:	($490,395)
Bureau(s) Responsible for Administration:	Medicaid Services, Medicaid Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Handbook/Rule Revision- minimum of 120 days • FMMIS programming to enforce the limits- 180 days • State Plan Amendment- 90 days
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	The Home Health Coverage and Limitations Handbook would need to be updated.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Agency Cost Efficiencies presentation, January 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #31 Cont.**

Lead Analyst:	Claire Davis
Secondary Analyst:	
Assumptions (Data source and methodology):	Based on Efficiency presentation which estimated a total of 62,415 visits by either a home health aide or nurse that was in excess of 3 per day.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($490,395)**		**($980,789)**
General Revenue:	**($218,471)**		**($436,941)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($271,924)**		**($543,848)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Note: The analysis was done prior to the estimating conference and home health visits have decreased significantly.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #31 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

42 CFR 441.15 and 440.70 requires a State Medicaid program to provide home health services to eligible Medicaid beneficiaries. Home health services include skilled nursing and home health aide services. Federal regulation allows States to set the limits on these services.

Home health aide services help maintain a recipient's health or facilitate treatment of the person's illness. Reducing home health aide services may be detrimental to recipients who need the service. Home health aide services provides assistance with activities of daily living and recipients who are either not eligible for a Medicaid waiver program (or who are on a waitlist) may only be able to receive this type of assistance in their home through other community resources (which are limited). However, for those recipients who are receiving 4 visits per day currently, this reduction in coverage ensures that a medical professional is entering the home intermittently up to 3 times during the day to check on the status of the recipient, ensure patient safety, and address any needs outlined in their plan of care.

Summary	
Total	($980,789)
GR	($436,941)
MCTF	($543,848)

Number of Visits Per Day > 3 Authorized	Reimbursement per Aide Visit	Cost if All Units Used	Reduction	Potential Cost Savings
62,415	$17.46	$1,089,765.90	90%	**$980,789.31**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #32

Proposal Name:	Limit Private Duty Nursing Services
Brief Description of Proposal:	Provide estimate of savings if there is a limit on private duty nursing services to 12 continuous hours per day (currently 24 hours per day is allowed).
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/1/2011
If not July 1, start date; please explain.	This will require a state plan amendment and rule promulgation
Total Cost/(Savings)/{Revenue}:	($6,052,870)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	6 Months- The Home Health Coverage and Limitations Handbook would require updating and the Agency would need to submit a State Plan Amendment.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	This can take up to 90 days in order to receive CMS approval.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	The Home Health Coverage and Limitations Handbook would require updating. This takes a minimum of 120 days, and may be challenged.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #32 Cont.**

Lead Analyst:	Claire Davis
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Calculations from an analysis done for a Medicaid Efficiency presentation in January 2010. Calculation was based on the private duty nursing LPN reimbursement rate.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($6,052,870)**		**($12,105,740)**
General Revenue:	**($2,696,554)**		**($5,393,107)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($3,356,316)**		**($6,712,633)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #32 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The Agency would have to have a process in place that allows for exceptions because federal regulations (EPSTD) require that children must receive any service that is medically necessary. Therefore, if the parent or legal guardian cannot participate in the care of their child because of extenuating circumstances (i.e. health condition), the Medicaid program would have cover the medically necessary hours above the 12 hour limitation.

This proposal is likely to generate concern from advocacy organizations and families of medically complex children. Rule promulgation could be challenged, and any reductions in service would be eligible for challenge through the Medicaid Fair Hearing Process. This would delay and possibly eliminate savings.

Requiring families to participate more in the care of children with significant medical complications or disabilities could increase strain on families.

Home health agencies are reluctant to staff private duty nursing cases for shorter blocks of time because nurses tend to prefer longer shifts and Medicaid does not pay for the time to travel to and from the home.

Summary

Total	($12,105,740)
GR	($5,393,107)
MCTF	($6,712,633)

Hours Currently Approved	Potential Expenditures if all Hours Used	Average Percentage Reduction in Hours	Potential Savings
13-16/hours/day	$26,908,000	8%	$2,152,640
17-23 hours/day	$42,090,000	12%	$5,050,800
24 hours/day	$37,710,000	13%	$4,902,300
Total			**$12,105,740**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #33

Proposal Name:	Medically Needy
Brief Description of Proposal:	Provide an estimate of savings from reducing the benefits covered under the Medically Needy program. Analysis should discuss any federal or state implementation issues and identify whether premiums could be imposed for adults as approved under the Deficit Reduction Act (DRA).
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	04/01/2011
If not July 1, start date; please explain.	A mechanism for collecting premiums is needed as well as system changes to the DCF automated eligibility system to not allow authorization of eligibility prior to the individual's payment of the premium. System changes are needed to FMMIS to limit services for Medically Needy. If a contractor is used for the premium collection, sufficient time to procure the contractor and to work out the data exchange between the DCF eligibility system and the contractor is needed.
Total Cost/(Savings)/{Revenue}:	($55,850,317)
Bureau(s) Responsible for Administration:	Medicaid Services; Medicaid Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		See below for details
II. Will this proposal require a change in Florida Statute?	Yes	A Florida statutory change would be needed to permit the state to impose a premium as a condition of eligibility for Medically Needy and to specify what services will be covered. The legislation must specify what the premium payment will be, who will collect the premiums as well as specify the disposition of collected premiums. The premium cannot be imposed on pregnant women. Premiums can be imposed on children and adults when the family's income exceeds 150% of the federal poverty level. The premium payment, combined with any other cost-sharing/copayments for Medicaid, cannot exceed 5% of the gross family income. Under Medically Needy, Medicaid must, at a minimum, provide prenatal and delivery services for pregnant women and during the pregnant woman's 2 month post partum coverage period, provide services that are necessary for the health and well-being of the pregnant woman or that have become necessary as a result of her having been pregnant. These must include but are not limited to postpartum care and family planning services. For any other Medically Needy recipients, Medicaid must provide at least one ambulatory service (for example, prescription coverage).

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III. Will this proposal require a State Plan Amendment?	Yes	A State Plan Amendment is needed both for the premium requirement and the reduction of services to Medically Needy. This takes a minimum of 90 days.
IV. Will this require the Procurement Process?	Possibly	Currently, neither DCF nor the Agency has a mechanism to collect premium payments (send invoices, track the payment, notify DCF), and deposit the funds as directed by any legislation implementing this provision. This capability would either need to be developed within an agency, which would require additional staffing, or competitively procured. Either option would take approximately 9 months to implement.
V. Will this proposal require an administrative rule?	Yes	Both DCF and the Agency would have to promulgate rules. DCF would have to include the premium payment as a condition of eligibility and the Agency would have to modify rules to indicate what services would be covered by Medically Needy. The Medicaid Provider General Handbook would have to be updated, and depending upon what services are covered and what groups, the Home Health, Hospital, Physician Services, Therapy Services, ADA Dental Claim, CMS 1500, Prescribed Drugs, Transportation and UB-04.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	No waiver is required, unless the legislature elects to limit services or impose premium payments beyond what is permitted by federal statute.
VII. Will this proposal require additional staffing?	Possibly	Assuming a contractor is needed to do premium collection, either the Agency or DCF would likely need a position to prepare the RFP, oversee contractor selection, and manage the contract and interface between DCF's system and the contractor's premium collection system. In addition, staffing may be needed for DCF for handling calls related to premium collection – unless the premium collection contractor is required to have a customer call center.
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Legislation was enacted in 2004 to reduce services to Medically Needy effective 7/1/2005; legislation enacted in 2005 to restore full benefits prior to 7/1/2005.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

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Analysis: **Issue #33 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Martha Crabb
Assumptions (Data source and methodology):	Medicaid Claims data.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**3**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($55,850,317)**		**($223,401,268)**
General Revenue:	**($25,995,067)**		**($103,980,266)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($32,355,251)**		**($129,421,003)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Cut Non Ambulatory Services for Medically Needy	
Hospital Inpatient	
FY1011	
Total	(223,401,268)
GR	(103,980,266)
MCTF	(129,421,003

Work Papers/Notes/Comments: **Issue #33 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
Under the current Florida Statute for Medically Needy (409.904(2), F.S.), the only individuals who will be covered starting January 1, 2011 are pregnant women and children. Medicaid cannot impose a premium requirement on pregnant women and must provide for prenatal and delivery services, as well as coverage of post-partum care. Premiums can be imposed on the children only when the family's income exceeds 150% of the federal poverty level and the premium payment, combined with any other cost-sharing requirements for Medicaid for the family, cannot exceed 5% of the gross family income.

If there is more than one adult in the family for whom a premium will be collected (or if the state elected to collect a premium for children), the premiums and any other cost-sharing (copayments) for Medicaid for all of the family members cannot exceed 5% of the family's gross income.

Since families must spend down to the Medically Needy Income Level (MNIL), each month before becoming Medicaid eligible, it is possible the family would not be able to afford a premium. For persons who cannot pay the premium and therefore are unable to have Medicaid assist with their cost of care, any necessary care not covered by Medicaid becomes uncompensated care, which affects providers and results in higher costs to the insured and private payers.

Family Size	MNIL	Asset Limit
1	$180	$5000
2	$241	$6000
3	$303	$6000
4	$364	$6500
5	$426	$7000

A large implementation obstacle is the cost of collecting the premiums versus the amount of premiums actually collected. Neither the Agency nor DCF is currently equipped to collect premiums.

Other issues to consider are:
Cost of contract; Staff for contract procurement/management;
(Will premiums along with budget authority be given to the Agency to offset Medicaid costs for the Medically Needy, or other disposition of funds? Must be specified by the legislation.)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #34

Proposal Name:	Risk Adjusted HMO Rates Statewide
Brief Description of Proposal:	Provide an estimate of savings if risk adjusted rates were implemented for HMOs based on the FY 2010-11 estimate.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	09/01/2010
If not July 1, start date; please explain.	This will follow the HMO rate setting which is September 1.
Total Cost/(Savings)/{Revenue}:	$391,229
Bureau(s) Responsible for Administration:	Medicaid Quality Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Timing is dependent on phase-in. It will likely take 8 months internally to be ready to go statewide plus the roll-out time externally.
II. Will this proposal require a change in Florida Statute?	Yes	We have authority to go statewide with the 1115 Reform Waiver. If we do not expand Reform we will need to a statute change for the authority to risk-adjust rates.
III. Will this proposal require a State Plan Amendment?	Yes	See above
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	We have authority to go statewide with the 1115 Reform Waiver. If we do not expand Reform we will need a new waiver or we will need to modify our 1915B waiver.
VII. Will this proposal require additional staffing?	Yes	We only have risk adjusted rates in 5 counties and 1 staff. To go statewide we would need 3 staff plus additional contractor time (the contractor currently runs the model for us). If we transition from a contractor running the model we may need additional staff. $241,229 Staffing, $150,000 in contracting dollars.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #34 Cont.**

Lead Analyst:	Peggy Claborn
Secondary Analyst:	
Assumptions (Data source and methodology):	Risk adjustment does not result in additional savings but rather distributes payments to plans according to the risk of enrolled members. Statewide implementation of risk adjustment would result in an overall cost to the state due to additional staffing and contracting needs.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	2/9/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$391,229**		
General Revenue:	**($195,615)**		
Administrative Trust Fund:	**($195,614)**		
Medical Health Care Trust Fund:	**($0)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #35

Proposal Name:	**Managed Care Expansion – MediPass** (mandatory population only)
Brief Description of Proposal:	Provide the estimated savings by mandating MediPass recipients, excluding voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($27,546,295)
Bureau(s) Responsible for Administration:	HSD, MCM, BMHC

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**12 month Phase-In with process starting on July 1, 2010**	To implement under **non-reform waiver**, the Agency would need to allow for a 12 month phase-in period. The Agency would need to: • Ensure choice of managed care plans as required by federal regulations by confirming at least 2 managed care plans are available by in each transition county. Currently, **19 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., and the capacity to transition the mandatory population. • Submit phase-in plan to federal CMS along with a waiver amendment to the 1915(b) Managed Care Waiver. The expansion cannot be implemented until federal CMS approves the amendment. Federal CMS has two 90 day periods to review and approve the waiver amendment once submitted. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary.

Issue #35 Cont.

		• Confirm sufficient Medicaid Options resources are available (call center and field staff). To implement under **1115 reform waiver**, the Agency does not need to amend the waiver. The expansion would be phased-in over 12 month period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 capitated health plans as defined in s. 409.91211, F.S., are available by in each transition county. Currently, **19 counties** have at least 2 capitated health plans as defined in s. 409.91211, F.S., and the capacity to transition the mandatory population. • Submit the phase-in plan to federal CMS. • Process new and existing reform plan applications for expansion counties. Based on initial implementation in 2006, the majority of existing plan applications could be processed in under 3 months. New plan applications may take longer to process depending on the applicant's qualifications and provider network readiness. • Implement fiscal agent system changes. • Confirm sufficient plan capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Choice Counseling resources are available (call center and field staff).

Issue #35 Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	***Expansion in <u>non-reform areas</u> would require amendments to the following sections:*** • 409.9121, F.S., to update legislative findings, intent, and remove reference to MediPass in specified counties. • 409.912(4)(b)3 and (d), (30) and (34), F.S., to remove reference to MediPass in specified counties. • 409.912(26), F.S., to remove reference to MediPass in specified counties and revise the Agency's enrollment and disenrollment responsibilities. • 409.912(49), F.S., to remove reference to MediPass in specified counties. MPN providers are also MediPass providers, the Agency would need to amend the MPN agreements accordingly. • 409.91188, F.S., to remove reference to MediPass in specified counties. • 409.9122(1),(2)(a) thru (k),(3)(b),(4), (5)(b), (7) and (9)(c), F.S., to remove reference to MediPass in specified counties, add new description of the mandatory Medicaid managed care assignment process • 409.9123, F.S., to remove reference to MediPass in specified counties. • 409.91207(2)(b)(4)(h) and (5), F.S., to remove reference to MediPass and MediPass providers in specified counties. • 409.91211(2)(a)(c) and (3)(aa), F.S., to remove reference to MediPass in specified counties. ***Additional Information regarding non-reform expansion***: • 409.912, F.S., authorizes the Agency to contract with certain entities to provide select services such as behavioral health care services, dental services, minority physician network services, pediatric emergency room diversion services, and disease management services. The majority of these programs were created as an overlay service to MediPass enrollees. .

Issue #35 Cont.

		• 409.912(4)(b), F.S., provides that MediPass enrollees are automatically assigned to prepaid mental health plans. If MediPass is removed as an option in counties with 2 or more plans, other statutory changes may need to be considered to allow PMHPs to receive enrollees or to revise the areas where PMHPs operate. • 409.9122(2)(k), F.S., defines the term "managed care plans" to include exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. ***Expansion of <u>reform areas</u> would require an amendment to section:*** • 409.91211(1) and (5), F.S.
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**No**	
V. Will this proposal require an administrative rule?	**No**	Technically, Rule 59G-8.400, Medicaid Physician Access System will not need to be amended to implement this issue. However, this rule should be reviewed once legislation becomes law to determine if it needs to be updated.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes,** non-reform **No,** reform	For non-reform, see response to item I above. For reform, the Agency would need to submit a phase-in plan to federal CMS for expansion areas. The plan must be designed to ensure smooth transition process for beneficiaries, providers and all stakeholders.
VII. Will this proposal require additional staffing?	**Yes**	Any expansion is estimated to require an additional 22 FTEs as well as contract expenses for choice counseling.
VIII. Is there a previous or concurrent Analysis by the Agency?	**Yes**	Agency 2010 analysis for Committee presentations. (This did not factor in any administrative costs).
IX. Is this proposal included in the current Governors recommendations?	**No**	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #35 Cont.**

Lead Analyst:	Linda Macdonald
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Assumes a 12-month phase-in beginning July 1, 2010. Estimates based on February 2010 SSEC and January 2010 enrollment. Savings based on actual area managed care discount including an additional 4.5% in Miami for fraud and abuse. Analysis factors in associated administrative costs for expansion. The $2 PCCM MediPass fee is also factored into this analysis.
FY Impacted by Implementation:	2010-11 and 2011-12
Date Analysis Completed:	02/17/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**12**	**N/A**
Total (Savings) Cost of Proposal:	**($27,546,295)**		**($59,630,803)**
General Revenue:	**($9,479,958)**	**-**	**($25,389,396)**
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**($18,192,826)**	**-**	**($34,358,896)**
Refugee Assistance Trust Fund:			
Health Care Trust fund:	**$126,489**	**-**	**$117,489**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Any expansion is estimated to require an additional 20 FTEs as well as contract expenses for choice counseling. Administrative costs are estimated to be $10.3 million, the majority of which is choice counseling expenses.

Work Papers/Notes/Comments: **Issue #35 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Capacity Issues

An additional 8 counties have at least 2 managed care plans as defined in s. 409.9122, F.S., but do not have capacity to transition the mandatory population (see issues #35a for details).

Non-reform Expansion

Additional Impact: Programs that were implemented as overlays or enhancements to the MediPass Program in non-reform areas may be impacted by this change. The programs that would be impacted include disease management program, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program. To implement this change, the Agency would need to amend the program contracts to reduce the geographic areas served by the program.

Rate Development

At present capitation rates are developed by Medicaid area and not for specific counties. Implementing a transition of recipients eligible for mandatory assignment in certain counties within a Medicaid area and not all counties within a Medicaid area may have impact rate reimbursement and consideration may need to be given to developing rates by counties or including an adjustment for certain counties.

Funding Implications:

Currently, counties submit intergovernmental transfers (IGTs) to help fund the hospital inpatient service line item. The funding is used to support the Low Income Pool and fund the state share of the following issues:

- Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP
- Eliminate Inpatient Reimbursement Ceilings-11% Screen
- Eliminate Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%
- Special Medicaid Payments-Liver Transplant Facilities
- Hospital Reimbursement Ceiling Exemption

Counties have a strong incentive to provide intergovernmental transfers (IGTs) to support these payments since there is a direct relationship between the policies funded and fee-for-service payments to these qualifying hospitals. Counties provide local financial support to hospitals that provide a significant amount of Medicaid and uncompensated care. Using these local funds as state match through Medicaid allows local governments to partner with the state, earn federal matching funds and help cover the costs of Medicaid and uncompensated care. For FY 2008-09, the IGT funding is estimated at $706 million in county contributions.

If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the 19 counties with 2 or more managed care plans (with capacity to transition mandatory population) resulting in an increase in the penetration of managed care plans, there will be a significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

Medicaid Impact Conference Issues

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Work Papers/Notes/Comments: **Issue #35 Cont.**

Counties may be reluctant to maintain the same level of IGTs (for FY 2008-09 contributions are estimated at $706 million) to support the state share of hospital inpatient payments when services are shifted from fee-for-service to capitated managed care. The relationship between funding and payments is not direct when services are provided through capitated managed care plans. Counties are concerned that capitated managed care organizations may not use the same hospitals that have historically received fee-for-service payments. In addition, if capitated managed care organizations do use these hospitals, there is no guarantee what payment level or utilization level will materialize.

County	Mandatory	Total Savings	State Share	General Revenue	IGT (GDTF)
BREVARD	4,857	$ (471,376.72)	$ (180,635.68)	$ 113,861.40	$ (294,497.09)
CITRUS	4,152	$ (223,063.69)	$ (85,479.77)	$ 158,327.75	$ (243,807.52)
DADE	119,239	$ (25,587,890.58)	$ (9,805,505.35)	$ (1,957,798.01)	$ (7,847,707.34)
GADSDEN	2,383	$ (31,043.27)	$ (11,895.93)	$ 123,783.31	$ (135,679.24)
HERNANDO	2,713	$ (145,754.29)	$ (55,854.19)	$ 103,454.52	$ (159,308.72)
HILLSBOROUGH	23,166	$ (1,906,301.71)	$ (730,511.36)	$ 658,824.14	$ (1,389,335.50)
JEFFERSON	475	$ (6,187.81)	$ (2,371.20)	$ 24,673.55	$ (27,044.75)
LAKE	5,858	$ (314,717.52)	$ (120,602.24)	$ 223,382.45	$ (343,984.69)
LIBERTY	389	$ (5,067.49)	$ (1,941.89)	$ 20,206.34	$ (22,148.23)
MADISON	896	$ (11,672.17)	$ (4,472.83)	$ 46,542.11	$ (51,014.94)
MANATEE	2,597	$ (213,703.94)	$ (81,893.21)	$ 73,856.79	$ (155,749.99)
ORANGE	14,423	$ (1,399,766.62)	$ (536,402.81)	$ 338,114.68	$ (874,517.49)
OSCEOLA	3,325	$ (322,694.59)	$ (123,659.39)	$ 77,947.12	$ (201,606.51)
PALM BEACH	29,359	$ (3,753,389.00)	$ (1,438,332.00)	$ 381,861.00	$ (1,820,193.00)
PASCO	7,743	$ (867,944.21)	$ (332,603.92)	$ 141,918.78	$ (474,522.71)
PINELLAS	13,719	$ (1,537,818.24)	$ (589,305.59)	$ 251,450.83	$ (840,756.42)
POLK	8,751	$ (720,109.05)	$ (275,952.04)	$ 248,872.06	$ (524,824.09)
SEMINOLE	2,836	$ (275,236.65)	$ (105,473.09)	$ 66,483.62	$ (171,956.71)
WAKULLA	790	$ (10,291.31)	$ (3,943.68)	$ 41,036.01	$ (44,979.69)
Totals	247,671	$ (37,804,028.85)	$ (14,486,836.15)	$ 1,136,798.46	$ (15,623,634.61)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #36

Proposal Name:	**Managed Care Expansion – MediPass** (including voluntary populations)
Brief Description of Proposal:	Provide the estimated savings by mandating MediPass recipients, including voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues. In general, the voluntary populations for Medicaid managed care are: - Dually enrolled in both Medicaid and Medicare, - American Indians who are members of federally-recognized tribes, - Children with Chronic Conditions, - Children who are in foster care or other out-of-home placement or receiving foster care or adoption assistance, and - Pregnant women with incomes above 1931 level. [*Note: Section 1932 of SSA provides exemption for American Indians who are members of federally-recognized tribes from being mandatory enrolled in managed care unless the managed care program is operated by an Indian Health Service/Program*.]
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($48,426,225)
Bureau(s) Responsible for Administration:	HSD, BMHC, MCM

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**12 month Phase-In with process starting on July 1, 2010**	To implement under **non-reform waiver**, the Agency would need to allow for at least 12 month phase-in period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 managed care plans are available in each transition county. Currently, **16 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., and the capacity to transition the mandatory and voluntary population. An additional **3 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population.

