Minutes of the
Medical Care Advisory Committee Meeting
Tuesday, October 23, 2012
1:00 PM – 4:00 PM
AHCA Conference Room A
Participants/Invitees

Members Present

Martha Pierce
Paul Belcher
Jennifer Lange
Catherine Moffitt, MD
Secretary Chuck Corley
Richard R. Thacker, DO

Members Not Present

Amy Guinan
Robert Payne, DDS
DOH Representative

AHCA Staff Present

Justin Senior
David Rogers
Melanie Brown-Woofter
Josh Davis
Robin Ingram
Carla Sims
Millie Markey

Welcoming Remarks/Roll Call

The Medical Care Advisory Committee (MCAC) meeting began with welcoming remarks by Deputy Secretary for Medicaid, Justin Senior, followed by a roll call of Committee members.

Mr. Senior explained that the MCAC meeting would serve as a public forum to discuss the 1115 Waiver for the Medically Needy component of Statewide Medicaid Managed Care. He then introduced Mr. David Rogers, Assistant Deputy Secretary for Medicaid Health Systems.

1115 Waiver for the Medically Needy

Mr. Rogers explained that the Agency for Health Care Administration (Agency) must submit a new 1115 Waiver application to the Federal Centers for Medicare and Medicaid Services (CMS), for changes made in Florida law regarding the Medically Needy program. Prior to submitting the new 1115 Waiver application, the Agency must meet the following requirements:

- The Agency must provide at least a 30-day public notice and comment period.
- At least 20 days prior to submitting an application for a new 1115 Waiver, the State must have conducted at least two public hearings, on separate dates and at separate locations.

Mr. Rogers advised that the following public meetings were scheduled to discuss the new 1115 Waiver application:

October 19, 2012, 2-5:00 p.m.
The Westin Ft. Lauderdale
400 Corporate Drive
Ft. Lauderdale, Florida 33334

October 23, 2012, 1-4:00 p.m.
Medical Care Advisory Committee Meeting
Agency for Health Care Administration
2727 Mahan Drive
Building 3, Conference Room A
Tallahassee, Florida 32308

Mr. Rogers then made a PowerPoint presentation, explaining the following:

What is the Medically Needy Program?

- The Medically Needy component of Florida Medicaid is designed for beneficiaries with slightly higher incomes or assets, whose medical costs may be catastrophic or ongoing.
- Medically Needy recipients must incur medically necessary bills to meet a share of cost each month, determined by their income.
- Medically Needy services and current eligibility requirements are outlined in the Florida Medicaid State Plan.

Additional Medically Needy Program Facts

- Medically Needy was implemented in Florida in 1986, and is considered an optional population.
- Currently, the Medically Needy program serves an average of 48,158 individuals during any month, and provides services for at least one month to more than 250,000 individuals annually.
- Total Medicaid services expenditures reimbursed for the Medically Needy program during State Fiscal Year (SFY) 2010-11 were $808.6 million, and costs for the program for SFY 2011-12 are estimated to be $938.6 million.
- Prior to the 2011 legislative session, section (s.) 409.904(2)(a), Florida Statutes (F.S.), authorized the Medically Needy program with an ending date for non-pregnant adults of June 30, 2011.

Why does the State have to submit a new 1115 Waiver for this program?

- During the 2011 legislative session, the Florida Legislature passed House Bills 7107 and 7109 for Statewide Medicaid Managed Care, which contained new provisions for the Medically Needy program. Governor Scott signed the bills into law June 2, 2011.

- The law continued the Medically Needy program and directed the Agency for Health Care Administration to seek federal waiver authority for the items listed on the following pages.
- Change the program to provide additional months of coverage.
- Provide care coordination and utilization management to achieve more cost-effective services.
- Enroll Medically Needy recipients into their choice of managed care plans.
- Implement a premium payment that would not exceed the share of cost.
- Provide a grace period of 90 days before the recipient can be dis-enrolled for non-payment of the premium.

The law does the following:

- Provides additional months of coverage for Medically Needy recipients.
- Once determined eligible, allows recipients to enroll into their choice of managed care plan.
- Ensures recipients will be assigned a premium payment, not to exceed their share of cost, to be made to their managed care plan.
- Allows recipients to remain enrolled in their plan and Medicaid eligible up to 12 additional months after their initial eligibility by paying the monthly premium amount, not to exceed their share of cost.

The law does not:

- Discontinue the Medically Needy program.
- Change the initial eligibility requirements for Medically Needy recipients.
- Eliminate any services currently provided under the Medicaid State Plan for Medically Needy recipients.

What do Medically Needy recipients receive from the managed care plan?