Issue #36 Cont.

		• Submit phase-in plan to federal CMS along with a waiver amendment to the 1915(b) Managed Care Waiver. The expansion cannot be implemented until federal CMS approves the amendment. Federal CMS has two 90 day periods to approve the amendment once submitted. The waiver amendment would: (1) move voluntary populations to mandatory status; (2) eliminate MediPass as option in expansion areas; and (3) revise geographic areas were specified programs operate [including disease management, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program]. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Medicaid Options resources are available (call center and field staff). To implement under **1115 reform waiver**, the Agency would need to allow for at least 12 month phase-in period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 managed care plans are available in each transition county. Currently, **16 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., and the capacity to transition the mandatory and voluntary population. An additional **3 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population.

Issue #36 Cont.

I. Anticipated implementation time line and process.		• Submit phase-in plan to federal CMS along with written notification 90 days prior to transitioning the voluntary populations (see below) to a mandatory status in reform. - Children with Chronic Conditions, - Children in Foster Care or other out-of-home placement or receiving foster care or adoption assistance, and - SOBRA Pregnant Women with incomes above 1931 poverty level. • Submit a waiver amendment to move duals into mandatory status in reform. Federal CMS must approve this amendment before implementing. There are no established timeframes for federal CMS to approve 1115 waiver amendment requests. • Process new and existing reform plan applications for expansion counties. Based on initial implementation in 2006, the majority of existing plan applications could be processed in under 3 months. New plan applications may take longer to process depending on the applicant's qualifications and provider network readiness. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Medicaid Options resources are available (call center and field staff).

Issue #36 Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	***Expansion in <u>non-reform areas</u> would require amendments to the following sections:*** • 409.9121, F.S., to update legislative findings, intent, and remove reference to MediPass in specified counties. • 409.912(4)(b)3 and (d), (30) and (34), F.S., to remove reference to MediPass in specified counties. • 409.912(26), F.S., to remove reference to MediPass in specified counties and revise the Agency's enrollment and disenrollment responsibilities. • 409.912(49), F.S., to remove reference to MediPass in specified counties. MPN providers are also MediPass providers, the Agency would need to amend the MPN agreements accordingly. • 409.91188, F.S., to remove reference to MediPass in specified counties. • 409.9122(1),(2)(a) thru (k),(3)(b),(4), (5)(b), (7) and (9)(c), F.S., to remove reference to MediPass in specified counties, revise exempted or voluntary populations, and add new description of the mandatory Medicaid managed care assignment process. • 409.9123, F.S., to remove reference to MediPass in specified counties. • 409.91207(2)(b)(4)(h) and (5), F.S., to remove reference to MediPass and MediPass providers in specified counties. • 409.91211(2)(a)(c) and (3)(aa), F.S., to remove reference to MediPass in specified counties. ***Additional Information regarding non-reform expansion:*** • 409.912, F.S., authorizes the Agency to contract with certain entities to provide select services such as behavioral health care services, dental services, minority physician network services, pediatric emergency room diversion services, and disease management services. The majority of these programs were created as an overlay service to MediPass enrollees.

Issue #36 Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	• 409.912(4)(b), F.S., provides that MediPass enrollees are automatically assigned to prepaid mental health plans. If MediPass is removed as an option in counties with 2 or more plans, other statutory changes may need to be considered to allow PMHPs to receive enrollees or to revise the areas where PMHPs operate. • 409.9122(2)(k), F.S., defines the term "managed care plans" to include exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. ***Expansion of <u>reform areas</u> would require an amendment to section:*** • 409.91211(1) and (5), F.S.
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**No**	
V. Will this proposal require an administrative rule?	**No**	Technically, Rule 59G-8.400, Medicaid Physician Access System will not need to be amended to implement this issue. However, this rule should be reviewed once legislaiton becomes law to determine if it needs to be updated.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes**	For non-reform and reform, see response to item I above.
VII. Will this proposal require additional staffing?	**Yes**	Any expansion is estimated to require an additional 22 FTEs as well as contract expenses for choice counseling.
VIII. Is there a previous or concurrent Analysis by the Agency?	**Yes**	Agency 2010 analysis for Committee presentations. (This did not factor in any administrative costs).
IX. Is this proposal included in the current Governors recommendations?	**No**	

Medicaid Impact Conference Issues

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Analysis: **Issue #36 Cont.**

Lead Analyst:	Linda Macdonald
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Assumes a 12-month phase-in beginning July 1, 2010. Estimates based on February 2010 SSEC and January 2010 enrollment. Savings based on actual area managed care discount including an additional 4.5% in Miami for fraud and abuse. Analysis factors in associated administrative costs for expansion. The $2 PCCM MediPass fee is also factored into this analysis.
FY Impacted by Implementation:	2010-11 and 2011-12
Date Analysis Completed:	02/17/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($48,426,225)**		**($98,178,125)**
General Revenue:	**($17,481,331)**	**-**	**($42,153,627)**
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**($31,071,383)**	**-**	**($56,141,987)**
Refugee Assistance Trust Fund:			
Health Care Trust fund:	**$126,489**	**-**	**$117,489**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Any expansion is estimated to require an additional 20 FTEs as well as contract expenses for choice counseling. Administrative costs are estimated to be $10.3 million, the majority of which is choice counseling expenses.

Work Papers/Notes/Comments: **Issue #36 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Capacity Issues

An additional 3 counties have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population (see issues #36a for details).

Non-reform Expansion

Additional Impact: Programs that were implemented as overlays or enhancements to the MediPass Program in non-reform areas may be impacted by this change. The programs that would be impacted include disease management program, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program. To implement this change, the Agency would need to amend the program contracts to reduce the geographic areas served by the program.

Inclusion of Voluntary Populations

In the past, the advocacy organizations have raised concerns about requiring voluntary populations to mandatorily enroll in managed care whether under the non-reform or reform waiver. The Agency will need to work closely with the advocacy organizations, impacted beneficiaries and health plans to ensure smooth transition.

Rate Development

At present capitation rates are developed by Medicaid area and not for specific counties. Implementing a transition of recipients eligible for mandatory assignment in certain counties within a Medicaid area and not all counties within a Medicaid area may have impact rate reimbursement and consideration may need to be given to developing rates by counties or including an adjustment for certain counties.

Funding Implications:

Currently, counties submit intergovernmental transfers (IGTs) to help fund the hospital inpatient service line item. The funding is used to support the Low Income Pool and fund the state share of the following issues:

- Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP
- Eliminate Inpatient Reimbursement Ceilings-11% Screen
- Eliminate Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%
- Special Medicaid Payments-Liver Transplant Facilities
- Hospital Reimbursement Ceiling Exemption

Counties have a strong incentive to provide intergovernmental transfers (IGTs) to support these payments since there is a direct relationship between the policies funded and fee-for-service payments to these qualifying hospitals. Counties provide local financial support to hospitals that provide a significant amount of Medicaid and uncompensated care. Using these local funds as state match through Medicaid allows local governments to partner with the state, earn federal matching funds and help cover the costs of Medicaid and uncompensated care. For FY 2008-09, the IGT funding is estimated at $706 million in county contributions.

Medicaid Impact Conference Issues

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Work Papers/Notes/Comments: **Issue #36 Cont.**

If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the **16 counties** with two or more managed care plans (with capacity to transition mandatory population) resulting in an increase in the penetration of managed care plans, there will be a significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

Counties may be reluctant to maintain the same level of IGTs (for FY 2008-09 contributions are estimated at $706 million) to support the state share of hospital inpatient payments when services are shifted from fee-for-service to capitated managed care. The relationship between funding and payments is not direct when services are provided through capitated managed care plans. Counties are concerned that capitated managed care organizations may not use the same hospitals that have historically received fee-for-service payments. In addition, if capitated managed care organizations do use these hospitals, there is no guarantee what payment level or utilization level will materialize.

County	Mandatory + Voluntary	Total Savings	State Share	General Revenue	IGT (GDTF)
BREVARD	8,085	$ (784,657.36)	$ (300,687.56)	$ 189,534.58	$ (490,222.14)
CITRUS	5,152	$ (276,788.09)	$ (106,067.38)	$ 196,460.64	$ (302,528.02)
DADE	194,945	$ (41,833,891.00)	$(16,031,116.00)	$ (3,200,823.00)	$(12,830,293.00)
GADSDEN	2,383	$ (31,043.27)	$ (11,895.93)	$ 123,783.31	$ (135,679.24)
HERNANDO	4,154	$ (223,171.14)	$ (85,520.94)	$ 158,404.01	$ (243,924.96)
HILLSBOROUGH	35,607	$ (2,930,056.33)	$ (1,122,823.02)	$ 1,012,637.10	$ (2,135,460.12)
JEFFERSON	640	$ (8,337.26)	$ (3,194.88)	$ 33,244.36	$ (36,439.24)
LAKE	7,889	$ (423,831.76)	$ (162,415.68)	$ 300,830.35	$ (463,246.03)
LIBERTY	389	$ (5,067.49)	$ (1,941.89)	$ 20,206.34	$ (22,148.23)
MADISON	1,242	$ (16,179.50)	$ (6,200.06)	$ 64,514.84	$ (70,714.90)
MANATEE	4,221	$ (347,340.91)	$ (133,104.05)	$ 120,042.16	$ (253,146.21)
ORANGE	23,769	$ (2,306,805.30)	$ (883,987.96)	$ 557,210.56	$ (1,441,198.52)
OSCEOLA	5,452	$ (529,122.07)	$ (202,764.20)	$ 127,809.83	$ (330,574.04)
PALM BEACH	29,359	$ (3,753,389.00)	$ (1,438,332.00)	$ 381,861.00	$ (1,820,193.00)
PASCO	11,258	$ (1,261,954.79)	$ (483,592.27)	$ 206,344.01	$ (689,936.28)
PINELLAS	21,098	$ (2,364,960.21)	$ (906,273.73)	$ 386,697.99	$ (1,292,971.72)
POLK	13,515	$ (1,112,132.76)	$ (426,178.93)	$ 384,356.74	$ (810,535.67)
SEMINOLE	4,750	$ (460,992.27)	$ (176,656.27)	$ 111,353.03	$ (288,009.30)
WAKULLA	1,093	$ (14,238.48)	$ (5,456.25)	$ 56,775.14	$ (62,231.39)
Totals	375,001	$ (58,683,959.00)	$(22,488,209.00)	$ 1,231,243.00	$(23,719,452.00)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #35a

Proposal Name:	**Managed Care Expansion – MediPass** (mandatory population only)
Brief Description of Proposal:	Provide the estimated savings by mandating MediPass recipients, excluding voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans with no capacity or in counties with less than 2 managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($2,229,360)
Bureau(s) Responsible for Administration:	HSD, MCM, BMHC

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**18 month Phase-In with process starting on July 1, 2010**	To implement under **non-reform waiver**, the Agency would need to allow for an 18 month phase-in period. The Agency would need to: • Ensure choice of managed care plans as required by federal regulations by confirming at least 2 managed care plans are available by in each transition county. Currently, **8 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., without the capacity to transition any population (mandatory or voluntary). There are **35 counties** with less than 2 plans. • Submit phase-in plan to federal CMS along with a waiver amendment to the 1915(b) Managed Care Waiver. The expansion cannot be implemented until federal CMS approves the amendment. Federal CMS has two 90 day periods to review and approve the waiver amendment once submitted. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary.

Issue #35a Cont.

		• Confirm sufficient Medicaid Options resources are available (call center and field staff). To implement under **1115 reform waiver**, the Agency does not need to amend the waiver. The expansion would be phased-in over 12 month period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 capitated health plans as defined in s. 409.91211, F.S., are available by in each transition county. Currently, **19 counties** have at least 2 capitated health plans as defined in s. 409.91211, F.S., and the capacity to transition the mandatory population. • Submit the phase-in plan to federal CMS. • Process new and existing reform plan applications for expansion counties. Based on initial implementation in 2006, the majority of existing plan applications could be processed in under 3 months. New plan applications may take longer to process depending on the applicant's qualifications and provider network readiness. • Implement fiscal agent system changes. • Confirm sufficient plan capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Choice Counseling resources are available (call center and field staff).

Issue #35a Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	***Expansion in <u>non-reform areas</u> would require amendments to the following sections:*** • 409.9121, F.S., to update legislative findings, intent, and remove reference to MediPass in specified counties. • 409.912(4)(b)3 and (d), (30) and (34), F.S., to remove reference to MediPass in specified counties. • 409.912(26), F.S., to remove reference to MediPass in specified counties and revise the Agency's enrollment and disenrollment responsibilities. • 409.912(49), F.S., to remove reference to MediPass in specified counties. MPN providers are also MediPass providers, the Agency would need to amend the MPN agreements accordingly. • 409.91188, F.S., to remove reference to MediPass in specified counties. • 409.9122(1),(2)(a) thru (k),(3)(b),(4), (5)(b), (7) and (9)(c), F.S., to remove reference to MediPass in specified counties, add new description of the mandatory Medicaid managed care assignment process • 409.9123, F.S., to remove reference to MediPass in specified counties. • 409.91207(2)(b)(4)(h) and (5), F.S., to remove reference to MediPass and MediPass providers in specified counties. • 409.91211(2)(a)(c) and (3)(aa), F.S., to remove reference to MediPass in specified counties. ***Additional Information regarding non-reform expansion***: • 409.912, F.S., authorizes the Agency to contract with certain entities to provide select services such as behavioral health care services, dental services, minority physician network services, pediatric emergency room diversion services, and disease management services. The majority of these programs were created as an overlay service to MediPass enrollees. .

Issue #35a Cont.

		• 409.912(4)(b), F.S., provides that MediPass enrollees are automatically assigned to prepaid mental health plans. If MediPass is removed as an option in counties with 2 or more plans, other statutory changes may need to be considered to allow PMHPs to receive enrollees or to revise the areas where PMHPs operate. • 409.9122(2)(k), F.S., defines the term "managed care plans" to include exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. ***Expansion of <u>reform areas</u> would require an amendment to section:*** • 409.91211(1) and (5), F.S.
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**No**	
V. Will this proposal require an administrative rule?	**No**	Technically, Rule 59G-8.400, Medicaid Physician Access System will not need to be amended to implement this issue. However, this rule should be reviewed once legislation becomes law to determine if it needs to be updated.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes,** non-reform **No,** reform	For non-reform, see response to item I above. For reform, the Agency would need to submit a phase-in plan to federal CMS for expansion areas. The plan must be designed to ensure smooth transition process for beneficiaries, providers and all stakeholders.
VII. Will this proposal require additional staffing?	**Yes**	Any expansion is estimated to require an additional 22 FTEs as well as contract expenses for choice counseling.
VIII. Is there a previous or concurrent Analysis by the Agency?	**Yes**	Agency 2010 analysis for Committee presentations. (This did not factor in any administrative costs).
IX. Is this proposal included in the current Governors recommendations?	**No**	

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Analysis: **Issue #35a Cont.**

Lead Analyst:	Linda Macdonald
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Assumes an 18-month phase-in beginning July 1, 2010. Estimates based on February 2010 SSEC and January 2010 enrollment. Savings based on actual area managed care discount including an additional 4.5% in Miami for fraud and abuse. Analysis factors in associated administrative costs for expansion. The $2 PCCM MediPass fee is also factored into this analysis.
FY Impacted by Implementation:	2010-11 and 2011-12
Date Analysis Completed:	02/17/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**12**	**N/A**
Total (Savings) Cost of Proposal:	**($2,229,360)**		**($22,019,379)**
General Revenue:	**$221,713**	**-**	**($9,032,188)**
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**($2,577,562)**	**-**	**($13,104,680)**
Refugee Assistance Trust Fund:			
Health Care Trust fund:	**$126,489**	**-**	**$117,489**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Any expansion is estimated to require an additional 20 FTEs as well as contract expenses for choice counseling. Administrative costs are estimated to be $10.3 million, the majority of which is choice counseling expenses.

Work Papers/Notes/Comments: **Issue #35a Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Capacity Issues

An additional 8 counties have at least 2 managed care plans as defined in s. 409.9122, F.S., but do not have capacity to transition any population (mandatory or voluntary) (see issues #35a for details).

Non-reform Expansion

Additional Impact: Programs that were implemented as overlays or enhancements to the MediPass Program in non-reform areas may be impacted by this change. The programs that would be impacted include disease management program, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program. To implement this change, the Agency would need to amend the program contracts to reduce the geographic areas served by the program.

Rate Development

At present capitation rates are developed by Medicaid area and not for specific counties. Implementing a transition of recipients eligible for mandatory assignment in certain counties within a Medicaid area and not all counties within a Medicaid area may have impact rate reimbursement and consideration may need to be given to developing rates by counties or including an adjustment for certain counties.

Funding Implications:

Currently, counties submit intergovernmental transfers (IGTs) to help fund the hospital inpatient service line item. The funding is used to support the Low Income Pool and fund the state share of the following issues:

- Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP
- Eliminate Inpatient Reimbursement Ceilings-11% Screen
- Eliminate Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%
- Special Medicaid Payments-Liver Transplant Facilities
- Hospital Reimbursement Ceiling Exemption

Counties have a strong incentive to provide intergovernmental transfers (IGTs) to support these payments since there is a direct relationship between the policies funded and fee-for-service payments to these qualifying hospitals. Counties provide local financial support to hospitals that provide a significant amount of Medicaid and uncompensated care. Using these local funds as state match through Medicaid allows local governments to partner with the state, earn federal matching funds and help cover the costs of Medicaid and uncompensated care. For FY 2008-09, the IGT funding is estimated at $706 million in county contributions.

If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the 19 counties with 2 or more managed care plans (with capacity to transition mandatory population) resulting in an increase in the penetration of managed care plans, there will be a significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

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Work Papers/Notes/Comments: **Issue #35a Cont.**

Counties may be reluctant to maintain the same level of IGTs (for FY 2008-09 contributions are estimated at $706 million) to support the state share of hospital inpatient payments when services are shifted from fee-for-service to capitated managed care. The relationship between funding and payments is not direct when services are provided through capitated managed care plans. Counties are concerned that capitated managed care organizations may not use the same hospitals that have historically received fee-for-service payments. In addition, if capitated managed care organizations do use these hospitals, there is no guarantee what payment level or utilization level will materialize.

County	Mandatory	Total Savings	State Share	General Revenue	IGT (GDTF)
ALACHUA	19,468	$ (697,154.15)	$ (267,155.78)	$ 494,830.49	$ (761,986.27)
BAY	14,963	$ (129,900.32)	$ (49,778.93)	$ 517,969.34	$ (567,748.27)
BRADFORD	3,022	$ (108,218.61)	$ (41,470.35)	$ 76,812.09	$ (118,282.44)
CALHOUN	848	$ (7,361.86)	$ (2,821.13)	$ 29,354.94	$ (32,176.07)
CHARLOTTE	9,640	$ (720,473.56)	$ (276,091.91)	$ 117,805.61	$ (393,897.51)
COLLIER	22,080	$ (1,650,213.30)	$ (632,376.48)	$ 269,828.61	$ (902,205.09)
COLUMBIA	8,912	$ (319,141.04)	$ (122,297.74)	$ 226,521.95	$ (348,819.69)
DESOTO	4,311	$ (322,195.18)	$ (123,468.07)	$ 52,682.57	$ (176,150.64)
DIXIE	2,228	$ (79,785.26)	$ (30,574.43)	$ 56,630.49	$ (87,204.92)
ESCAMBIA	25,721	$ (223,295.20)	$ (85,568.65)	$ 890,375.55	$ (975,944.21)
FLAGLER	5,823	$ (376,772.09)	$ (144,382.34)	$ 91,009.64	$ (235,391.98)
FRANKLIN	1,103	$ (9,575.62)	$ (3,669.46)	$ 38,182.19	$ (41,851.66)
GILCHRIST	1,812	$ (64,888.19)	$ (24,865.74)	$ 46,056.75	$ (70,922.49)
GLADES	557	$ (41,629.02)	$ (15,952.61)	$ 6,806.82	$ (22,759.43)
GULF	1,372	$ (11,910.93)	$ (4,564.37)	$ 47,494.08	$ (52,058.45)
HAMILTON	1,843	$ (65,998.31)	$ (25,291.15)	$ 46,844.70	$ (72,135.85)
HARDEE	3,243	$ (177,796.51)	$ (68,133.38)	$ 61,447.11	$ (129,580.49)
HENDRY	5,053	$ (377,650.72)	$ (144,719.13)	$ 61,750.18	$ (206,469.31)
HIGHLANDS	5,224	$ (286,404.25)	$ (109,752.95)	$ 98,982.33	$ (208,735.27)
HOLMES	3,057	$ (26,539.15)	$ (10,170.03)	$ 105,823.18	$ (115,993.21)
INDIAN RIVER	8,784	$ (748,649.97)	$ (286,889.01)	$ 76,165.94	$ (363,054.95)
JACKSON	5,259	$ (45,655.67)	$ (17,495.65)	$ 182,049.11	$ (199,544.75)

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LAFAYETTE	738	$ (26,427.97)	$ (10,127.44)	$ 18,758.21	$ (28,885.65)
LEE	12,883	$ (962,848.64)	$ (368,972.20)	$ 157,436.68	$ (526,408.88)
LEON	6,296	$ (54,658.32)	$ (20,945.54)	$ 217,946.60	$ (238,892.14)
LEVY	4,941	$ (176,938.50)	$ (67,804.43)	$ 125,588.53	$ (193,392.96)
MARION	18,225	$ (652,642.00)	$ (250,098.32)	$ 463,236.37	$ (713,334.69)
MARTIN	2,339	$ (199,350.21)	$ (76,392.69)	$ 20,281.44	$ (96,674.13)
MONROE	3,784	$ (541,836.74)	$ (207,636.56)	$ (41,457.01)	$ (166,179.55)
OKALOOSA	8,697	$ (75,502.44)	$ (28,933.19)	$ 301,061.24	$ (329,994.43)
OKEECHOBEE	1,985	$ (169,179.21)	$ (64,830.91)	$ 17,211.91	$ (82,042.81)
PUTNAM	6,970	$ (249,597.52)	$ (95,648.03)	$ 177,160.91	$ (272,808.93)
SANTA ROSA	7,906	$ (68,635.43)	$ (26,301.69)	$ 273,679.45	$ (299,981.14)
SARASOTA	4,150	$ (310,162.37)	$ (118,856.99)	$ 50,715.07	$ (169,572.06)
ST. JOHNS	7,158	$ (463,152.09)	$ (177,483.90)	$ 111,874.81	$ (289,358.71)
ST. LUCIE	10,761	$ (917,147.35)	$ (351,458.63)	$ 93,308.48	$ (444,767.11)
SUMTER	3,067	$ (109,830.07)	$ (42,087.88)	$ 77,955.88	$ (120,043.76)
SUWANNEE	5,662	$ (202,757.70)	$ (77,698.58)	$ 143,914.64	$ (221,613.23)
TAYLOR	1,581	$ (13,725.35)	$ (5,259.67)	$ 54,728.97	$ (59,988.64)
UNION	1,670	$ (59,803.14)	$ (22,917.10)	$ 42,447.45	$ (65,364.55)
VOLUSIA	10,513	$ (680,234.41)	$ (260,671.73)	$ 164,311.24	$ (424,982.97)
WALTON	4,065	$ (35,290.03)	$ (13,523.45)	$ 140,716.79	$ (154,240.24)
WASHINGTON	3,014	$ (26,165.85)	$ (10,026.98)	$ 104,334.66	$ (114,361.64)
Totals	280,728	$ (12,487,094.23)	$ (4,785,165.22)	$ 6,310,635.98	$ (11,095,801.20)

Medicaid Impact Conference Issues

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Proposal: Issue #36a

Proposal Name:	**Managed Care Expansion – MediPass** (including voluntary populations)
Brief Description of Proposal:	Provide the estimated savings by mandating MediPass recipients, including voluntary eligibles, transition to managed care plans in counties where there are 2 or more managed care plans counties with no capacity or in counties with less than 2 managed care plans. Analysis should discuss any federal or state implementation issues, utilize the appropriate discount rate, and identify intergovernmental transfer (IGT) issues. In general, the voluntary populations for Medicaid managed care are: - Dually enrolled in both Medicaid and Medicare, - American Indians who are members of federally-recognized tribes, - Children with Chronic Conditions, - Children who are in foster care or other out-of-home placement or receiving foster care or adoption assistance, and - Pregnant women with incomes above 1931 level. [*Note: Section 1932 of SSA provides exemption for American Indians who are members of federally-recognized tribes from being mandatory enrolled in managed care unless the managed care program is operated by an Indian Health Service/Program*.]
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($4,342,111)
Bureau(s) Responsible for Administration:	HSD, BMHC, MCM

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**18 month Phase-In with process starting on July 1, 2010**	To implement under **non-reform waiver**, the Agency would need to allow for at least 18 month phase-in period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 managed care plans are available in each transition county. Currently **8 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., without the capacity to transition any population (mandatory or voluntary). There are **35 counties** with less than 2 plans. • Currently, **16 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., and the capacity to transition the mandatory and voluntary population. An additional **3 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population.

Issue #36a Cont.

		• Submit phase-in plan to federal CMS along with a waiver amendment to the 1915(b) Managed Care Waiver. The expansion cannot be implemented until federal CMS approves the amendment. Federal CMS has two 90 day periods to approve the amendment once submitted. The waiver amendment would: (1) move voluntary populations to mandatory status; (2) eliminate MediPass as option in expansion areas; and (3) revise geographic areas were specified programs operate [including disease management, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program]. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Medicaid Options resources are available (call center and field staff). To implement under **1115 reform waiver**, the Agency would need to allow for at least 12 month phase-in period. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 managed care plans are available in each transition county. Currently, **16 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., and the capacity to transition the mandatory and voluntary population. An additional **3 counties** have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population. •

Issue #36a Cont.

I. Anticipated implementation time line and process.		• Submit phase-in plan to federal CMS along with written notification 90 days prior to transitioning the voluntary populations (see below) to a mandatory status in reform. - Children with Chronic Conditions, - Children in Foster Care or other out-of-home placement or receiving foster care or adoption assistance, and - SOBRA Pregnant Women with incomes above 1931 poverty level. • Submit a waiver amendment to move duals into mandatory status in reform. Federal CMS must approve this amendment before implementing. There are no established timeframes for federal CMS to approve 1115 waiver amendment requests. • Process new and existing reform plan applications for expansion counties. Based on initial implementation in 2006, the majority of existing plan applications could be processed in under 3 months. New plan applications may take longer to process depending on the applicant's qualifications and provider network readiness. • Implement fiscal agent systems changes. • Confirm sufficient plan provider network capacity in expansion counties. • Amend managed care contracts to include geographic expansion, benefit package and capitation rate changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Medicaid Options resources are available (call center and field staff).

Issue #36a Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	***Expansion in <u>non-reform areas</u> would require amendments to the following sections:*** • 409.9121, F.S., to update legislative findings, intent, and remove reference to MediPass in specified counties. • 409.912(4)(b)3 and (d), (30) and (34), F.S., to remove reference to MediPass in specified counties. • 409.912(26), F.S., to remove reference to MediPass in specified counties and revise the Agency's enrollment and disenrollment responsibilities. • 409.912(49), F.S., to remove reference to MediPass in specified counties. MPN providers are also MediPass providers, the Agency would need to amend the MPN agreements accordingly. • 409.91188, F.S., to remove reference to MediPass in specified counties. • 409.9122(1),(2)(a) thru (k),(3)(b),(4), (5)(b), (7) and (9)(c), F.S., to remove reference to MediPass in specified counties, revise exempted or voluntary populations, and add new description of the mandatory Medicaid managed care assignment process. • 409.9123, F.S., to remove reference to MediPass in specified counties. • 409.91207(2)(b)(4)(h) and (5), F.S., to remove reference to MediPass and MediPass providers in specified counties. • 409.91211(2)(a)(c) and (3)(aa), F.S., to remove reference to MediPass in specified counties. ***Additional Information regarding non-reform expansion:*** • 409.912, F.S., authorizes the Agency to contract with certain entities to provide select services such as behavioral health care services, dental services, minority physician network services, pediatric emergency room diversion services, and disease management services. The majority of these programs were created as an overlay service to MediPass enrollees.

Issue #36a Cont.

II. Will this proposal require a change in Florida Statute?	**Yes**	• 409.912(4)(b), F.S., provides that MediPass enrollees are automatically assigned to prepaid mental health plans. If MediPass is removed as an option in counties with 2 or more plans, other statutory changes may need to be considered to allow PMHPs to receive enrollees or to revise the areas where PMHPs operate. • 409.9122(2)(k), F.S., defines the term "managed care plans" to include exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. ***Expansion of <u>reform areas</u> would require an amendment to section:*** • 409.91211(1) and (5), F.S.
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**No**	
V. Will this proposal require an administrative rule?	**No**	Technically, Rule 59G-8.400, Medicaid Physician Access System will not need to be amended to implement this issue. However, this rule should be reviewed once legislaiton becomes law to determine if it needs to be updated.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes**	For non-reform and reform, see response to item I above.
VII. Will this proposal require additional staffing?	**Yes**	Any expansion is estimated to require an additional 22 FTEs as well as contract expenses for choice counseling.
VIII. Is there a previous or concurrent Analysis by the Agency?	**Yes**	Agency 2010 analysis for Committee presentations. (This did not factor in any administrative costs).
IX. Is this proposal included in the current Governors recommendations?	**No**	

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Analysis: **Issue #36a Cont.**

Lead Analyst:	Linda Macdonald
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Assumes a 12-month phase-in beginning July 1, 2010. Estimates based on February 2010 SSEC and January 2010 enrollment. Savings based on actual area managed care discount including an additional 4.5% in Miami for fraud and abuse. Analysis factors in associated administrative costs for expansion. The $2 PCCM MediPass fee is also factored into this analysis.
FY Impacted by Implementation:	2010-11 and 2011-12
Date Analysis Completed:	02/17/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($4,342,111)**		**($27,463,793)**
General Revenue:	**($587,912)**	**-**	**($11,399,964)**
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**($3,880,688)**	**-**	**($16,181,318)**
Refugee Assistance Trust Fund:			
Health Care Trust fund:	**$126,489**	**-**	**$117,489**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Any expansion is estimated to require an additional 20 FTEs as well as contract expenses for choice counseling. Administrative costs are estimated to be $10.3 million, the majority of which is choice counseling expenses.

Work Papers/Notes/Comments: **Issue #36a Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Capacity Issues

An additional 3 counties have at least 2 managed care plans as defined in s. 409.9122, F.S., but only have capacity to transition the mandatory population (see issues #36a for details).

Non-reform Expansion

Additional Impact: Programs that were implemented as overlays or enhancements to the MediPass Program in non-reform areas may be impacted by this change. The programs that would be impacted include disease management program, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program. To implement this change, the Agency would need to amend the program contracts to reduce the geographic areas served by the program.

Inclusion of Voluntary Populations

In the past, the advocacy organizations have raised concerns about requiring voluntary populations to mandatorily enroll in managed care whether under the non-reform or reform waiver. The Agency will need to work closely with the advocacy organizations, impacted beneficiaries and health plans to ensure smooth transition.

Rate Development

At present capitation rates are developed by Medicaid area and not for specific counties. Implementing a transition of recipients eligible for mandatory assignment in certain counties within a Medicaid area and not all counties within a Medicaid area may have impact rate reimbursement and consideration may need to be given to developing rates by counties or including an adjustment for certain counties.

Funding Implications:

Currently, counties submit intergovernmental transfers (IGTs) to help fund the hospital inpatient service line item. The funding is used to support the Low Income Pool and fund the state share of the following issues:

- Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP
- Eliminate Inpatient Reimbursement Ceilings-11% Screen
- Eliminate Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%
- Special Medicaid Payments-Liver Transplant Facilities
- Hospital Reimbursement Ceiling Exemption

Counties have a strong incentive to provide intergovernmental transfers (IGTs) to support these payments since there is a direct relationship between the policies funded and fee-for-service payments to these qualifying hospitals. Counties provide local financial support to hospitals that provide a significant amount of Medicaid and uncompensated care. Using these local funds as state match through Medicaid allows local governments to partner with the state, earn federal matching funds and help cover the costs of Medicaid and uncompensated care. For FY 2008-09, the IGT funding is estimated at $706 million in county contributions.

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Work Papers/Notes/Comments: **Issue #36a Cont.**

If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the **16 counties** with two or more managed care plans (with capacity to transition mandatory population) resulting in an increase in the penetration of managed care plans, there will be a significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

Counties may be reluctant to maintain the same level of IGTs (for FY 2008-09 contributions are estimated at $706 million) to support the state share of hospital inpatient payments when services are shifted from fee-for-service to capitated managed care. The relationship between funding and payments is not direct when services are provided through capitated managed care plans. Counties are concerned that capitated managed care organizations may not use the same hospitals that have historically received fee-for-service payments. In addition, if capitated managed care organizations do use these hospitals, there is no guarantee what payment level or utilization level will materialize.

County	Mandatory + Voluntary	Total Savings	State Share	General Revenue	IGT (GDTF)
ALACHUA	22,126	$ (792,337.83)	$ (303,631.03)	$ 562,390.56	$ (866,021.59)
BAY	16,848	$ (146,264.82)	$ (56,049.95)	$ 583,221.78	$ (639,271.72)
BRADFORD	3,411	$ (122,148.80)	$ (46,808.53)	$ 86,699.55	$ (133,508.07)
CALHOUN	1,075	$ (9,332.54)	$ (3,576.31)	$ 37,212.93	$ (40,789.24)
CHARLOTTE	10,768	$ (804,777.93)	$ (308,398.10)	$ 131,590.33	$ (439,988.42)
COLLIER	23,801	$ (1,778,837.26)	$ (681,666.33)	$ 290,860.09	$ (972,526.42)
COLUMBIA	10,053	$ (360,000.55)	$ (137,955.47)	$ 255,523.47	$ (393,478.94)
DESOTO	4,715	$ (352,389.30)	$ (135,038.73)	$ 57,619.65	$ (192,658.38)
DIXIE	2,542	$ (91,029.68)	$ (34,883.40)	$ 64,611.62	$ (99,495.02)
ESCAMBIA	29,683	$ (257,691.05)	$ (98,749.44)	$ 1,027,526.83	$ (1,126,276.27)
FLAGLER	6,505	$ (420,900.30)	$ (161,292.65)	$ 101,668.85	$ (262,961.50)
FRANKLIN	1,277	$ (11,086.19)	$ (4,248.33)	$ 44,205.50	$ (48,453.82)
GILCHRIST	2,041	$ (73,088.74)	$ (28,008.27)	$ 51,877.39	$ (79,885.66)
GLADES	624	$ (46,636.46)	$ (17,871.51)	$ 7,625.59	$ (25,497.10)
GULF	1,549	$ (13,447.54)	$ (5,153.21)	$ 53,621.23	$ (58,774.45)
HAMILTON	2,105	$ (75,380.60)	$ (28,886.53)	$ 53,504.12	$ (82,390.65)
HARDEE	3,666	$ (200,987.36)	$ (77,020.35)	$ 69,461.95	$ (146,482.29)
HENDRY	5,573	$ (416,514.43)	$ (159,612.05)	$ 68,104.84	$ (227,716.89)
HIGHLANDS	6,260	$ (343,202.64)	$ (131,518.65)	$ 118,612.05	$ (250,130.71)
HOLMES	3,418	$ (29,673.15)	$ (11,371.01)	$ 118,319.80	$ (129,690.81)

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INDIAN RIVER	9,657	$ (823,054.73)	$ (315,401.54)	$ 83,735.71	$ (399,137.26)
JACKSON	6,205	$ (53,868.31)	$ (20,642.80)	$ 214,796.48	$ (235,439.28)
LAFAYETTE	788	$ (28,218.49)	$ (10,813.58)	$ 20,029.10	$ (30,842.67)
LEE	16,147	$ (1,206,793.21)	$ (462,453.94)	$ 197,324.39	$ (659,778.33)
LEON	7,953	$ (69,043.46)	$ (26,458.05)	$ 275,306.43	$ (301,764.48)
LEVY	5,476	$ (196,096.99)	$ (75,146.14)	$ 139,186.96	$ (214,333.10)
MARION	21,524	$ (770,780.05)	$ (295,369.89)	$ 547,089.14	$ (842,459.04)
MARTIN	2,863	$ (244,010.12)	$ (93,506.74)	$ 24,825.03	$ (118,331.78)
MONROE	4,532	$ (648,944.00)	$ (248,681.00)	$ (49,652.00)	$ (199,029.00)
OKALOOSA	10,120	$ (87,856.13)	$ (33,667.23)	$ 350,320.77	$ (383,988.00)
OKEECHOBEE	2,371	$ (202,077.54)	$ (77,437.82)	$ 20,558.91	$ (97,996.73)
PUTNAM	8,076	$ (289,203.66)	$ (110,825.46)	$ 205,272.81	$ (316,098.27)
SANTA ROSA	9,069	$ (78,731.94)	$ (30,170.76)	$ 313,938.65	$ (344,109.40)
SARASOTA	5,928	$ (443,046.40)	$ (169,779.34)	$ 72,443.12	$ (242,222.45)
ST. JOHNS	8,179	$ (529,214.99)	$ (202,799.78)	$ 127,832.36	$ (330,632.15)
ST. LUCIE	13,275	$ (1,131,412.61)	$ (433,566.89)	$ 115,107.34	$ (548,674.23)
SUMTER	3,652	$ (130,779.07)	$ (50,115.72)	$ 92,825.20	$ (142,940.92)
SUWANNEE	6,272	$ (224,601.95)	$ (86,069.50)	$ 159,419.40	$ (245,488.90)
TAYLOR	1,883	$ (16,347.14)	$ (6,264.37)	$ 65,183.20	$ (71,447.57)
UNION	1,831	$ (65,568.59)	$ (25,126.48)	$ 46,539.69	$ (71,666.16)
VOLUSIA	14,615	$ (945,650.71)	$ (362,381.57)	$ 228,422.79	$ (590,804.35)
WALTON	4,441	$ (38,554.25)	$ (14,774.32)	$ 153,732.66	$ (168,506.99)
WASHINGTON	3,486	$ (30,263.48)	$ (11,597.23)	$ 120,673.74	$ (132,270.97)
Totals	326,383	**$ (14,599,845.00)**	**$ (5,594,790.00)**	$ 7,309,170.00	$ (12,903,960.00)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #37

Proposal Name:	Managed Care Organizations – Medical Loss Ratios
Brief Description of Proposal:	Provide the established savings from the establishment of a minimum medical loss ratio of 85% of all Medicaid HMOs similar to behavioral health services.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	09/1/2010
If not July 1, start date; please explain.	This will follow the HMO rate setting which is September 1.
Total Cost/(Savings)/{Revenue}:	($2,676,788)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	September 1, 2010
II. Will this proposal require a change in Florida Statute?	Yes	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #37 Cont.**

Lead Analyst:	Milliman
Secondary Analyst:	Jack Shi
Assumptions (Data source and methodology):	The methodology used started with revenue and claims by HMOs as reported in their quarterly filings for the 4th quarter of 2008 and the 1st quarter of 2009. The revenue and claims were annualized, and then projected to the September 2009 through August 2010 period using the same assumptions as were used in the rate certification process for that period
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**10**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,676,788)**		**($3,212,146)**
General Revenue:	**($1,025,155)**		**($1,230,186)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($1,640,355)**		**($1,968,426)**
Refugee Assistance Trust Fund:	**($11,278)**		**($13,534)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #37 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The projected loss ratios were tested against the minimum of 85%; if the projected loss ratio was less than 85%, it was determined the revenue reduction needed to raise the loss ratio to 85% and assumed this is the amount payable to AHCA.

Our methodology is based on projected medical loss ratios given a set of assumptions. Actual results will vary depending on the actual enrollment, revenue, and medical expenses of each HMO.

There are some items to consider in the implementation of a minimum loss ratio requirement.

1. Items that are considered Medical expenses will need to be clearly defined. As an example, should Medical Management expenses be counted as a medical expense for the purpose of measuring the loss ratio?

2. Loss ratios may be volatile from year to year, especially for smaller plans, and there may be push back on this requirement since there is no mechanism in place for plans to recover losses from poor experience years in good experience years. You may want to measure the minimum loss ratio over multiple years, or use a rolling period as the basis for measurement.

3. The HMOs currently report the financial results of multiple programs together as their “Medicaid” line of business, including the reform HMO program, non-reform HMO program, Frail Elder, Nursing Home Diversion, and Florida Healthy Kids. Financial reporting may need modification depending on how the medical loss ratio minimum is implemented.

HMO rates are set September 1 each year and are subject to actuarial calculations.