- All medically necessary covered Medicaid services.
- Care coordination and utilization management per the Statewide Medicaid Managed Care contract through their choice of managed care plan.
- Continued coverage for up to 12 months, as long as the premium payment, not to exceed share of cost, is made to their managed care plan.

What happens if Medically Needy recipients do not pay their premium?

- The Medically Needy recipient receives a 90-day grace period before being dis-enrolled from their plan for non-payment of the premium.
- Once a Medically Needy recipient is dis-enrolled they must be determined eligible again through the existing Medicaid eligibility process administered by the Florida Department of Children and Families, and incur medical bills to meet their share of cost amount.

Mr. Rogers then presented the following timeline for submitting the 1115 Waiver for the Medically Needy component of Statewide Medicaid Managed Care, and turned the meeting over to Melanie Brown-Woofter who opened the floor for public comments:

- October 11, 2012 - Public Comment Period begins
- October 11, 2012 - Website goes live on www.AHCA.MyFlorida.com
- October 19, 2012 - Public Meeting #1 in Ft. Lauderdale

- October 23, 2012 - Public Meeting #2 in Tallahassee
- October 23, 2012 - Begin compiling public comments
- November 26, 2012 - Submit 1115 Medically Needy Waiver Application to CMS - Website remains live

Ms. Brown-Woofter then recognized Mr. Stan Whittaker, with the Florida Council of Advanced Practice Nurses.

Mr. Whitaker shared his concerns with how the Medicaid Managed Care Waiver would potentially impact the role of Nurse Practitioners. He added that currently Nurse Practitioners encompass 20% of the Medicaid workforce, serving thousands of Medicaid patients. These Medicaid recipients will be adversely affected if Nurse Practitioners are not able to deliver the level of care they have previously provided under fee for service.

Mr. Whittaker further noted that while many Nurse Practitioners have their own practices, they work with and through physicians, some of whom do not accept Medicaid. These Nurse Practitioners provide Medicaid services that are directly reimbursed under fee for service from Medicaid. However, under the new managed care system, Nurse Practitioners will not be able to continue to provide care to Medicaid recipients, unless the physicians, with whom they work, become Medicaid providers. Mr. Whittaker added that this will create a major problem for individuals in rural areas, since due to limited physician availability in those area, Nurse Practitioners provide the majority of care. With managed care only recognizing the physicians, and all payments going to the physicians, not to the Nurse Practitioners, their ability to continue their practices will be severely limited, if not discontinued. He further noted that, while it appears this is an unintended consequence of the law that was passed back in 2011, this may result in several hundred Nurse Practitioners closing their practices, and asked that his concerns be taken into consideration.

Next, Ms. Brown-Woofter recognized Mr. Paul Belcher, with the Florida Hospital Association.

Mr. Belcher noted that a large percentage of the $938 million dollars in expenditures for the medically needy program goes toward hospital care. So, the Florida Hospital Association has a very significant concern about this chronically ill patient population, and is worried that under managed care they may not receive the same level of care they do today. He also shared his concern with their level of the share of cost, as it is very low for this particular population, and requested that his concerns on this issue be relayed to federal CMS.

Mr. Belcher then asked if there were changes in the process for share of cost coverage, with regard to a look-back period, where some of the costs were paid by Medicaid. He noted that it now appears to be solely the responsibility of the individual who is eligible for the program, and asked, if the 48-50,000 individuals eligible monthly, have they been looked at from an income standard to compare those to the 138% federal poverty level to see how many will likely convert if the Affordable Care Act is implemented?

Mr. Rogers responded that AHCA had looked into this and there were a fairly large number of individuals below the 138% federal poverty level. He added that the Agency would consider readdressing the share of cost process in the waiver application.

Referred to the Medically Needy capitation rate, Mr. Belcher then asked, if like with TANF and SSI, the actuary will calculate that component separately, and then average it into the overall capitation rate for a managed care plan?

Mr. Rogers responded that the Agency will certainly look at the population separately in developing the capitation rate, since if you look at our claims history, it is usually time-limited. So that capitation rate will be developed separately. However, the approach for the Managed Medical Assistance portion of Statewide Medicaid Managed Care has not yet been finalized, so I cannot tell you at this point how we have structured the bidding process related to those rates. But, we are certainly going to be looking at rates for this specific population.

With no further questions, Mr. Rogers concluded the public meeting and turned the Medical Care Advisory Committee meeting over to Carla Sims.

Minutes

Ms. Sims explained that the minutes of the July 31, 2012, MCAC meeting had been sent to committee members for review prior to the meeting, and asked if there were any questions or comments. With no questions or comments by Committee members, a motion was made and seconded for approval of the minutes.

Ms. Sims then advised committee members that if there were no objections, the next MCAC meeting would be scheduled in January 2013, using previously agreed upon agenda topics.

Adjourn

At 2:00 p.m. the meeting was adjourned.