Medicaid Impact Conference Issues

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Proposal: Issue #38

Proposal Name:	Managed Care Organizations – Fraud Detection
Brief Description of Proposal:	Provide the estimated savings by expanding efforts to monitor for potentially abusive or fraudulent corporate practices. Analysis should discuss estimated resource needs, impacts to plan performance, and measures required to maintain plan performance.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Unable to Determine Total Savings/Revenue = federal 50-75% through Medical Care Trust Fund.
Bureau(s) Responsible for Administration:	MPI

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		90 days to hire staff.
II. Will this proposal require a change in Florida Statute?	No	N/A
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	Yes	It is important to note that the need for fee-for-service (FFS) fraud and abuse detection and program integrity oversight will continue for several years beyond the date of managed care expansion, therefore resources already dedicated to that effort will require continued dedication to the FFS area. Depending on the rate and level of managed care expansion, FFS program integrity resources could eventually be transitioned to managed care fraud and abuse program integrity functions. Currently, the Agency has approximately $9 billion in Medicaid funds contracted to capitated managed care organizations for the period 2009-2012, or approximately $3 billion in annual expenditures. Medicaid Program Integrity (MPI) resources exclusively dedicated to the managed care fraud and abuse area are two FTEs. Implementation of this proposal would require additional Medicaid Program Integrity

Issue #38 Cont.

		staffing resources estimated at $718,116 annually, of which from 50% to 75% would be federally funded through Medical Health Care Trust Fund dollars. Estimated Salaries/Expenses/OCO* AHCA Administrator (1) $90,122 RN Consultant (2) $190,104 SMA II (2) $180,244 Medical Health Care Prog. Analyst (3) $257,646 TOTAL (8) $718,116 ***Funded from 50%-75% federal funds, 100% through the Medical Health Care Trust Fund.** As in most preventative actions, it is difficult to determine a monetary return on this investment; however, the cost of not implementing additional fraud/abuse oversight of billions in Medicaid dollars could be significant to the State.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis: **Issue #38 Cont.**

Lead Analyst:	Kathy Pilkenton (OIG) and Vicki Mildenberger (OIG/MPI)
Secondary Analyst:	Jo Landa Givens (OIG/MPI)
Assumptions (Data source and methodology):	**Assumptions:** • Undetected corporate fraud/abuse presents an untenable risk to the Agency in terms of revenue loss, reputation, citizens' confidence, and organizational success in providing quality health care to Medicaid recipients. • The lack of adequate anti-fraud controls within a managed care organization (MCO or health plan) impacts the viability of the health plan through increased risk of exposure to fraud. Such exposure compromises financial solvency, and may result in enrollees receiving inadequate medical services or service denial. • Health plans have a contractual obligation for robust fraud and abuse compliance programs, including responsibility to exercise due diligence in fraud prevention. • The State has the fiduciary responsibility of assessing health plan effectiveness in fraud/abuse prevention, detection and mitigation efforts. • The loss of a viable MCO due to undetected fraud presents a loss to the State and potentially compromises Medicaid patient safety and access to healthcare. • Undetected MCO corporate fraud or abuse presents a direct loss of Medicaid funds that may also compromise health care access, medical services, and patient safety. • Increasing the perception of detection is a deterrent to fraud. • The threat of an in-depth audit, as opposed to a superficial review, is an effective detection and deterrence device. Cases have been documented in Florida and other parts of the country where health plans or health plan employees have engaged in fraudulent or abusive practices. Examples include improper accounting or inflation of administrative costs where medical/loss ratios were impacted, and discrimination against high-risk patient populations. This proposal will provide the State with enhanced capability to prevent, detect and mitigate the State's exposure not only to the loss of a once viable health plan, but

Medicaid Impact Conference Issues

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Issue #38 Cont.

Assumptions (Data source and methodology):	Federal agencies, and other state program integrity and Medicaid Fraud Control Units across the nation and, 3) conduct in-depth, comprehensive audits of MCO compliance programs.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	2/22/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$718,116**		
General Revenue:	**($0)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**$718,116**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #38 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Source References:

1. AICPA Audit Committee Toolkit: Government. Fraud and the Responsibilities of the Government Audit Committee. From The AICPA Audit Committee Toolkit, 2004, American Institute of Certified Public Accountants, Inc., New York, New York.
2. Joseph T. Wells, "Corporate Fraud Handbook, Prevention and Detection", 2nd edition, 2007.
3. "2008 Report to the Nation on Occupational Fraud and Abuse". Association of Certified Fraud Examiners, Inc., 2008.
4. Peter N. Francis, PhD. "Detecting and Controlling Fraud and Abuse in Managed Care Organizations, pages 44-45. Health Care Compliance Association, December 2009.
5. WellCare Deferred Prosecution Agreement, (Florida) $80 million, (2009).
6. Amerigroup Settlement Agreement (Illinois), $225 million, (2008).
7. Healthfirst Settlement Agreement (New York), $35 million (2008).
8. Giordano, Christine. "HMO says exec stole $1.3M." Florida Health News, March 11, 2009.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #39

Proposal Name:	Managed Care Organizations
Brief Description of Proposal:	Provide the estimated savings by making managed care organizations at risk for all Medicaid services, including long term care, and enrollment growth within geographic areas.
Proposed State Fiscal Year: 10/11	10/11
Proposed Start Date: 07/01/2010	7/1/2011
If not July 1, start date; please explain.	N/A
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services, Medicaid Program Analysis

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	This is a proposal for an all-inclusive managed care program (similar to the original Florida Senior Care design) that would provide all medically necessary acute and long term care services to enrolled Medicaid recipients. • FY 2010-2011 - The program would need to be designed, the waiver document(s) written and submitted to the Centers for Medicare and Medicaid Services for review, and the procurement document written. • FY 2011-2012 – Once waiver approval is received from CMS, the procurement document could be released. • FY 2011-2012 – Contractors would need to be selected and contracts would need to be written. • FY 2012-2013 – Program could be implemented. The time line could be abbreviated if this program was implemented in limited areas of the state with a limited number of providers.
II. Will this proposal require a change in Florida Statute?	Yes	Implementation of an all-inclusive managed care program would require legislative authority.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	Unless any qualified managed care organization is allowed to enroll and provide services, this would require a competitive procurement process.
V. Will this proposal require an administrative rule?	No	This program could be operated under Federal waiver authority

Issue #39 Cont.

VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	This will likely require that the State design and submit a new waiver request to CMS, rather than simply modifying an existing waiver.
VII. Will this proposal require additional staffing?	Yes	If a new waiver program is implemented or an existing waiver program is substantially expanded, additional contract managers would need to be hired. Generally, one staff member could manage 1-2 contracts, depending on the size of the contract (numbers of enrollees). If there were 10 contracts to be managed, there would be a need for additional 5-10 contract managers.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Fred Roberson
Secondary Analyst:	Wendy Smith, Medicaid Services
Assumptions (Data source and methodology):	Based on February 2010 SSEC.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		
General Revenue:	**($0)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($0)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #39 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros: Managed care can provide predictability for future expenditures. An all-inclusive managed care program could potentially provide better integration and care management prior to an enrollee becoming seriously ill or incapacitated, which could result in avoiding more costly and restrictive hospital or nursing home stays.

Cons: Unless there is sufficient funding for long term care services within a monthly capitation payment, the most qualified providers will not participate in the program. The Agency pays managed care organizations a per-member-per-month capitation payment. If the Medicaid population increases within a specified area, unless managed care organizations are provided an incentive to take on new enrollees, they would likely find a way to refuse to enroll new recipients, or would make a "business decision" to pull out of that area of the state, leaving the Agency with recipients to be transitioned into other plans.

Industry Concerns: During the design of Florida Senior Care, a managed integrated care program, advocacy groups and provider organizations launched a media campaign against mandatory long term managed care for elders and adults with disabilities. Because of this negative campaign, the design of Florida Senior Care was significantly altered to the point that the viability of the program was a concern, and the State did not receive sufficient interest from qualified managed care plans to ensure success of the program.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #40

Proposal Name:	**Statewide Contracting - Medicaid HMO**
Brief Description of Proposal:	Provide the estimated savings by limiting the number of Medicaid HMO providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	N/A
Bureau(s) Responsible for Administration:	HSD / Contract Management / Managed Health Care

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**13 month Phase-In with process starting on July 1, 2010**	To implement under **non-reform waiver**, the Agency would need to allow for a **12 month period** to award the contracts and up to **30 additional days to begin** first enrollment in the plans. The Agency would need to: • Ensure choice of managed care plans as required by federal regulations by confirming at least 2 managed care plans are available in each transition county. • Submit the phase-in plan to federal CMS along with an amendment to the 1915(b) Managed Care Waiver. This expansion cannot be implemented until federal CMS approves the amendment. Federal CMS has two 90 day periods to review and approve the waiver amendment once submitted. • Develop, release, and award RFP. On average, awarding health plan contracts using the competitive procurement process takes 12 months (includes readiness review). If protests are received, the process may take more than 12 months. Federal CMS would need to review the RFP. The Agency would need up to **30 additional days** to begin first enrollment in the plans. During this time period, the Agency will complete: - Final systems checks, - Update enrollment materials and call center scripts, and - Update provider files. • Implement fiscal agent systems changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries.

		• Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Medicaid Options resources are available (call center and field staff). To implement under **1115 reform waiver**, the Agency would need to allow for a **12 month period** to award the contracts and up to **30 additional days to begin** first enrollment in the plans. The Agency would need to: • Ensure choice as required by federal regulations by confirming at least 2 capitated health plans as defined in s. 409.91211, F.S., are available in each transition county. • Submit the phase-in plan to federal CMS along with an amendment to the 1115 Reform Waiver. The Agency needs waiver authority to limit the number of plans through competitively procurement. This change cannot be implemented until federal CMS approves the amendment. Federal CMS has no established timeframes for approving 1115 waiver amendments. • Develop, release, and award RFP. On average, awarding health plan contracts using the competitive procurement process takes 12 months (includes readiness review). If protests are received, the process may take more than 12 months. Federal CMS would need to review the RFP. The Agency would need up to **30 additional days** to begin first enrollment in the plans. During this time period, the Agency will complete same tasks as outlined above under non-reform. Implement fiscal agent system changes. • Provide written notification of transition to all impacted beneficiaries, providers and stakeholders and provide choice period to all impacted beneficiaries. • Provide outreach to beneficiaries, providers and all impacted stakeholders as necessary. • Confirm sufficient Choice Counseling resources are available (call center and field staff).
II. Will this proposal require a change in Florida Statute?	**Yes**	***Competitive Procurement of Plans in non-reform*** The Agency currently uses an open application process to procure health plans in non-reform. The Agency would need statutory authority in s. 409.912, F.S., to: • Maintain contracts with existing plan (HMOs, PSNs) that were procured using an open application process.

		• Contract with new plans HMOs, PSNs, EPOs) using competitive procurement process. Sections needing amended include: 409.912(3) for HMOs, 409.12(4)(d) for PSNs, and 409.912(8) for EPOs. ***Competitive Procurement of Plans in reform*** The Agency would need statutory authority in ss. 409.91211, in addition to s. 409.912, F.S., to: • Maintain contracts with existing plan (HMOs, PSNs) that were procured using an open application process. • Contract with new plans (HMOs, PSNs, EPOs) using competitive procurement process. Sections needing amending include: 409.912(3) for HMOs, 409.912(4)(d) for PSNs, and 409.912(8) for EPOs. ***Geographic Expansion of <u>reform areas</u> would require an amendment to section:*** • 409.91211(1) and (5), F.S.
III. Will this proposal require a State Plan Amendment?	**No**	
IV. Will this require the Procurement Process?	**Yes**	For non-reform and reform, see response to item I above.
V. Will this proposal require an administrative rule?	**Yes**	**Rule 59G-8.100** Medicaid Contracts for Prepaid Health Plans would need revised to include competitive procurement under the health plan application process.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	**Yes**	For non-reform and reform, see response to item I above.
VII. Will this proposal require additional staffing?	**No**	Not any additional to what was identified in issues 35-38.
VIII. Is there a previous or concurrent Analysis by the Agency?	**No**	
IX. Is this proposal included in the current Governors recommendations?	**No**	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #40 Cont.**

Lead Analyst:	Linda Macdonald
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Procurement does not result in any additional savings not already addressed in issues 35-38 since the capitation rate methodology will remain unchanged. It does delay implementation and maximum savings will not be achieved in the same time period.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/21/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**N/A**		
General Revenue:	**N/A**		
Administrative Trust Fund:	**N/A**		
Medical Health Care Trust Fund:	**N/A**		
Refugee Assistance Trust Fund:	**N/A**		
Tobacco Settlement Trust fund:	**N/A**		
Grants and Donation Trust Fund:	**N/A**		
Public Medical Assistance Trust Fund:	**N/A**		
Other State Funds:	**N/A**		

Work Papers/Notes/Comments: **Issue #40 Cont.**
(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Competitive Procurement Process (reform and non-reform)
The staff time required to develop, release and award health plan contracts using competitive procurement is estimated to be 12 months. The Agency would have to obtain waiver authority to limit the number of plans using competitive procurement process (limiting competition using competitive procurement may be viewed by the federal government as a significant change in the 1115 reform waiver). If protests are received, the process may take more than 12 months.

Competitive Procurement Process (reform and non-reform)
The staff time required to develop, release and award health plan contracts using competitive procurement is estimated to be 12 months. The Agency would have to obtain waiver authority to limit the number of plans and to allow the Agency to continue contracting with existing plans that were procured using an open application process. If protests are received, the process may take more than 12 months.

If the decision is made to end contracts with existing plans in these areas that were not awarded the competitive bid, then a transition plan for enrolled recipients will be necessary. If the current plans are allowed to continue then no transition plan is necessary, but waiver authority will be necessary.

Federal and State Procurement Requirements
Federal CMS must approve the amendment request before the Agency could implement this change including allowing the Agency to continue contracting with health plans that were procured using an open application process. The Agency needs waiver authority to limit the number of plans through competitively procuring the plans (limiting competition using competitive procurement may be viewed by the federal government as a significant change in the waiver).

Geographic Expansion of Managed Care (reform and non-reform)
Additional Impact: Programs that were implemented as overlays to the MediPass Program in non-reform areas would be impacted by this change. The programs that would be impacted include disease management program, prepaid mental health plans, Integrative Medical Therapies, and the Hospitalist Program. To implement this change, the Agency may need to amend or even terminate most if not all of these program contracts as enrollees would be served by the health plans.

Rate Development
At present capitation rates are developed by Medicaid area and not for specific counties. Implementing a transition of recipients eligible for mandatory assignment in certain counties within a Medicaid area and not all counties within a Medicaid area may have impact rate reimbursement and consideration may need to be given to developing rates by counties or including an adjustment for certain counties.

Medicaid Impact Conference Issues

February 26, 2010

Funding Implications:

Currently, counties submit intergovernmental transfers (IGTs) to help fund the hospital inpatient service line item. The funding is used to support the Low Income Pool and fund the state share of the following issues:

- Remove Hospital Inpatient Reimbursement Ceilings/Teaching, Specialty, CHEP
- Eliminate Inpatient Reimbursement Ceilings-11% Screen
- Eliminate Inpatient Reimbursement Ceilings -Trauma Centers/Medicaid days 7.3%
- Special Medicaid Payments-Liver Transplant Facilities
- Hospital Reimbursement Ceiling Exemption

Counties have a strong incentive to provide intergovernmental transfers (IGTs) to support these payments since there is a direct relationship between the policies funded and fee-for-service payments to these qualifying hospitals. Counties provide local financial support to hospitals that provide a significant amount of Medicaid and uncompensated care. Using these local funds as state match through Medicaid allows local governments to partner with the state, earn federal matching funds and help cover the costs of Medicaid and uncompensated care. For FY 2008-09, the IGT funding is estimated at $706 million in county contributions.

If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the 19 counties with 2 or more managed care plans (with capacity to transition mandatory population) resulting in an increase in the penetration of managed care plans, there will be a significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

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If there is a legislative change to remove the choice of MediPass for Medicaid eligibles subject to mandatory assignment in the **34 counties** with less than 2 managed care plans resulting in **an** increase in the penetration of managed care plans, there will be a

significant reduction in hospital services for which fee-for-service reimbursement is provided. Counties do not currently contribute funding (IGTs) to the state to help fund capitated managed care plan (the prepaid line item of the Medicaid budget) as they currently do for hospital fee-for–service expenditures.

Counties may be reluctant to maintain the same level of IGTs (for FY 2008-09 contributions are estimated at $706 million) to support the state share of hospital inpatient payments when services are shifted from fee-for-service to capitated managed care. The relationship between funding and payments is not direct when services are provided through capitated managed care plans. Counties are concerned that capitated managed care organizations may not use the same hospitals that have historically received fee-for-service payments. In addition, if capitated managed care organizations do use these hospitals, there is no guarantee what payment level or utilization level will materialize.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #41

Proposal Name:	Statewide Contracting - Pharmacy
Brief Description of Proposal:	Provide the estimated savings by limiting the number of pharmacy providers to further leverage the state's purchasing power. Analysis should discuss state and federal implementation issues.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	N/A - No savings / No additional revenue
Bureau(s) Responsible for Administration:	Bureau of Pharmacy Services

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	This proposal will generate objections from chain pharmacy providers and the independent pharmacies represented by Florida Pharmacy Association. Currently, any willing provider who maintains appropriate enrollment with Medicaid and accepts Medicaid reimbursement can provide services.
V. Will this proposal require an administrative rule?	Yes	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
VIV. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #41 Cont.**

Lead Analyst:	Anne Wells, Pharm.D. MS / Bureau Chief, Medicaid Pharmacy Services
Secondary Analyst:	Marie Donnelly, Government Analyst II
Assumptions (Data source and methodology):	N/A
FY Impacted by Implementation:	N/A
Date Analysis Completed:	02/03/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**N/A**		
General Revenue:	**N/A**		
Administrative Trust Fund:	**N/A**		
Medical Health Care Trust Fund:	**N/A**		
Refugee Assistance Trust Fund:	**N/A**		
Tobacco Settlement Trust fund:	**N/A**		
Grants and Donation Trust Fund:	**N/A**		
Public Medical Assistance Trust Fund:	**N/A**		
Other State Funds:	**N/A**		

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

There are no savings associated with this proposal. The reimbursement rate for retail pharmacies is in Florida Statute 409.912(39)(a)2: Reimbursement to pharmacies for Medicaid prescribed drugs shall be set at the lesser of: the average wholesale price (AWP) minus 16.4 percent, the wholesaler acquisition cost (WAC) plus 4.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider.

Reducing the number of contracted pharmacies does not generate savings and could result in lack of access to pharmacy providers in some areas of the state.

Currently, the state leverages its purchasing power by:

1. Controlling reimbursement via electronic claims adjudication through the pharmacy benefit manager, First Health Corp.
2. Maximizing generic substitution and timely calculation and updates of "state maximum allowable" (SMAC) pricing for generics.
3. Maximizing rebate negotiations through the P&T Committee and Preferred Drug List processes.
4. Maximizing rebate invoicing and collections through the contracted rebate vendor, Unisys Corp.

All enrolled pharmacy providers are currently subject to these controls.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #42

Proposal Name:	Statewide Contracting-Durable Medical Equipment
Brief Description of Proposal:	Limit the number of durable medical equipment providers to further leverage the state's purchasing power.
Proposed State Fiscal Year: 00/00	Not given, anticipate 12/13
Proposed Start Date: 00/00/0000	Not given, anticipate 7/1/2012, please see below.
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	A year+	In addition to the time it would take to complete the procurement and implementation process, providers may legally protest the limitation and procurement.
II. Will this proposal require a change in Florida Statute?	Yes	Need legislative authority to begin federal CMS waiver process. F.S. 409.906(10)
III. Will this proposal require a State Plan Amendment?	Yes	Three months to define access to providers.
IV. Will this require the Procurement Process?	Yes	Six to nine months to go through the procurement process plus more time is needed if there is a legal challenge as anticipated. Florida Medicaid has released an Intent to Negotiate limited DME items twice in the past. There were multiple challenges and the awards withdrawn both times.
V. Will this proposal require an administrative rule?	Yes	A minimum number of 120 days months to update the handbooks as incorporated by the rule. Part of this can be concurrent with the procurement.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Three months to go apply and receive a federal CMS waiver, 1915 (b) waiver, to limit the number of single provider type of services. (In the past, a waiver was not needed since a limited product within the durable medical equipment program was addressed. Since more products will be affected, a waiver is necessary.)
VII. Will this proposal require additional staffing?	Yes	1 staff person to manage resulting procurement and contracts.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #42 Cont.**

Lead Analyst:	Dan Gabric
Secondary Analyst:	
Assumptions (Data source and methodology):	
FY Impacted by Implementation:	
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**Pending**		
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #43

Proposal Name:	Statewide Contracting- Home Health Service
Brief Description of Proposal:	Provide the estimated savings by limiting the number of home health services providers to further leverage the state's purchasing power.
Proposed State Fiscal Year: 00/00	11/12
Proposed Start Date: 00/00/0000	7/1/2011
If not July 1, start date; please explain.	The Agency will need to work with the Centers for Medicare & Medicaid Services in order to obtain the appropriate approval for a 1915 (b) (4) selective contracting waiver and will have to competitively procure to limit the number of providers.
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	• Development and routing of 1915 (b) waiver application- 180 days • Handbook/Rule Update- 180 days • Procurement Process- 9-12 months after CMS approval. This timeframe includes the possibility of protests.
II. Will this proposal require a change in Florida Statute?	Yes	Need legislative authority to begin federal CMS waiver process. F.S. 409.905(5)
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	We will have to contract with home health agencies to provide services within each county.
V. Will this proposal require an administrative rule?	Yes	We will need to amend the provider qualifications in the Home Health Coverage and Limitations Handbook.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	1915(b) (4) selective contracting waiver
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #43 Cont.**

Lead Analyst:	**Claire Davis**
Secondary Analyst:	
Assumptions (Data source and methodology):	
FY Impacted by Implementation:	
Date Analysis Completed:	02/20/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**Pending**		
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The Agency would need to seek a 1915 (b) waiver to limit the number of providers that can enroll. Florida's current reimbursement for home health services is below the fair market value. This proposal assumes that the State could leverage the fact that providers will have increased caseloads, so it will drive costs down. However, home health costs are driven by staffing costs, unlike commodities, where price can be lowered by purchasing in bulk. There is no evidence that by purchasing staff related services in bulk can reduce costs. In addition, there has been no reimbursement rate increase for home health services in 20 years, so it is unlikely that there would be room in home health agency budgets for a reduction in reimbursement. Finally, home health agencies may be reluctant to bid because a contract would commit them to serving all Medicaid beneficiaries in an area. Because of nationwide nursing shortages, many home health agencies would not be able to commit to that level of staffing.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #44

Proposal Name:	Statewide Contracting-Hospital Services
Brief Description of Proposal:	Limit the number of hospital service providers to further leverage the state's purchasing power.
Proposed State Fiscal Year: 00/00	Not given, anticipate 12/13
Proposed Start Date: 00/00/0000	Not given, anticipate 7/1/2012
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		
II. Will this proposal require a change in Florida Statute?	Yes	Need legislative authority to begin federal CMS waiver process. F.S. 409.905(5)
III. Will this proposal require a State Plan Amendment?	Yes	Three months to define access to benefits.
IV. Will this require the Procurement Process?	Yes	Six to nine months to go through the procurement process plus more time is needed if there is a legal challenge as anticipated.
V. Will this proposal require an administrative rule?	Yes	A minimum of four months to update the handbooks as incorporated by the rule. Part of this can be concurrent with the procurement.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Six months to apply for and receive a federal CMS 1915 (b) waiver, which limits the number of overall providers for specific services. Florida Medicaid would not be able to limit the number of hospitals for emergency services.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #44 Cont.**

Lead Analyst:	Mike Bolin
Secondary Analyst:	Princilla Jefferson
Assumptions (Data source and methodology):	
FY Impacted by Implementation:	
Date Analysis Completed:	02/20/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**Pending**		
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #45

Proposal Name:	Pharmacy Ingredient Cost Reimbursement
Brief Description of Proposal:	Provide the estimated savings from lowering the Average Wholesale Price (AWP) component in the pharmacy reimbursement methodology from AWP minus 16.4% to minus 17.4%; and lowering the Wholesale Acquisition Cost (WAC) pricing component
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	N/A - Please see options in analysis.
Bureau(s) Responsible for Administration:	Bureau of Pharmacy Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	System programming could be completed for 7/1/10 start.
II. Will this proposal require a change in Florida Statute?	Yes	Section 409.912(39)(a)(2), F.S.
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Will require change to pharmacy reimbursement rule 59G-4.251, F.A.C.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Similar AWP reduction issue in FY 2008-2009.
IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Anne Wells, Pharm.D. MS / Bureau Chief, Medicaid Pharmacy Services
Secondary Analyst:	Marie Donnelly, Government Analyst II
Assumptions (Data source and methodology):	Please see attachment.
FY Impacted by Implementation:	10/11
Date Analysis Completed:	02/04/10

Medicaid Impact Conference Issues

February 26, 2010

Issue #45 Cont.

Funding Sources:	Start Year	Additional Year	Annualized
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**N/A**		
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
See attached spreadsheet for ingredient cost reimbursement calculation options.

Notes:
The first tab of the attached spreadsheet responds to the request to calculate the impact of lowering the AWP-based calculation in the retail pharmacy reimbursement from AWP – 16.4% to AWP – 17.4%. The impact of this reduction must be viewed in the context of estimated acquisition cost (EAC) and the published wholesaler acquisition cost (WAC) for two reasons: 1) AWP will cease to be published sometime in 2011; and 2) Reducing the current AWP-based calculation may bring reimbursement below the acquisition cost for some pharmacies. The attached spreadsheet shows the impact of a range of options for WAC-based pricing, and their relative impacts to current expenditures for AWP-based ingredient reimbursement at the current level of AWP – 16.4%.

Notes:
When AWP ceases to be published in March 2011, the cost to the state will be $83,068,296 based on current statute. This was factored into the SSEC February 2010 conference.
In order to maintain the current post-AWP rollback reimbursement level, the WAC calculation currently in statute must be changed.
If the statute is changed to reflect WAC + $3.73, the annualized cost will be $38,935,054.
To maintain current reimbursement levels with the AWP rollback, the state will have to re-price at WAC – 4.37% + 3.73 which is not anticipated to be approved by CMS.

Medicaid Impact Conference Issues

February 26, 2010

Issue #45 Cont.

Date Range: 10/01/2009 - 11/30/2009

Current Pricing Formula	# Claims	Actual Paid Amount
AWP - 16.4% + $3.73	689376	$ 150,935,677.40
Less Dispensing Fees		$ (2,571,372.48)
Current Ingredient Cost		$ 148,364,304.92

Re-Pricing Formulas	# Claims	Claim cost calculation based on WAC	Ingredient Cost Only	Ingredient Cost Difference	Annualized
WAC + 4.75% + $3.73	689376	$ 164,195,500.20	$ 162,209,020.90	$ 13,844,715.98	$ 83,068,295.86
WAC + 3.75% + $3.73	689376	$ 162,785,955.22	$ 160,660,486.09	$ 12,296,181.17	$ 73,777,087.03
WAC + 2.75% + $3.73	689376	$ 161,366,019.01	$ 159,111,951.29	$ 10,747,646.37	$ 64,485,878.19
WAC + 1.75% + $3.73	689376	$ 159,939,306.20	$ 157,563,416.48	$ 9,199,111.56	$ 55,194,669.36
WAC + 1.00% + $3.73	689376	$ 158,863,859.45	$ 156,402,015.38	$ 8,037,710.46	$ 48,226,262.73
WAC + $3.73	689376	$ 157,424,853.05	$ 154,853,480.57	$ 6,489,175.65	$ 38,935,053.90
WAC - 4.37% + 3.73	689376	$ 150,935,677.40	$ 148,364,304.92	$ -	
AWP - 17.4% + $3.73			$ 146,880,661.87	$ (1,483,643.05)	**$ (8,901,858.30)**

Analysis: Re-price prescriptions from Oct 1 – Nov 30, 2009 as follows:

1. Select prescriptions originally priced according to the AWP – 16.4% + $3.73
2. This sample included 689,376 prescriptions totaling $150,935,677.40
3. Re-price the prescriptions as if the AWP formula no longer exists (WAC + 4.75% + $3.73) and calculate the financial impact.
4. Re-price the same sample of prescriptions at incrementally lower WAC-based formulas, until the analysis achieves one of the following:
    a. Parity with the AWP formula ($150,935,677.40) OR
    b. Parity with the request by the retail federation to "restore" $35,000,000 to the budget
    c. Lowest possible pricing at WAC + dispensing fee

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #46

Proposal Name:	**Prepaid Dental Program**
Brief Description of Proposal:	Provide the estimated savings from expanding the prepaid dental program statewide outside Reform. Non-Reform health plans would continue to be allowed to provide the optional dental service.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	13 month phase-in. Procurement documents will have to be developed. State procurement timeframes will have to be followed. On-site visit will be necessary, with time for review of any necessary corrective action. Contracts will have to be executed. Fiscal agent set-up and testing will have to occur. Recipients will have to be transitioned.
Total Cost/(Savings)/{Revenue}:	**($5,554,857) ANNUALIZED**
Bureau(s) Responsible for Administration:	Health Systems Development

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	**13 month Phase-In with process starting on July 1, 2010**	• FY 2010-2011 A minimum of 12 months will be needed to draft and release procurement documents, receive bidder response, evaluate and post award, possible protest period, readiness review and systems testing for selected vendor(s) and recipient notice, public outreach and transitioning populations The 1915(b) Managed Care Waiver would need to be amended to allow for expansion into additional counties, obtain authority to competitively procure plan and obtain authority for the lock-in period. The federal government has two 90 day periods to review and approve 1915(b) waiver applications. Implementing such a process would impact current health plan contracts, requiring contract amendment and/or termination of contracts and transition of enrollees. HOW? • FY 2011-12 – Implement program statewide

Issue #46 Cont.

II. Will this proposal require a change in Florida Statute?	No	S. 409.912(43), F.S., authorizes the Agency to contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services to Medicaid enrollees.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	Competitive Procurement/Invitation to Negotiate
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The 1915(b) Managed Care Waiver would need to be amended to allow for expansion into additional counties, obtain authority to competitively procure plan and obtain authority for the lock-in period.
VII. Will this proposal require additional staffing?	Yes	It would increase the workload and budgetary considerations for Medicaid/Health Systems Development (contracting and policy), Medicaid Contract Management (choice counseling, systems issues), the Medicaid Fiscal Agent (managed care programming), and Health Quality Assurance/Bureau of Managed Health Care (monitoring and oversight).
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #46 Cont.**

Lead Analyst:	Melissa Vergeson
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Project capitation rate and enrollment based on case load for TANF and SSI children under 21 statewide. The current PDHP capitation rate does not include a discount by area.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($5,554,857)**		**($0)**
General Revenue:	**($2,471,737)**		**($0)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($3,076,495)**		**($0)**
Refugee Assistance Trust Fund:	**($6,625)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #46 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Implemented in 2005, the Prepaid Dental Health Plan (PDHP) is a pilot program operating in Miami-Dade County to increase access to dental services for Medicaid-enrolled children (ages 20 and under). There are currently two PDHPs operating in the program: Atlantic Dental, Inc. (ADI) and MCNA Dental Plans (MCNA). The PDHPs must provide the same dental services offered in the Medicaid State Plan. Enrollment in the PDHP is mandatory. Non-Reform health plans may provide children's dental as an optional service statewide. There are currently three HMOs providing optional dental services in Miami-Dade County: Jackson Memorial Health Plan, Sunshine State Health Plan, and Molina Health Plan. Reform health plans are required to provide dental services.

We assume the intent of this proposal is for the Agency to procure a single statewide dental plan outside Reform. Non-Reform health plans would continue to be allowed to provide the optional dental service.

Pros

If the prepaid dental program works as anticipated, expanding it statewide would increase utilization of dental benefits, increase recipient compliance with the dental component of the CHCUP, increase the number of dental providers available to Medicaid recipients, better managed fraud and abuse and not increase cost to Medicaid. Traditionally, non Reform health plans have not elected to provide the optional dental service. In non Reform areas at present, Jackson Memorial Health Plan, Sunshine State Health Plan, Molina Health Plan and Healthy Palm Beaches plan are the only plans that have elected to provide the optional dental service.

Cons

Utilization data for the existing pilot PDHPs is being validated at present. Until the data is validated, it is difficult to confirm actual utilization of service. Without that evidence, it may premature to assume statewide expansion would create cost efficiency.

Critical mass (enrollment) will have to be assured to allow plans to be able to provide services in rural areas as well as the more populated urban areas. In addition, plans may have difficulty enlisting dental providers to create an adequate network to serve the enrolled population (although interested parties have assured staff this would not be an issue).

Industry Concerns

Advocates may oppose this proposal as it may limit choice for recipients. The Florida Dental Association initially opposed the PDHP in Dade county, but has since changed its position as competition and choice of plans now exists in Dade county for PDHP.

Implementation Obstacles

Until the Medicaid encounter data system is fully operational, it will be difficult to fully measure the impact of the program.

Reform health plans are required to cover state plan dental services and non-Reform health plans may elect to provide the optional dental service.

Medicaid fiscal agent systems issues may also be encountered with choice (Medicaid options) and enrollment. The FMMIS will have to be programmed for statewide expansion.

Medicaid Impact Conference Issues

February 26, 2010

Issue #46 Cont.

Reduction for expanding Prepaid Dental Statewide	
TOTAL COST	($5,554,857)
TOTAL GENERAL REVENUE	($2,471,737)
TOTAL MEDICAL CARE TRUST FUND	($3,076,495)
TOTAL REFUGEE ASSISTANCE TF	($6,625)

Fy1011	Children's Dental Program				
	Total	Capitated	Remainder		
DENTAL CASELOAD	898,455	202,115	696,340	696,340	
DENTAL UTILIZATION RATE	49.89%				
DENTAL SERVICES PER MONTH	448,247	202,115			
DENTAL UNIT COST	$16.40	$5.93	$8.83	$8.17	
DENTAL TOTAL COST	$88,201,476	$14,377,463	$73,824,013	$68,269,156	
TOTAL COST	$88,201,476	$14,377,463	$73,824,013	$68,269,156	($5,554,857)
TOTAL GENERAL REVENUE	$39,246,891	$6,397,520	$32,849,371	$30,377,634	($2,471,737)
TOTAL MEDICAL CARE TRUST FUND	$48,849,386	$7,962,795	$40,886,591	$37,810,096	($3,076,495)
TOTAL REFUGEE ASSISTANCE TF	$105,199	$17,148	$88,051	$81,426	($6,625)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #47

Proposal Name:	**HIV/AIDS Specialty Plan**
Brief Description of Proposal:	Provide the estimated savings from expanding the specialty plan to include home and community based services. We assume the specialty plan will operate statewide and will be the only provider of PAC (home and community based) services for individuals living with HIV and AIDS. Enrollment into the plan is voluntary. The only way to receive PAC services is to enroll in the plan.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	Pending approval
If not July 1, start date; please explain.	See item I. below for explanation
Total Cost/(Savings)/{Revenue}:	Pending
Bureau(s) Responsible for Administration:	HSD/Medicaid Services/BMHC

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Unknown	The Agency would need to obtain federal approval to allow a statewide specialty health plan to provide both medical and home and community based services to eligible individuals living with HIV or AIDS. The federal government has two 90 day periods to review and approve 1915(b)(c) waiver applications. The HIV/AIDS specialty plan that provides medical services only is operating under the 1115 Reform Waiver authority with an anticipated implementation date of May 1, 2010, in Broward County only. Due to the complexity involved in allowing the statewide plan to offer home and community based services in addition to medical services, the implementation time line cannot be determined at this time due to the following reasons: • The Agency would need to submit a 1915(b)(c) waiver application to provide services to eligible individuals in areas outside reform counties.

Issue #47 Cont.

		• The Agency would need to amend budget neutrality for the 1115 Reform waiver to provide home and community based services under the 1115 Reform Waiver. • The Agency would need to submit a statewide transition plan for individuals enrolled in the current 1915(c) project AIDS care waiver to allow for their transition to the 1915(b)(c) waiver and 1115 Reform waiver to ensure continuity of care. • The Agency would be required to competitively procure the specialty plan in areas outside the reform counties pursuant to s. 409.91188, F.S. • The Agency would need to amend the current specialty plan contract to allow for the provision of home and community based services and Agency monitoring of the contract would become more complex. • Fiscal Agent systems changes would be needed to implement. • Changes to the Florida Administrative Rule and handbook would be needed. (The "Project AIDS Care Waiver Services Coverage and Limitations Handbook) • The specialty plan would have to secure appropriate additions to its provider network and case management staff.
II. Will this proposal require a change in Florida Statute?	No	***Please note***: amending s. 409.91188, F.S., to remove the competitive procurement requirement could decrease the amount of time needed to implement. However, the Agency would have to use an open application process which could result in more than 1 plan submitting an application. The state could not limit qualified applicants without using a competitive procurement process.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	The Agency would be required to competitively procure the specialty plan in non-reform areas pursuant to s. 409.91188, F.S.

Issue #47 Cont.

V. Will this proposal require an administrative rule?	Yes	The current home and community based services for people living with HIV or AIDS are provided under the Project AIDS Care Waiver. The established program procedures have been promulgated into a Florida Administrative Rule – see the "Project AIDS Care Waiver Services Coverage and Limitations Handbook." Allowing the specialty health plan to provide home and community based services would require changes in this administrative rule and manual.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The Medicaid medical and home and community based services currently provided to eligible individuals living with HIV or AIDS operate under the authority of 3 different federal waivers (1915(c) Project AIDS Care Waiver, 1915(b) Managed Care Waiver, and 1115 Reform Waiver). Therefore prior to implementation, the Agency would need to submit a 1915(b)(c) waiver application to provide services to eligible individuals in areas outside reform counties. The Agency would need to amend budget neutrality for the 1115 Reform waiver to provide home and community based services under the 1115 Reform Waiver. In addition, the Agency would be required to submit a transition plan for individuals enrolled in the current 1915(c) project AIDS care waiver to allow for their transition to the 1915(b)(c) waiver and 1115 Reform waiver to ensure continuity of care.
VII. Will this proposal require additional staffing?	No	Re-assignment of current PAC staff would be needed.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #47 Cont.**

Lead Analyst:	Medicaid Services
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims data and SSEC February 2010
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/20/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**Pending**		
General Revenue:			
Administrative Trust Fund:			
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:			
Tobacco Settlement Trust fund:			
Grants and Donation Trust Fund:			
Public Medical Assistance Trust Fund:			
Other State Funds:			

It is estimated that $35.84 would be added to the capitation rate.

Work Papers/Notes/Comments: **Issue #47 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Currently, HIV/AIDS recipient's access home and community based services (HCBS) through the PAC Waiver. Eligibility for the PAC waiver is determined by the Department of Elder Affairs through a CARES assessment. PAC case managers and the current HIV/AIDS disease management vendor complete a full medical and psycho/social evaluation to determine the level of care needed, which then determines what services and how many units the recipient qualifies to receive. The HIV/AIDS disease management vendor is also responsible for medical case management, as well as for providing prior authorization if a recipient needs services above and beyond the limits in Medicaid handbook. PAC case managers are also responsible for oversight of services and for coordination of other social services.

In non-Reform counties, PAC Waiver enrollees are excluded from managed care enrollment. In Reform counties, PAC Waiver recipients may also enroll in managed care organizations. Reform health plans are required to coordinate services and provide referrals.

Pros
Requiring the specialty plan to cover HCBS could increase continuity of care regarding the coordination between the medical and home and community based services.

Cons
The Agency would need to develop a mechanism to ensure home and community based services were being appropriately provided by the plan and that needed services were not being denied unnecessarily.

Industry Concerns
There could be a conflict of interest if the vendor assessing the need for PAC services is also providing the PAC services.

Capitation rates for the HIV/AIDS recipients in Reform do not include provision of home and community based services. These services are billed FFS. The HIV/AIDS Specialty Plan would likely request an increase in their capitation rates if they were required to provide HCBS services.

Implementation Obstacles
Due to the complexity involved in allowing the statewide plan to offer home and community based services in addition to medical services, the implementation time line cannot be determined at this time due to the following reasons:

- The Agency would need to submit a 1915(b)(c) waiver application to provide services to eligible individuals in areas outside reform counties.
- The Agency would need to amend budget neutrality for the 1115 Reform waiver to provide home and community based services under the 1115 Reform Waiver.
- The Agency need to submit a statewide transition plan for individuals enrolled in the current 1915(c) project AIDS care waiver to allow for their transition to the 1915(b)(c) waiver and 1115 Reform waiver to ensure continuity of care.

Medicaid Impact Conference Issues

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Work Papers/Notes/Comments: **Issue #47 Cont.**

(The Agency would be required to competitive procure the specialty plan in areas outside the reform counties pursuant to s. 409.91188, F.S.

- The Agency would need to amend the current specialty plan contract in reform areas to allow for the provision of home and community based services.
- Systems changes would be needed to implement.
- Changes to the Florida Administrative Rule and handbook would be needed. (The "Project AIDS Care Waiver Services Coverage and Limitations Handbook)
- The specialty plan contract would have to be amended and Agency monitoring of the contract would become more complex.
- The specialty plan would have to secure appropriate additions to its provider network and case management staff.

Other Issues*:*

- The federal government will not allow the state to operate 2 PAC waivers for the same population. Therefore, eligible individuals (including duals) would have to voluntary enroll in the plan to receive PAC services. For duals that are enrolled in a Medicare plan for the medical care, the Agency would need to work with federal CMS to see if it is possible to operate a stand-alone PAC waiver for just these individuals. If federal government will not approve a separate-stand alone PAC waiver for duals enrolled in a Medicare plan, these individuals would not be able to access PAC services.
- The Legislature would need to direct the Agency in proviso (GAA) to allocate the home and community based PAC services to Specialty plan (prepaid health plan line item).
- Currently, certain populations receiving PAC services are excluded from managed care. The Agency would need to address this populations needs for home and community based services.

Pay AIDS WAIVER thru Aids specialty plan	
PMPM	$35.84
Will add this much to the Capitation Rate	

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #48

Proposal Name:	**Nursing Home - Intermediate Care II**
Brief Description of Proposal:	Provide the estimated savings from a focused effort to transition Intermediate Care II clients to Assisted Living Facilities.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($55,985,619)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Minimum of one year to: • Identify Intermediate Care II nursing home residents through data analysis • Locate Assisted Living Facilities willing to accept these individuals • Give Intermediate Care II recipients choice counseling regarding the option of moving into an Assisted Living Facility • Transfer Intermediate Care II recipients from nursing homes to Assisted Living Facilities
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #48 Cont.**

Lead Analyst:	Susan Rinaldi, Medicaid Services
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims data and SSEC dated February 2010
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($55,985,619)**		
General Revenue:	**($21,532,069)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($34,453,550)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #48 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:
Medicaid recipients are eligible for nursing facility services if they meet Skilled Care, Intermediate Care I, or Intermediate Care II level of care criteria. In addition to the nursing home, individuals also have a choice of living in an Assisted Living Facility or receiving HCBS waiver services. Under Federal law, individuals must be choice counseled regarding all available options. An individual in a nursing home cannot be mandated to leave the nursing home if the individual wishes to remain in the nursing home.

Pros:
The state may realize savings if Medicaid recipients chose to move to Assisted Living Facilities.

Cons:
Individuals with an Intermediate Care II level of care cannot be mandated to move out of a nursing home. Under Federal law individuals must be choice counseled regarding all available options. Individuals may freely choose among the available services, regardless of the cost to the state.

Services outside the nursing home setting for individuals between the ages of 18 and 59 are limited.

This would create a workload issue for the Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES) Program because the recipients would need help locating Assisted Living Facilities willing to admit Medicaid recipients.

The recipient would need to be able to private pay to reside in an Assisted Living Facility. Medicaid does is not allowed to pay Assisted Living Facilities for costs associated with room and board. Only a limited number of Assisted Living Facilities are willing to accept Medicaid recipients due to low reimbursement rates for provided services.

Currently the Department of Elder Affairs, the Department of Children and Families, and the Department of Health are actively identifying and reaching out to Medicaid recipients in nursing homes who have expressed the desire to transition to a community setting, such as an Assisted Living Facility. This is a comprehensive review of all Medicaid recipients that is not dependent upon status as Intermediate Care I or Intermediate Care II level of care.

Industry Concerns:

Individuals at an Intermediate Care II level of care require lower levels of staffing and care, so the nursing homes may be unwilling to lose these residents.

Implementation Requirement:

None. Outreach to the nursing home population that desires to return to a less restrictive community setting is ongoing.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #48 Cont.**

FY1011	
ICFII population	1,368
PMPM for ICFII	$4,614.69
PMPM for ALF	$1,204.26
Difference	($3,410.43)
Reduction	($55,985,619)
General Revenue	($21,532,069)
MCTF	($34,453,550)

The savings on this issue is the maximum and may not be achieved in reality.

From past studies conducted, the actual number of Intermediate Care II clients who transferred were minimal compared to the Skilled and Intermediate Care I client.

Also there may be an issue in transferring these clients to an Assisted Living facility. There are about 428 such providers across the state and they only accept a certain number of recipients. These providers are required to have advance licenses and therefore pay more insurance. Also federal law states that the process to transfer clients must be the same.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #49

Proposal Name:	ICF/DD Assessment
Brief Description of Proposal:	Provide an estimate of revenue generated by requiring an assessment of net revenue to ICF/DD facilities up to the maximum allowable amount of 5.5%. Estimate should include the amount of state funds that could be eliminated from this service and hold the providers harmless.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	ICFs rates are established October 1st for the SFY 10/11
Total Cost/(Savings)/{Revenue}:	{$2,522,639}
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	Yes	409.9083
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX ICF-DD Reimbursement Plan and submit to CMS no later than September 30, 2010
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Quality assessment from 2009-10 GAA provided to buy back ICF-DD rate reduction, effective October 1, 2009
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #49 Cont.**

Lead Analyst:	W. Rydell Samuel
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Based on the initial ICF rates established at October 1, 2009
FY Impacted by Implementation:	SFY 2010 / 2011
Date Analysis Completed:	February 22, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		
General Revenue:	**($1,552,432)**		**($2,069,910)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:			
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**$2,522,639**		**$3,363,519**
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #49 Cont.**

		For 9 months		Annualized
Average Revenue Per Patient Day		**344.94**		
Total Patient Days of Assessed Facilities		**609,522**		
Total Net Patient Service Revenue		**210,248,771.61**		
Maximum Assessment Allowable (5.5% of Net Patient Service Revenue)		**$11,563,682.44**		**$15,418,243**
Total Quality Assessment		**$9,041,043**		**$12,054,724**
Meets Test (Yes or No)		**Yes**		
Additional		**$2,522,639**		**$3,363,519**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #50

Proposal Name:	Nursing Home/Hospice Assessment
Brief Description of Proposal:	Provide an estimate of revenue generated by requiring an assessment of net revenue to Nursing Home/Hospice facilities up to the maximum allowable amount of 5.5%. Estimate should include the amount of state funds that could be eliminated from this service and hold the providers harmless.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	{$53,600,846} Revenue
Bureau(s) Responsible for Administration:	Program Analysis, Finance & Accounting - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Implementation on 07/01/2010
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 12, 2008
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #50 Cont.**

Lead Analyst:	Stephen Russell
Secondary Analyst:	
Assumptions (Data source and methodology):	The revenue projected from the assessment at 5.5% of Total Net Patient Service Revenue is based on all skilled nursing facilities participating in the Nursing Facility Quality Assessment (NFQA) as of 01/01/2010.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/08/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		
General Revenue:	**($32,985,961)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($0)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**$53,600,846**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #50 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:
The current assessment percentage is 5.06% of the maximum 5.5% of Total Net Patient Service Revenue. The maximum that can be appropriated for NFQA is $349 million.

Pros:
Simplification to implement**. $53 million can be appropriated in addition to the current $295 million level** in effect creating a $53 million savings to the state.

Cons:
The Quality Assessment is fully implemented, however the state is waiting on federal approval.

Industry Concerns:
The nursing homes providers have supported the Quality Assessment as way to buy back recurring budget reductions.

Implementation Requirement:

- Provider notification

Projected FY1011 - NFQA Revenue Test			
Average Revenue Per Patient Day		**$**	**257.79**
Total Patient Days of Assessed Facilities	x		**24,636,957**
Total Net Patient Service Revenue		**$**	**6,351,161,145**
	x		**5.5%**
Maximum Assessment Allowable (5.5% of Net Patient Service Revenue)		**$**	**349,313,863**
Current Assessment - FY0910	**-**	**$**	**295,713,017**
Projected Revenue		**$**	**53,600,846**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #51

Proposal Name:	HMO Assessment
Brief Description of Proposal:	Provide an estimate of revenue generated by requiring an assessment of net revenue to managed care organizations. Include the maximum allowable amount of 5.5% and a mechanism to calculate a lower amount.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	{$410,263,079} (Revenue)-using a 5.5% assessment
Bureau(s) Responsible for Administration:	Florida Department of Revenue; Health Quality Assurance; Office of Insurance Regulation

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Depends on other agencies.
II. Will this proposal require a change in Florida Statute?	Yes	Current provisions in statutes will need to be amended or new sections adopted. See the Additional Comments section below.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Assessments in accordance with Section 624.509, are administered in accordance with Section 12B-8.001 Florida Administrative Code
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	Assessments collected in accordance with section 624.509 are the responsibility of the Florida Department of Revenue
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009.
VIV. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #51 Cont.**

Lead Analyst:	Tom Wallace
Secondary Analyst:	Tom Warring
Assumptions (Data source and methodology):	Used DFS-OIR NAIC Schedule T as of 9/30/09 that shows HMO premiums for the 2009 calendar year through 9/30/09. Total premiums for calendar year 2009 were estimated by a straight line projection. The estimated annual premiums were adjusted to deduct Medicare, Federal Employees Plans, and the estimated federal share of Medicaid related premiums. The total for the estimated premiums subject to the assessment is $7.459 billion.
FY Impacted by Implementation:	FY 10/11
Date Analysis Completed:	02/22/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		**($0)**
General Revenue:	**($410,263,079)**		**($410,263,079)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($0)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($410,263,079)**		**($410,263,079)**

Work Papers/Notes/Comments:
(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The HMO providers will probably oppose the assessment.

641.26, F.S., and 69O-137.001, F.A.C., requires every health maintenance organization to file with the Office of Insurance Regulation on or before March 1, an annual statement covering the preceding calendar year. Reports are also required for the first three calendar quarters ending on March 31, June 30, and September 30 of each year. The quarterly reports are to be filed within 45 calendar days after the end date of the quarter.

Issue #51 Cont.

641.26, F.S., and 69O-137.002, F.A.C, requires every HMO to file an annual, audited financial statement with the Office of Insurance Regulation.

641.201, F.S., exempts HMOs from other provisions of the Florida Insurance Code except those provisions of the Florida Insurance Code that are explicitly made applicable to HMOs.

624.509, F.S., provides for a premium tax on certain insurers to be collected by the Department of Revenue on or before March 1 in each year, for premiums and other specified considerations received by the insurer during the preceding calendar year. 12B-8.001, F.A.C., provides for the rate and computation of the premium tax. The rule provides for installments of tax filed on April 15, June 15, and October 15 which shows the amount of tax due for the preceding quarter, except that the June 15 installment shall be for the period ending June 30. Payment of the estimated tax is due at the time the reports are filed. On or before March 1, an annual return shall be filed showing, by quarters, the gross amount of receipts taxable for the preceding year and the installment payments made during the year. A final payment of tax due for the preceding year shall be made at the time the annual report is filed.

The assumption is that Florida Statutes and Florida Administrative Code will be amended to provide for the 1 percent assessment on HMO premiums and that the premiums will be collected under provisions similar to 624.509 F.S, and 12B-8.001. F.A.C.

Re: Question whether amount of revenue should be reduced.
The estimated assessment collected in FY10-11 could be at the amount shown assuming that the assessment is implemented on HMO premiums effective 7/1/10. Current premiums tax/assessments for other insurers are collected on a calendar year basis. Under provisions of rule 12B-8.001, F.A.C., insurers' reports are due as follows:

Quarter ended March 31: Quarterly report due on April 15 with estimated tax for the quarter (3rd collection for FY 2010-11);
Quarter ended June 30: Quarterly report due on June 15 (estimated for the period ended June 30) with estimated tax for the quarter (4th collection for FY 2010-11);
Quarter ended September 30: Quarterly report due on October 15 with estimated tax for the quarter; (1st collection for FY 2010-11);
Quarter ended December 31: Annual report due on March 1 with final payment of tax due for calendar year (2nd collection for FY 2010-11).

If assessment on HMO premiums is implemented in the same manner as the current tax on premiums for other insurers and the effective date of implementation is July 1, 2010, then all of the assessments (estimated) for FY 2010-11 would be due by June 15, 2011

Medicaid Impact Conference Issues

February 26, 2010

Issue #61 Cont

Managed Care Organizations	Total Premiums	Accident & Health Premiums				Reported 1/1/09 - 9/30/09 9 Months	Projected 10/1/09-12/31/09 3 Months	Projected 1/1/09-12/31/09 12 Months
		Commercial	Medicare	Medicaid	Federal Employees			
AETNA HEALTH INC.	$1,499,287,491	$1,479,518,051	$19,769,440	$0	$0	$1,479,518,051	$493,172,684	$1,972,690,735
AIDS HEALTHCARE FOUNDATION MCO OF FLORIDA	$5,448,508	$0	$5,448,508	$0	$0	$0	$0	$0
AMERICAN PIONEER HEALTH PLANS, INC.	$0	$0	$0	$0	$0	$0	$0	$0
AMERICA'S HEALTH CHOICE MEDICAL PLANS, INC.	$0	$0	$0	$0	$0	$0	$0	$0
AMERIGROUP FLORIDA, INC.	$423,014,139	$62,657,492	$13,553,068	$346,803,579	$0	$174,883,130	$58,294,377	$233,177,507
AVMED, INC.	$785,070,249	$534,169,240	$239,410,093	$0	$11,490,916	$534,169,240	$178,056,413	$712,225,653
CAPITAL HEALTH PLAN, INC.	$402,947,388	$319,443,533	$74,395,734	$0	$9,108,121	$319,443,533	$106,481,178	$425,924,711
CAREPLUS HEALTH PLANS, INC.	$748,660,317	$0	$748,660,317	$0	$0	$0	$0	$0
CIGNA HEALTHCARE OF FLORIDA, INC.	$19,765,832	$19,765,832	$0	$0	$0	$19,765,832	$6,588,611	$26,354,443
CITRUS HEALTH CARE, INC.	$217,971,595	$805,932	$153,440,600	$63,725,063	$0	$21,427,362	$7,142,454	$28,569,816
FIRST MEDICAL HEALTH PLAN OF FLORIDA, INC.	$2,917,942	$0	$2,917,942	$0	$0	$0	$0	$0
FLORIDA HEALTH CARE PLANS, INC.	$220,660,335	$104,887,847	$115,772,488	$0	$0	$104,887,847	$34,962,616	$139,850,463
FREEDOM HEALTH, INC.	$247,653,888	$0	$241,858,180	$5,795,708	$0	$1,875,491	$625,164	$2,500,655
HEALTH FIRST HEALTH PLANS, INC.	$289,287,619	$89,460,558	$199,827,061	$0	$0	$89,460,558	$29,820,186	$119,280,744
HEALTH OPTIONS, INC.	$516,371,342	$307,110,253	$209,261,089	$0	$0	$307,110,253	$102,370,084	$409,480,337
HEALTHEASE OF FLORIDA, INC.	$345,021,463	$9,899,920	$0	$335,121,543	$0	$118,345,251	$39,448,417	$157,793,668
HEALTHSPRING OF FLORIDA, INC.	$368,883,167	$0	$368,883,167	$0	$0	$0	$0	$0
HEALTHSUN HEALTH PLANS, INC.	$39,586,730	$0	$39,586,730	$0	$0	$0	$0	$0
HEALTHY PALM BEACHES, INC.	$10,362,590	$1,481,646	$0	$8,880,944	$0	$4,355,519	$1,451,840	$5,807,359
HUMANA ADVANTAGECARE PLAN, INC.	$67,277,750	$0	$67,277,750	$0	$0	$0	$0	$0
HUMANA MEDICAL PLAN, INC.	$3,446,909,629	$494,425,411	$2,796,358,645	$130,546,606	$25,578,967	$536,670,293	$178,890,098	$715,560,391
MEDICA HEALTH PLANS OF FLORIDA, INC.	$3,190,351	$3,190,351	$0	$0	$0	$3,190,351	$1,063,450	$4,253,801
MEDICA HEALTHCARE PLANS, INC.	$189,402,767	$0	$189,402,767	$0	$0	$0	$0	$0
MOLINA HEALTHCARE OF FLORIDA, INC.	$66,322,229	$0	$0	$66,322,229	$0	$21,461,873	$7,153,958	$28,615,831
NEIGHBORHOOD HEALTH PARTNERSHIP, INC.	$324,012,237	$324,012,237	$0	$0	$0	$324,012,237	$108,004,079	$432,016,316
OPTIMUM HEALTHCARE, INC.	$30,253,063	$0	$30,253,063	$0	$0	$0	$0	$0
PHYSICIANS HEALTH CHOICE OF FLORIDA, INC.	$218,984	$0	$218,984	$0	$0	$0	$0	$0
PHYSICIANS UNITED PLAN, INC.	$116,989,827	$0	$116,989,827	$0	$0	$0	$0	$0
PREFERRED CARE PARTNERS, INC.	$245,898,416	$0	$245,898,416	$0	$0	$0	$0	$0
PREFERRED MEDICAL PLAN, INC.	$92,433,994	$52,125,295	$0	$40,308,699	$0	$65,169,190	$21,723,063	$86,892,253
QUALITY HEALTH PLANS, INC.	$122,115,160	$18,025,290	$104,089,870	$0	$0	$18,025,290	$6,008,430	$24,033,720
SUMMIT HEALTH PLAN, INC.	$200,536,233	$0	$200,536,233	$0	$0	$0	$0	$0
SUNSHINE STATE HEALTH PLAN, INC.	$54,080,452	$0	$0	$54,080,452	$0	$17,500,434	$5,833,478	$23,333,912
THE PUBLIC HEALTH TRUST OF DADE COUNTY	$88,202,307	$46,518,522	$0	$40,533,517	$1,150,268	$59,635,168	$19,878,389	$79,513,557
TOTAL HEALTH CHOICE, INC.	$54,776,728	$18,671,518	$0	$36,105,210	$0	$30,355,164	$10,118,388	$40,473,552
UNITED HEALTHCARE OF FLORIDA, INC.	$983,135,312	$497,008,423	$232,125,816	$250,179,106	$3,821,967	$577,966,382	$192,655,461	$770,621,843
UNIVERSAL HEALTH CARE, INC.	$209,789,915	$277,272	$147,885,396	$61,627,247	$0	$20,219,849	$6,739,950	$26,959,799
VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	$237,012,275	$84,017,032	$107,962,780	$38,720,657	$6,311,806	$96,547,037	$32,182,346	$128,729,383
VISTA HEALTHPLAN, INC.	$579,666,205	$477,394,997	$42,575,713	$59,695,495	$0	$496,712,459	$165,570,820	$662,283,279
WELLCARE OF FLORIDA, INC.	$1,076,826,761	$44,641,505	$701,075,132	$331,110,124	$0	$151,788,741	$50,596,247	$202,384,988
TOTAL	**$14,331,961,190**	**$4,989,508,157**	**$7,415,434,809**	**$1,869,556,179**	**$57,462,045**	**$5,594,496,535**	**$1,864,832,181**	**$7,459,328,716**

Assessment Percentage **5.50%**

Source of Data: "Managed Care Quarterly Data Summary as of September 30, 2009", Florida Office of Insurance Regulation

Estimated Assessment **$410,263,079**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #52

Proposal Name:	Hospital IP Assessment Increase
Brief Description of Proposal:	Provide an estimate of revenue generated from increasing the inpatient hospital assessment by 1%. Provide a mechanism to calculate the assessment.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	Annualized
If not July 1, start date; please explain.	Assessments could be implemented for Hospitals reporting revenue after July 1, 2009. Collections would occur after implementation.
Total Cost/(Savings)/{Revenue}:	{$215,096,033} – Increase over the current rate of 1.5%
Bureau(s) Responsible for Administration:	HQA; Program Analysis; Finance and Accounting

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Dependent on Statute change
II. Will this proposal require a change in Florida Statute?	Yes	Assessment percentages are established in S. 395.701, F. S.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #52 Cont.**

Lead Analyst:	Ryan Fitch (HQA)
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	Based on hospital financial data reported for fiscal years ending 2008
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	February 2, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		**($0)**
General Revenue:	**($215,096,033)**		**($215,096,033)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($0)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**$215,096,033**		**$215,096,033**
Other State Funds:	**($0)**		

* Note: The assessment revenue is treated as an offset to the General Revenue.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #52 Cont.**

The current mechanism to calculate the assessment:

- Hospitals report financial data to AHCA in the Florida Hospital Uniform Reporting System (FHURS).
- Financial Analysis Unit at AHCA approves FHURS data and certifies the PMATF amount (Net Inpatient revenue from FHURS data multiplied by the current assessment rate of 1.5%)
- AHCA issues a Final Order with the certified PMATF amount
- Finance and Accounting Unit at AHCA downloads the assessment data from the FHURS and issues invoices to the Hospitals.

Below is a table with the current and proposed assessment:

PUBLIC MEDICAL ASSISTANCE TRUST FUND ASSESSMENT CH. 395.701 F.S.

Data as of 2/2/10 2008 Hospital Data	Current Net Inpatient Assessment	Proposed Net Inpatient Assessment
Total Inpatient Revenue	$21,509,603,347	$21,509,603,347
Assessment Rate	1.50%	2.50%
Assessment Amount	$322,644,050	$537,740,084
Increase Over Current Assessment		**$215,096,033**

Pros – Increase in revenue to the Public Medical Assistance Trust Fund
Cons – Reduces the operating and total margins of Hospitals (Profitability)
Industry Concerns – Increased costs, most likely to be raised by the Rural Hospitals
Implementation Obstacles – Requires a Statutory Change

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #53

Proposal Name:	Hospital OP Assessment Increase
Brief Description of Proposal:	Provide an estimate of revenue generated from increasing the outpatient hospital assessment by 1%. Provide a mechanism to calculate the assessment.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	Annualized
If not July 1, start date; please explain.	Assessments could be implemented for Hospitals reporting revenue after July 1, 2009. Collections would occur after implementation.
Total Cost/(Savings)/{Revenue}:	{$111,524,195} – Increase over the current rate of 1.0%
Bureau(s) Responsible for Administration:	HQA; Program Analysis; Finance and Accounting

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Dependent on Statute change
II. Will this proposal require a change in Florida Statute?	Yes	Assessment percentages are established in S. 395.701, F. S.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 16, 2009
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #53 Cont.**

Lead Analyst:	Ryan Fitch (HQA)
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	Based on hospital financial data reported for fiscal years ending 2008
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	February 2, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		**($0)**
General Revenue:	**($111,524,195)**		**($111,524,195)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($0)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**$111,524,195**		**$111,524,195**
Other State Funds:	**($0)**		

* Note: The assessment revenue is treated as an offset to the General Revenue.

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #53 Cont.**

The current mechanism to calculate the assessment:

- Hospitals report financial data to AHCA in the Florida Hospital Uniform Reporting System (FHURS).
- Financial Analysis Unit at AHCA approves FHURS data and certifies the PMATF amount (Net Outpatient revenue from FHURS data multiplied by the current assessment rate of 1.0%)
- AHCA issues a Final Order with the certified PMATF amount
- Finance and Accounting Unit at AHCA downloads the assessment data from the FHURS and issues invoices to the Hospitals.

Below is a table with the current and proposed assessment:

PUBLIC MEDICAL ASSISTANCE TRUST FUND ASSESSMENT CH. 395.701 F.S.

Data as of 2/2/10 2008 Hospital Data	Current Net Outpatient Assessment	Proposed Net Outpatient Assessment
Total Inpatient Revenue	$11,152,419,495	$11,152,419,495
Assessment Rate	1.00%	2.00%
Assessment Amount	$111,524,195	$223,048,390
Increase Over Current Assessment		**$111,524,195**

Pros – Increase in revenue to the Public Medical Assistance Trust Fund
Cons – Reduces the operating and total margins of Hospitals (Profitability)
Industry Concerns – Increased costs, most likely to be raised by the Rural Hospitals
Implementation Obstacles – Requires a Statutory Change

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #54

Proposal Name:	Nursing Home County Billing
Brief Description of Proposal:	Provide an estimate of revenue generated from increasing the county contribution for nursing home and intermediate care facilities from $55 per month to $202.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	{66,682,221}
Bureau(s) Responsible for Administration:	Finance and Accounting

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	Yes	
III. Will this proposal require a State Plan Amendment?	N/A	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	N/A	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	N/A	
IX. Is this proposal included in the current Governors recommendations?	N/A	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #54 Cont.**

Lead Analyst:	Paula Shirley
Secondary Analyst:	Henry Evans
Assumptions (Data source and methodology):	County Billing Reports. Averaged previous 3 years of Nursing home billings, divided by the current $55 charge to get the number of claims, multiplied the number of claims by the proposed amount $202 and estimated 75% collections. Then averaged the amounts collected the 3 previous years and subtracted this average from the projected collection at the proposed rate ($202) to determine the amount of increased revenue.
FY Impacted by Implementation:	2010/11
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		
General Revenue:	**$33,341,111**		**$66,682,221**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**$33,341,111**		**$66,682,221**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #54 Cont.**

County Billing - Nursing Home Billed Amounts Proposed increase from $55 to $202			County Billing - Nursing Home Collection Amounts	
2006/2007	32,411,888.74		23,470,007.63	
2007/2008	35,234,372.65		25,358,016.83	2008/2009 amount
2008/2009	30,767,778.73		22,211,259.47	estimated based on the average collection
	98,414,040.12		71,039,283.93	percentage
				of the previous 2 years.
	32,804,680.04	Average for 3 years	23,679,761.31	
number of charges	596,449	Average divided by $55.00		
increased billing	120,482,643.06	Charges @ $202.00		
anticipated annual collections	90,361,982.29		66,682,220.98	Increased revenue projection.

If this increase causes the percentage of the county contribution to become greater than it was at the time ARRA became effective, the state is at risk of losing ARRA funds.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #55

Proposal Name:	KidCare
Brief Description of Proposal:	Cost of providing dental services in accordance with the provisions of the Children's Health Insurance Program Reauthorization Act (CHIRPA) of 2009 for the Healthy Kids program.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	N/A
Total Cost/(Savings)/{Revenue}:	$2,196,524
Bureau(s) Responsible for Administration:	Medicaid Services (manages contract with Florida Healthy Kids Corporation)

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Implementation 07/01/2010.
II. Will this proposal require a change in Florida Statute?	No	Last session, 409.815(2)(q), F.S. was amended for benchmark dental services to comply with federal requirements.
III. Will this proposal require a State Plan Amendment?	Yes	State Plan Amendment will need to include new dental services and no annual benefit limit. SPA with an effective date of 0701/10, would be submitted no later than 09/30/10 and include all Title XXI legislative changes.
IV. Will this require the Procurement Process?	No	A new procurement should not be necessary for this benefit change. However, if FHKC is not able to reach an agreement with the existing 4 statewide dental plans (or at least two of them) to change the benefits within the available funding, a procurement process may be necessary that could delay the implementation date. There is year-to-year proviso language that limits the dental per member per month to $12. This proviso language will expire with the fiscal year 6/30/10.
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This was an Impact item last legislative session (March 16, 2009), but at that time $0 cost was proposed as it was expected that Healthy Kids dental services would meet federal regulations as being actuarially equivalent. CMS has advised CHIPRA does not accept actuarially equivalency as meeting federal requirements.

Medicaid Impact Conference Issues

Issue #55 Cont

IX. Is this proposal included in the current Governors recommendations?	No	

Analysis:

Lead Analyst:	Greg Bracko
Secondary Analyst:	Gail Hansen
Assumptions (Data source and methodology):	Based on January 20 Kidcare SSEC.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$2,196,524**		**$2,196,524**
General Revenue:	**$692,125**		**$692,125**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**$1,504,399**		**$1,504,399**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

Work Papers/Notes/Comments: **Issue #55 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
In order for the Healthy Kids dental plan to be compliant with CHIPRA legislation, and receive Title XXI funding, the annual benefit limit must be eliminated. The other Title XXI programs: MediKids and Children's Medical Services Network are CHIPRA compliant.

Assumptions:

Program implementation date 7/1/2010.

Projected Florida Healthy Kids 205,667

Title XXI Federal Dental Assistance blended rate 68.74%

Program component.	Avg Monthly Caseload	$PMPM	Total	Federal	State
Florida Healthy Kids					
-Results from January 29, 2010 SSEC	205,667				
Dental		$11.10	$27,394,844		
Cost		$11.10	$27,394,844	$18,831,216	$8,563,628
Florida Healthy Kids					
-Adjusted to include CHIPRA changes	205,667				
Dental		$11.99	$29,591,368		
Cost		$11.99	$29,591,368	$20,341,106	$9,250,262
Total Increase	205,667				
Dental		$0.89	$2,196,524		
Total Savings		$0.89	$2,196,524	$1,509,890	$686,633

Medicaid Impact Conference Issues

Issue #55 Cont.

Health Care Services (68500000)	
Children's Special Health Care Trust Fund (68500100)	
(1000-2) General Revenue (State)	$686,633
(2474-3) Medical Care Trust Fund	$1,509,890
Total	$2,196,524

Footnotes

1. This change represents an 8% increase in the average dental per member per month cost. The resulting average dental rate is expected to remain within the existing proviso language maximum of $12.00 PMPM.
2. The source of the original per member per month cost is the January 29, 2010, SSEC, SFY 10-11.
3. The Dental per member per month cost is also addressed in Impact Conference item #18.

Medicaid Impact Conference Issues

Proposal: Issue #56

Proposal Name:	Medicaid Waiver
Brief Description of Proposal:	Provide estimated savings from the approval of a waiver that would limit Medicaid expenditures to legislative appropriations. Analysis should include recommended level of funding that would be necessary to obtain such waiver.
Proposed State Fiscal Year: 00/00	2011/12
Proposed Start Date: 00/00/0000	1/1/2012
If not July 1, start date; please explain.	This project would require an 1115 approved by CMS
Total Cost/(Savings)/{Revenue}:	N/A
Bureau(s) Responsible for Administration:	MPA/HQA

Key Elements:	**Yes/No**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Due to the complexity of obtaining a waiver to structure and limit Medicaid expenditures as designed by the legislature more direction and analysis would have to be prepared and researched prior to submission of a waiver application. Therefore, it is anticipated that the earliest start date of a new program would be January 1, 2012.
II. Will this proposal require a change in Florida Statute?	Yes	Depending on the structure of the program, multiple areas of Section 409. F.S would need to be amended. In addition, authority to seek and operate a waiver is needed.
III. Will this proposal require a State Plan Amendment?	Yes	The state plan would need to be amended to reflected changes in services as impacted by the waiver.
IV. Will this require the Procurement Process?		It is unknown at this if any aspect of the waiver would require procurement.
V. Will this proposal require an administrative rule?	Yes	The handbooks and reimbursements are currently in Rule and would need to be changed.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	An 1115 Demonstration Waiver would be needed to implement.
VII. Will this proposal require additional staffing?	Yes	This is a major change to the Medicaid program and would require additional staff and resources.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
VIV. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #56 Cont.**

Lead Analyst:	Michele Hudson
Secondary Analyst:	
Assumptions (Data source and methodology):	
FY Impacted by Implementation:	SFY 2011/12
Date Analysis Completed:	2/26/10

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($0)**		
General Revenue:	**($0)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($0)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Any expansion is estimated to require an additional 20 FTEs as well as contract expenses for choice counseling. Administrative costs are estimated to be $10.3 million, the majority of which is choice counseling expenses.

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #57

Proposal Name:	Medically Needy (Split Billing)
Brief Description of Proposal:	Provide estimated savings if the agency considered "split billings" in the share of cost calculation. Please discuss any federal implementation issues.
Proposed State Fiscal Year: 00/00	11/12
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	Implementation requires extensive programming in both the FLORIDA and FMMIS systems.
Total Cost/(Savings)/{Revenue}:	($21,144,000)
Bureau(s) Responsible for Administration:	Medicaid Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		
II. Will this proposal require a change in Florida Statute?	Yes	409.904 (2) must be modified to indicate: "Expenses used to meet spend-down liability are not reimbursable by Medicaid."
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	The Agency will have to update the General Provider Handbook to include the policy for reduction of payment to the provider based on a deduction for the appropriate share of cost. Minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This provision was enacted by the Florida Legislature in 2002 to be effective in 5/2003. The 2003 Legislative regular session changed the implementation date to 7/2003 and the 2003 special session removed the language that prohibited Medicaid from paying expenses used to spend-down liability. The Medically Needy program was the subject of a special report issued by the Senate Committee on Health, Aging and Long-Term Care in November 2000. OPPAGA has reviewed issues related to Medically Needy reduction of services and converting Medically Needy to Medicaid Buyin program; the OPPAGA reports were published in 2005.
IX. Is this proposal included in the current Governors recommendations?		No

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #57 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Martha Crabb
Assumptions (Data source and methodology):	Medicaid Claims data.
FY Impacted by Implementation:	2010/11
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($21,144,000)**		**($21,144,000)**
General Revenue:	**($8,131,982)**		**($8,131,982)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($13,012,018)**		**($13,012,018)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #57 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The barriers for implementation of this provision are significant. Major system changes for both FMMIS and DCF's FLORIDA system would be required. DCF would have to communicate the remaining share of cost for a family to the Medicaid system; not all of the family members are on Medicaid, but their medical expenses may be used to meet the share of cost if their income was used to determine eligibility for other family members. In addition, the bills used in bill tracking may be from non-Medicaid providers or be for non-compensable Medicaid services. DCF staff would have to know which services were not Medicaid reimbursable services to deduct them from the share of cost before submitting the remaining share of cost to FMMIS. FMMIS would then have to deduct the share of cost from bills submitted by the provider for the date of service for the first day of eligibility until the individual's share of cost in FMMIS reached zero. Providers would have to know how much to collect from the recipient, and Medicaid would have to be vigilant that providers did not bill Medicaid for portions of the bill paid for by the recipient.

The Medically Needy Income Level (MNIL) represents the monthly income remaining to a family for their living expenses after the share of cost is met. The share of cost is equal to the difference between their countable income and the Medically Needy Income Level (MNIL). Using nearly all of their income to pay for medical care would likely leave an insufficient amount of income to cover shelter, food and other basic needs.

Family Size	MNIL*	Asset Limit
1	$180	$5000
2	$241	$6000
3	$303	$6000
4	$364	$6500
5	$426	$7000

Most individuals who quality for Medically Needy coverage are either unable to afford health insurance, or are unable to purchase health care due to pre-existing conditions.

Individuals who cannot afford to pay for services such as prescription drugs to meet their share of cost, may forgo taking medications. This can result in higher medical care costs and increased visits to the emergency room. Since hospitals have to provide emergency care, and the amount of the hospital bills are likely to be used to meet the family's or individual's share of cost, hospitalizations will likely still be billed to Medicaid (but the share of cost would be deducted from the Medicaid reimbursement to the hospital.) About 43% of the Medically Needy costs are inpatient hospitalizations.

Medicaid Impact Conference Issues

February 26, 2010

Issue #57 Cont.

Possible reduction due to Split Billing	
Total	($21,144,000)
GR	($8,131,982)
MCTF	($13,012,018)

Caseload	18,318
	19.24%
Admissions	3,524
days per stay	4.71
perdiem	$1,559.57
Total	$310,795,268
Reduce by $500 per admission	$500
Reduction	$21,144,000
GR	$8,131,982
MCTF	$13,012,018

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #58

Proposal Name:	**Medicare Special Needs Plans (SNPs)**
Brief Description of Proposal:	Provide estimated savings if persons eligible for both Medicare and Medicaid (dual eligibles), were mandatorily enrolled in SNPs.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Contracts between Medicare Advantage Organizations (MAO) and the HHS are calendar year contracts. The contract between the state and the MAO must parallel the contract period since HHS requires the arrangement with the state to be outlined in the MAOs' bids for the next calendar year.
Total Cost/(Savings)/{Revenue}:	($26,155,207)
Bureau(s) Responsible for Administration:	**Health systems Development**

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Projected implementation date: January 1, 2011. The Agency will need to collaborate with federal partners, Medicare Advantage Plans, and all impacted stakeholders prior to implementation. Medicare Advantage Special Needs Plan Project Team will meet twice a month. Implementation process must include communication with interested parties, drafting and implementing contract for CY 2011, calculating rate in consultation with Medicaid Program Analysis and actuaries, changing operational processes for dually eligible recipients, and coordinating policy documentation updates. The Agency would need to submit a State Plan Amendment using the Integrated Medicare and Medicaid State Plan Preprint to outline Florida's Medicare SNP program. This submission would be done in conjunction with the submission to seek a new waiver or amend an existing waiver. The Agency would need to work with federal CMS to determine if this program could be amended into an existing waiver (1915(b) Managed Care Waiver, 1115 Reform Waiver, or another existing waiver) or if a new 1115 research and demonstration waiver would be appropriate. The Agency would need federal approval prior to implementation. Federal CMS has two 90 day periods to approve the amendment once submitted.

Issue #58 Cont.

II. Will this proposal require a change in Florida Statute?	Yes	Language is needed to authorize the Agency to mandatorily enroll duals in Medicare Advantage Special Needs Plans. The language in s. 409.912(7), F.S., allows contracts with health insurers. Therefore, the statute provides authority to contract with the Medicare Advantage Special Needs Plans which are health maintenance organizations and health insurers. ***Statutory Changes***: Add a subsection to 409.912, authorizing the contract (permitted by s. 409.912(7), F.S.) with the MAOs. *The subsection should specify that the MAOs shall not be included in the definition of managed care plans, and are not subject to the requirements in s. 409.9122, F.S. Furthermore, s. 409.91211, F.S., would need to be amended to include the clarification that the Medicare Advantage Special Needs Plans are not subject to the requirements of that subsection.* The added language should authorize the Agency to mandatorily enroll duals with all willing and Medicaid enrolled Medicare Advantage Special Needs Plans for coverage of cost sharing and Medicaid services not to include home and community based waiver program services or long term residential care services. The subsection should permit implementing greater integration (specifically inclusion of home and community based services) over time. The added language to s. 409.912, F.S., should also authorize the Agency to seek or amend federal waivers and to amend the State Plan as necessary to implement this program.
III. Will this proposal require a State Plan Amendment?	Yes	The State Plan Amendment must be approved before the contract can be implemented.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	As long as the statute can be amended to specify *MAOs shall not be included in the definition of managed care plans and are therefore not subject to the requirements in s. 409.9122, F.S. Furthermore, s. 409.91211, F.S., would need to be amended to include the clarification that the Medicare Advantage Special Needs Plans are not subject to the requirements in this section.*

Issue #58 Cont.

		NOTE: If language above cannot be legislated then 59G 8.100 will require revision.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The state would need to submit and obtain federal approval of a waiver amendment to mandatorily enroll dual eligibles in Medicare Advantage SNPs. The Agency would need to work with federal CMS to determine if this program could be amended into an existing waiver (1915(b) Managed Care Waiver, 1115 Reform Waiver, or another existing waiver) or if a new 1115 research and demonstration waiver would be appropriate. The Agency would need federal approval prior to implementation. Federal CMS has two 90 day period is to approve the amendment once submitted.
VII. Will this proposal require additional staffing?	Yes	Staff needed to implement the program, review and monitor documentation, manage contracts. 2 FTEs, pay grade 24 to perform contract management and monitoring activities and one FTE pay grade 25 to administer unit. FTEs would need travel expense.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #58 Cont.**

Lead Analyst:	Melanie Brown-Woofter and Christina Lopez
Secondary Analyst:	Linda Macdonald
Assumptions (Data source and methodology):	Medicaid claims. Assume we can assign duals mandatorily.
FY Impacted by Implementation:	2010/11
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($26,155,207)**		**($52,310,413)**
General Revenue:	**($11,652,145)**		**($23,304,289)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($14,503,062)**		**($29,006,124)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #58 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

See II, regarding statutory changes needed.

Reduction If we could mandatory assign all of duals to SNP	
Total cost	($52,310,413)
GR	($23,304,289)
MCTF	($29,006,124)

At 55.45%			
	Current	**SNP**	
Caseload	359,009	359,009	
PMPM	$62.14	$50.00	
Total cost	$267,715,813	$215,405,400	($52,310,413)
GR	$119,267,395	$95,963,106	($23,304,289)
MCTF	$148,448,418	$119,442,294	($29,006,124)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #59

Proposal Name:	Expand coverage of disposable incontinence products
Brief Description of Proposal:	Expand coverage of disposable incontinence supply products to Medicaid state plan beneficiaries under 21 years of age. Analysis should include the amount of funding that should be moved from the HCBS waivers for these products in APD.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	01/01/2011
If not July 1, start date; please explain.	Rule promulgation
Total Cost/(Savings)/{Revenue}:	$9,752,840
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	6 months	Implement rule and system updates to allow coverage is needed.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Minimum of 120 days. Adopt rule to change policy and incorporate in the handbooks and update the fee schedules. If there is a rule challenge, the process could take longer than three months.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	
IX. Is this proposal included in the current Governors recommendations?	Yes	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #59 Cont.**

Lead Analyst:	Dan Gabric and John Loar
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$9,752,840**		**$19,505,680**
General Revenue:	**$4,344,890**		**$8,689,780**
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**$5,407,950**		**$10,815,900**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #59 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Incontinence Supplies

	Total	Current in DD waiver	Need
Caseload	14,260	(1,700)	12,560
PMPM	$129.42	$129.42	$129.42
Total cost	$22,145,780	(2,640,100)	$19,505,680
GR	$8,517,267	(1,015,382)	$8,689,780
MCTF	$13,628,513	(1,624,718)	$10,815,900

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #60

Proposal Name:	Statewide Implementation of Hospitalist Program
Brief Description of Proposal:	Provide estimated savings associated with statewide expansion of the Hospitalist programs.
Proposed State Fiscal Year: 00/00	11/12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	Rule promulgation; outreach and training; working with CMS on waiver.
Total Cost/(Savings)/{Revenue}:	($17,961,463)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	12 months- The Agency would need to work with the Centers for Medicare and Medicaid Services in order to amend the 1915(b) waiver to implement this program statewide. We would need to execute contracts for the provision of hospitalist services in other areas of the State, and we will need to include time for outreach and training in the affected hospitals that will not be excluded from the program (i.e. designated teaching hospitals).
II. Will this proposal require a change in Florida Statute?	Yes	409.905, F.S. will require the Legislature to clarify their intent since one section gives the Agency the authority to select the counties, and another section specifically states the counties that the vendors can employ the hospitalist physicians.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	The Agency would need additional funding to amend the contracts to include additional hospitals.
V. Will this proposal require an administrative rule?	Yes	Existing rule would require revisions- Physician's Services Handbook. This takes a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	1915(b) Waiver. This takes a minimum of 90 days for approval once submitted.
VII. Will this proposal require additional staffing?	Yes	2 Full Time Equivalent positions to manage the additional contracts. These would replace a full-time OPS position.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #60 Cont.**

Lead Analyst:	Lakia Daniels
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Medicaid claims data. FMAP of 55.45% used.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	
Total (Savings) Cost of Proposal:	**($17,961,463)**		
General Revenue:	**($8,001,832**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($9,959,631**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #60 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

The Centers for Medicare and Medicaid Services (CMS) has indicated that the Agency must offer choice of both participating and non-participating hospitals (within a certain geographic distance) to Medicaid recipients residing in the affected counties that this pilot program is operational. So, we could not expect that all hospitals would be included in the pilot. In addition, statute exempts designated teaching hospitals from participation in the program, and proviso language passed in the 2009 Legislative Session specifically exempted the University of Miami- Cedars Hospital.

CMS may require the agency to continue the independent evaluation requirement under the 1915 (b) waiver if the expansion is approved. This would require additional funding to expand the scope of work of the current contract with Health Services Advisory Group, as they are contracted to evaluate the current pilot. The current cost is $ 150,000 annually.

The current contracts are managed by 1 OPS staff position, which has resulted 300% turnover in the last 2 years because the position is temporary. The Agency cannot absorb the increased workload associated with managing the additional contracts within existing resources and would need FTE positions to ensure a successful implementation.

Projected number of admissions managed	29,380
Projected number of hospitalist visits	58,760
Cost of Physician visits	$2,938,000
Net Reduction	($17,961,463)
GR	($8,001,832)
MCTF	($9,959,631)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #61

Proposal Name:	Supplemental Nursing Home payments for AIDS Care.
Brief Description of Proposal:	Provides estimated savings from eliminating the supplemental payment for AIDS patients served in Nursing Homes. Analysis should include providers claiming the supplemental payment and reporting the off-set on cost reports as well as providers claiming the care cost and not reporting the off-set.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($400,983)
Bureau(s) Responsible for Administration:	Program Analysis - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	A rule change for hand book is required for this issue. If authority is granted, the policy would be effective July 1, 2010.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	N/A	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #61 Cont.**

Lead Analyst:	Stephen Russell
Secondary Analyst:	
Assumptions (Data source and methodology):	The comparison is of providers reporting AIDS offsets for the January 1, 2009, rate semester. The comparison was between the current reimbursement that those providers received for AIDS and what their change in reimbursement would have been had the AIDS costs been included in their regular cost report.
FY Impacted by Implementation:	The savings would begin upon implementation; however there would be a delayed effect on the cost reporting and rate setting process since prior period cost reports are used to set prospective rates for Medicaid.
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($400,983)**		
General Revenue:	**($154,218)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($246,765)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #61 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:
Medicaid currently reimburses nursing homes at a higher rate for Medicaid recipients with AIDS. The nursing homes are required to remove the additional costs related to the AIDS days from the Medicaid cost report (usually a direct offset of the revenue collected) to ensure that the AIDS costs are not reimbursed through the regular per diem rate.

Pros:
The state may realize a savings if Medicaid eliminates the Aids supplemental payments and allows for aids offset cost to be report in the Medicaid cost report as an allowable cost. This would simplify the cost reporting process.

Cons:
The Aids supplemental provides an incentive to providers to care for aids patients knowing that the additional cost associated with this group will not be held to target or ceilings.

Industry Concerns:
The industry expressed mild support for the this proposal in the recent Nursing Home Workgroup Report

Implementation Requirement:

- Modify the Florida Medicaid Management Information System to accommodate reimbursement change
- Revised Nursing Facility Services Coverage and Limitations Handbook
- Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook
- Provider notification

Work Papers/Notes/Comments: **Issue #61 Cont.**

AIDS OFFSETS COMPARISON FOR THE 200901 RATE SEMESTER

Medicaid Number	Proposed Dollar Amounts	Current Total Dollar Amount	Difference Between Proposed And Total Dollar Amount
Provider A	$4,752,503	$4,813,883	($61,380)
Provider B	$3,899,042	$3,977,913	($78,871)
Provider C	$4,877,716	$5,130,189	($252,473)
Provider D	$5,037,948	$5,057,322	($19,374)
Provider E	$3,955,651	$3,952,138	$3,513
Provider F	$2,714,663	$2,717,555	($2,891)
Provider G	$5,132,610	$5,142,966	($10,357)
Provider H	$13,854,203	$13,833,353	$20,850
Total	**$44,224,336**	**$44,625,319**	($400,983)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #62

Proposal Name:	Capitated Incontinence Supplies
Brief Description of Proposal:	Implement a statewide capitated incontinence supply program.
Proposed State Fiscal Year: 00/00	Not given, anticipate 12/13
Proposed Start Date: 00/00/0000	Not given, anticipate 7/1/2012
If not July 1, start date; please explain.	Procurement; system changes; waiver application.
Total Cost/(Savings)/{Revenue}:	($1,106,576)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	A year+	Completing procurement, applying for CMS waiver, major system changes. Potential legal challenges
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	Three months to define benefits.
IV. Will this require the Procurement Process?	Yes	Six to nine months to go through the procurement process plus more time is needed if there is a legal challenge as anticipated.
V. Will this proposal require an administrative rule?	Yes	A minimum of 120 days to update the handbooks as incorporated by the rule. Part of this can be concurrent with the procurement.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Three months to apply and receive a federal CMS waiver, 1915 (b) waiver, limits number of providers for services.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #62 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Dan Gabric and John Loar
Assumptions (Data source and methodology):	Medicaid claims data. FMAP of 55.45% used.
FY Impacted by Implementation:	2010/11
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,106,576)**		
General Revenue:	**($492,980)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($613,596)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #62 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Capitate Incontinence Supplies

	Total	Capitate for 5%	
Caseload	14,260	14,260	
PMPM	$129.42	$122.95	
Total cost	$22,145,780	$21,039,204	($1,106,576)
GR	$9,865,945	$9,372,965	($492,980)
MCTF	$12,279,835	$11,666,239	($613,596)

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #63a

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associate with eliminating nursing home bed hold days or limiting to four days instead of eight. Analysis should show savings at 85 percent occupancy rates.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($12,349,884)
Bureau(s) Responsible for Administration:	Program Analysis, Medicaid Services - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	2003 legislative session reduced the number of bed hold days nursing homes were eligible for Medicaid reimbursement. This new policy was effective 7/1/04.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #63a Cont.**

Lead Analyst:	Stephen Russell
Secondary Analyst:	Fred Roberson, Susan Rinaldi
Assumptions (Data source and methodology):	Calculated the savings associate with limiting to four days instead of eight plus the increase in cost by changing the required threshold to bill for Medicaid days from 95% occupancy to 85% occupancy.
FY Impacted by Implementation:	The savings would begin upon implementation; however there would be a delayed effect on the cost reporting and rate setting process since prior period cost reports are used to set prospective rates for Medicaid.
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($12,349,884)**		**($12,349,884)**
General Revenue:	**($4,749,765)**		**($4,749,765)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,600,119)**		**($7,600,119)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #63a Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:
When the occupancy rate of a nursing facility is 95 percent or greater, Medicaid may pay a nursing home to hold a recipient's bed for up to eight days while the individual is temporarily discharged to a hospital. There is no federal regulation that mandates Medicaid pay nursing home bed hold days.

Pros:
The state would realize savings if Medicaid maintained the 95 percent occupancy and eliminated payments to nursing homes for hospital bed hold days, or if the number of allowed hospital hold days was limited to four days instead of eight days.

Cons:
Reducing the Medicaid occupancy requirement to 85% would increase the number of providers that would qualify to receive payment for bed hold days. This would increase cost to the state.

When Medicaid does not pay a nursing home to hold a bed while a recipient is temporarily discharged from the facility, there is no federal regulation that precludes a facility from placing someone else in the recipient's vacant bed or requires a facility readmit a recipient to the same bed previously occupied by the recipient. If the nursing home fills a bed vacant because a Medicaid recipient was temporarily discharged from the nursing home, federal regulations do require that the facility admit the recipient to the first available bed upon discharge from the hospital.

Patient advocates would be concerned that placing a patient in an unfamiliar nursing facility compounds the trauma of being hospitalized, and may reduce quality of care by placing the patient in a facility unfamiliar with the patient's individual needs.

Industry Concerns:
The nursing home providers would not support eliminating Medicaid payment for hospital bed hold days or limiting hospital bed hold days to four instead of eight days.

Implementation Requirement:
- Revise State Plan Amendment
- Modify the Florida Medicaid Management Information System to accommodate reimbursement change
- Revised Nursing Facility Services Coverage and Limitations Handbook
- Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook
- Provider notification

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #63a Cont.**

Bed Hold Day
Analysis

Projected (Savings)/ Cost

Reduction if we pay for	0 days	4 days	4 days
Occupancy Rate	Current 95%	Current 95%	85%

Nursing Homes

Total	($13,835,970)	($6,917,985)	$12,349,884
General Revenue	($5,321,314)	($2,660,657)	$4,749,765
MCTF	($8,514,656)	($4,257,328)	$7,600,119

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #63b

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associate with eliminating nursing home bed hold days or limiting to four days instead of eight. Analysis should show savings at 90 percent occupancy rates.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($6,200,564)
Bureau(s) Responsible for Administration:	Program Analysis, Medicaid Services - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	2003 legislative session reduced the number of bed hold days nursing homes were eligible for Medicaid reimbursement. This new policy was effective 7/1/04.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #63b Cont.**

Lead Analyst:	Stephen Russell
Secondary Analyst:	Fred Roberson, Susan Rinaldi
Assumptions (Data source and methodology):	Calculated the savings associate with limiting to four days instead of eight plus the increase in cost by changing the required threshold to bill for Medicaid days from 95% occupancy to 90% occupancy.
FY Impacted by Implementation:	The savings would begin upon implementation; however there would be a delayed effect on the cost reporting and rate setting process where since period cost reports are used to set prospective rates for Medicaid.
Date Analysis Completed:	02/08/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($6,200,564)**		**($6,200,564)**
General Revenue:	**($2,384,737)**		**($2,384,737)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($3,815,827)**		**($3,815,827)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #63b Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:
When the occupancy rate of a nursing facility is 95 percent or greater, Medicaid may pay a nursing home to hold a recipient's bed for up to eight days while the individual is temporarily discharged to a hospital. There is no federal regulation that mandates Medicaid pay nursing home bed hold days.

Pros:
The state would realize savings if Medicaid maintained the 95 percent occupancy and eliminated payments to nursing homes for hospital bed hold days, or if the number of allowed hospital hold days was limited to four days instead of eight days.

Cons:
Reducing the Medicaid occupancy requirement to 90% would increase the number of providers that would qualify to receive payment for bed hold days. This would increase cost to the state.

When Medicaid does not pay a nursing home to hold a bed while a recipient is temporarily discharged from the facility, there is no federal regulation that precludes a facility from placing someone else in the recipient's vacant bed or requires a facility readmit a recipient to the same bed previously occupied by the recipient. If the nursing home fills a bed vacant because a Medicaid recipient was temporarily discharged from the nursing home, federal regulations do require that the facility admit the recipient to the first available bed upon discharge from the hospital.

Patient advocates would be concerned that placing a patient in an unfamiliar nursing facility compounds the trauma of being hospitalized, and may reduce quality of care by placing the patient in a facility unfamiliar with the patient's individual needs.

Industry Concerns:
The nursing home providers would not support eliminating Medicaid payment for hospital bed hold days or limiting hospital bed hold days to four instead of eight days.

Implementation Requirement:
- Revise State Plan Amendment
- Modify the Florida Medicaid Management Information System to accommodate reimbursement change
- Revised Nursing Facility Services Coverage and Limitations Handbook
- Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook
- Provider notification

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #63b Cont.**

Bed Hold Day
Analysis

Projected (Savings)/ Cost

Reduction if we pay for	0 days	4 days	4 days
Occupancy Rate	Current 95%	Current 95%	90%

Nursing Homes

Total	($13,835,970)	($6,917,985)	$6,200,564
General Revenue	($5,321,314)	($2,660,657)	$2,384,737
MCTF	($8,514,656)	($4,257,328)	$3,815,827

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #64a

Proposal Name:	Eliminate /Reduce ICF-DD Bed Hold Days at 85 Percent
Brief Description of Proposal:	Savings associate with eliminating ICF-DD bed hold days or limiting to four days instead of eight.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	ICFs rates are established October 1st for the SFY 10/11
Total Cost/(Savings)/{Revenue}:	($132,192)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX ICF-DD Reimbursement Plan and submit to CMS no later than September 30, 2010
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #64a Cont.**

Lead Analyst:	W. Rydell Samuel
Secondary Analyst:	Fred Roberson, Stephen Russell
Assumptions (Data source and methodology):	Based on the initial rates for ICF/DD not Publicly Owned or Operated established at October 1, 2009. Analysis shows savings at 85 percent occupancy rates.
FY Impacted by Implementation:	SFY 2010 / 2011
Date Analysis Completed:	February 9, 2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($132,192)**		**($176,255)**
General Revenue:	**($50,841)**		**($67,788)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($81,350)**		**($108,467)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #64a Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Policy:
Per the ICF/DD Services Coverage and Limitation Handbook, "Bed hold days are those days representing empty bed days based upon a recipient's discharge." The current policy within the handbook does not indicate a maximum of 8 days for bed hold days. This policy is a nursing home policy regarding Bed hold days.

Pros:
The State may realize a saving, if there was implemented a maximum number of bed hold days which Medicaid pays an ICF/DD. Current policy does not have a maximum number of bed hold days.

Cons:
ICF-DDs are a 100 percent Medicaid recipients. The State would realize a very minimum saving in requiring an occupancy requirement of 90 percent or 85 percent for Bed hold day's payment. Currently, approximately 91 percent of the private ICF-DD has an occupancy rate of 90 percent and greater. In addition, approximately 95 percent of the private ICF-DD has an occupancy rate of 85 percent and greater.

Implementation Obstacles:

- Revise State Plan Amendment
- Modify the Florida Medicaid Management Information System to accommodate reimbursement change
- Revised ICF-DD Services Coverage and Limitations Handbook
- Promulgate rule for a revised ICF-DD Services Coverage and Limitations Handbook
- Provider notification and education of New Policy

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #64a Cont.**

Bed Hold Day Analysis

Projected (Savings)/ Cost

Reduction if we pay for number of days	**Eliminating Bed Hold Days**	N/A	**N/A**
Occupancy Rate	**N/A**	90%	**85%**

ICF-DD

Total	**($1,304,289)**	($105,753)	**$176,255**
General Revenue	**($501,630)**	($40,673)	**$67,788**
MCTF	**($802,659)**	($65,080)	**$108,467**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #64b

Proposal Name:	Eliminate /Reduce ICF-DD Bed Hold Days at 90 Percent
Brief Description of Proposal:	Savings associate with eliminating ICF-DD bed hold days or limiting to four days instead of eight.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	10/01/2010
If not July 1, start date; please explain.	ICFs rates are established October 1st for the SFY 10/11
Total Cost/(Savings)/{Revenue}:	($79,315)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2010
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX ICF-DD Reimbursement Plan and submit to CMS no later than September 30, 2010
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #64b Cont.**

Lead Analyst:	W. Rydell Samuel
Secondary Analyst:	Fred Roberson, Stephen Russell
Assumptions (Data source and methodology):	Based on the initial rates for ICF/DD not Publicly Owned or Operated established at October 1, 2009. Analysis shows savings at 90 percent occupancy rates.
FY Impacted by Implementation:	2010 / 2011
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($79,315)**		**($105,753)**
General Revenue:	**($30,505)**		**($40,673)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($48,810)**		**($65,080)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments: **Issue #64b Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Policy:
Per the ICF/DD Services Coverage and Limitation Handbook, "Bed hold days are those days representing empty bed days based upon a recipient's discharge." The current policy within the handbook does not indicate a maximum of 8 days for bed hold days. This policy is a nursing home policy regarding Bed hold days.

Pros:
The State may realize a saving, if there was implemented a maximum number of bed hold days which Medicaid pays an ICF/DD. Current policy does not have a maximum number of bed hold days.

Cons:
ICF-DDs are a 100 percent Medicaid recipients. The State would realize a very minimum saving in requiring an occupancy requirement of 90 percent or 85 percent for Bed hold day's payment. Currently, approximately 91 percent of the private ICF-DD has an occupancy rate of 90 percent and greater. In addition, approximately 95 percent of the private ICF-DD has an occupancy rate of 85 percent and greater.

Implementation Obstacles:

- Revise State Plan Amendment
- Modify the Florida Medicaid Management Information System to accommodate reimbursement change
- Revised ICF-DD Services Coverage and Limitations Handbook
- Promulgate rule for a revised ICF-DD Services Coverage and Limitations Handbook
- Provider notification and education of New Policy

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #64b Cont.**

(Work Papers/Notes/Comments:

Bed Hold Day
Analysis

Projected (Savings)/ Cost

Reduction if we pay for number of days	**Eliminating Bed Hold Days**	**N/A**	N/A
Occupancy Rate	**N/A**	**90%**	85%

ICF-DD

Total	**($1,304,289)**	**($105,753)**	$176,255
General Revenue	**($501,630)**	**($40,673)**	$67,788
MCTF	**($802,659)**	**($65,080)**	$108,467

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #65

Proposal Name:	Reduce Nurse Staffing Requirements to 2.6 Hours
Brief Description of Proposal:	Savings associated with reducing required nursing staffing ratios to 2.6 hours from the current 2.9 average hours.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	Due to the cost reporting process this savings may not be realized until 2011 unless a direct policy change is implemented to adjust rates.
Total Cost/(Savings)/{Revenue}:	($30,016,943)
Bureau(s) Responsible for Administration:	Program Analysis - AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Implement for all cost reports going forward starting with July 1, 2010.
II. Will this proposal require a change in Florida Statute?	Yes	The 2.9 staffing ratio is currently written into the Statutes so a change to 2.6 would require a change to the Statutes.
III. Will this proposal require a State Plan Amendment?	Yes	The 2.9 staffing ratio is in the current version of the State Plan so any changes would require a new version of State Plan.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	A rule change is required for this issue. If authority is granted, the policy would be effective July 1, 2008
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated March 12, 2008
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #65 Cont.**

Lead Analyst:	Thomas Parker
Secondary Analyst:	
Assumptions (Data source and methodology):	Data comes from the January 2010 rate setting Direct Care data. An hourly average for CNA was determined based on data. This number was then multiplied by the current staffing ratio (2.9) and the new staffing ratio (2.6). The difference between these two numbers is the savings per patient day. This savings was multiplied by the Annualized Medicaid Days for FYE 2010 to determine Annualized Medicaid portion. This number was then reduced by 15% to account for providers who would not be affected due to being held to Direct Care Ceilings.
FY Impacted by Implementation:	There would be a year delay on any savings due to the nature of the cost reporting and rate setting process where prior period cost reports are used to set prospective rates for Medicaid.
Date Analysis Completed:	02/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($30,016,943)**		**($30,016,943)**
General Revenue:	**($11,544,516)**		**($11,544,516)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($18,472,427)**		**($18,472,427)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #65 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Current Situation:

Currently the Staffing level is at 2.9

Pros:
Would represent a significant cost savings to both the State of Florida and to Skilled Nursing Providers throughout the state. Would require very little change to current processes currently in use by Medicaid Program Analysis staff.

Cons:
Decrease in staffing could potentially lead to a lower level of care to the patients in the Skilled Nursing Facilities.
Implementation: Because rates our set based on historical cost it could take several months after implementation before any savings are realized.

Obstacles: Public perception of level of care being provided based on reduced staffing.

Estimated Medicaid Savings

*Total Maximum cost savings		$117,301,064
**Assumption for staffing level being retained		50%
Total cost savings	X	$58,650,532
Annualized Total Patient Days		25,904,301
Unit cost per day	/	$2.2641
Annualized Medicaid Days		15,555,960
Annualized Medicaid Portion	X	$35,220,612
***Assumption for providers held to Targets, Ceilings		85%
Annualized Medicaid Savings		$30,016,943

***Total Maximum cost saving assumes, if allowed all providers would reduce staffing levels from 2.9 to 2.6.**

****Assumption for providers retaining staffing level at2.9. Example - 100% assumes all providers would maintain current staffing level.**

****Approximately 15% of providers are held to the direct care ceilings thus we would not recognize a savings for them as they are not being paid for their full cost currently.**

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #66

Proposal Name:	Limit Medicaid Hospice services to a maximum of 210 days
Brief Description of Proposal:	Implementation of a federal waiver to limit Medicaid Hospice services to a maximum of 210 days.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	07/01/2010
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($8,657,817)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	One year to: • Amend State Plan • Revise Hospice Coverage and Limitations Handbook and Provider Reimbursement Handbook UB-04 • Promulgate rules for revised handbooks • Modify FMMIS • Provider Notification • Recipient notification
II. Will this proposal require a change in Florida Statute?	No	Hospice is an optional service. Ch. 409.906 is permissive so it does not need to be changed
III. Will this proposal require a State Plan Amendment?	Yes	Minimum of 90 days for approval. State Plan Amendments can be retroactive.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	The Hospice Coverage and Limitations and Provider Reimbursement UB-04 Handbooks are in rule. Changes to the handbooks require a rule change.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	Federal regulations require states to provide at least 210 days of hospice services. Medicaid can limit Hospice services to a maximum of 210 days without a federal waiver.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #66 Cont.**

Lead Analyst:	Fred Roberson
Secondary Analyst:	Barbara Hengstebeck
Assumptions (Data source and methodology):	Medicaid claims data
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	2/22/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($8,657,817)**		**($8,657,817)**
General Revenue:	**($3,329,797)**		**($3,329,797)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($5,328,020)**		**($5,328,020)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Work Papers/Notes/Comments: **Issue #66 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

Pros: Currently Hospice services are provided to individuals with a terminal diagnosis and a life expectancy of six months or less if the terminal condition runs its normal course. Some hospice recipients stay in the program much longer. Federal regulations require Medicaid to provide a minimum of 210 days of hospice benefits. Limiting the number of days of hospice services to 210 can be done without a waiver and may result in cost savings.

Cons: Predicting the life expectancy of an individual is not an exact science. Because Hospice physicians may not be able to accurately predict how long an individual is going to live, capping the number of days to 210 may result in some recipients running out of Hospice benefits at the very end of their life. Since more services are typically utilized at the very end of an individual's life, more expensive acute care services may be utilized if hospice services are discontinued.

Industry concerns/Implementation obstacles: Hospice providers, the Hospice provider association (Florida Hospices and Palliative Care), hospice recipients and their families, AARP, advocacy groups and the general public may not support this change.

Limit Hospice care to 210 days	
TOTAL COST	($8,657,817)
TOTAL GENERAL REVENUE	($3,329,797)
TOTAL MEDICAL CARE TRUST FUND	($5,328,020)

Medicaid Impact Conference Issues

February 26, 2010

Issue #66 Cont

HOSPICE	FY1011	Limit to 210days	Reduction
MEDICAID CASELOAD	17,039	16,621	
MEDICAID UNIT COST	$1,726.04	$1,726.04	
MEDICAID TOTAL COST	$352,919,947	$344,262,130	
TOTAL COST	$352,919,947	$344,262,130	($8,657,817)
TOTAL GENERAL REVENUE	$82,882,027	$79,552,230	($3,329,797)
TOTAL MEDICAL CARE TRUST FUND	$217,186,935	$211,858,915	($5,328,020)
TOTAL REFUGEE ASSISTANCE TF	$0		$0
TOTAL HEALTH CARE TF	$42,000,000	$42,000,000	$0
TOTAL GRANTS AND DONATIONS TF	$10,850,985	$10,850,985	$0

Medicaid Impact Conference Issues

February 26, 2010

Proposal: Issue #67

Proposal Name:	Fraud and Abuse
Brief Description of Proposal:	Savings associated with reducing the managed care discount factor by 4.5% in Miami-Dade county due to a Fraud and Abuse Adjustment.
Proposed State Fiscal Year: 00/00	10/11
Proposed Start Date: 00/00/0000	09/01/2010
If not July 1, start date; please explain.	This will follow the HMO rate setting which is September 1.
Total Cost/(Savings)/{Revenue}:	($22,703,499)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		September 1, 2010
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	15% Budget Reduction, Agency Analysis 2010
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

February 26, 2010

Analysis: **Issue #67 Cont.**

Lead Analyst:	Jack Shi
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Data used was based on the current rates and the enrollment of March – May 2009. An additional 4.5% discount factor was then applied.
FY Impacted by Implementation:	2010-11
Date Analysis Completed:	02/24/2010

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**10**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($22,703,499)**		**($27,244,199)**
General Revenue:	**($8,731,766)**		**($10,478,119)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($13,971,733)**		**($16,766,080)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

February 26, 2010

Issue #67 Cont.

Work Papers/Notes/Comments:

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):

HMO rates are set September 1 each year and are subject to actuarial calculations.