FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

April 26, 2012

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

Dear Ms. Orris:

The Florida MEDS AD 1115 Research and Demonstration Waiver (CMS 11-W-00205/4) was originally approved by the Centers for Medicare and Medicaid Services (CMS) for the period 1/1/2006 through 12/31/2010, then was renewed for an additional three years through 12/31/2013. This demonstration provides access to Medicaid services for approximately 40,000 disabled or elderly individuals per month who would not otherwise be eligible for Medicaid services through the State Plan, and seeks to show improved outcomes through access to comprehensive services. The attached request to amend this demonstration proposes to provide additional months of Medicaid eligibility to recipients who become eligible for Medicaid through the Medically Needy program. Approval of this waiver would more than double the number of member months of Medicaid coverage for these individuals by making them eligible for up to six additional months of Medicaid eligibility through enrollment in a statewide Provider Service Network (PSN).

This proposed amendment does not change the existing process for determining initial eligibility for the Medically Needy program. Under this proposed demonstration, recipients would initially become eligible as in the current program, by incurring bills for medical expenses that exceed their share of cost (SOC) amounts. Currently, eligibility begins on the day the SOC is met and continues through the end of that same month. This would not change, but under the proposed demonstration, the month after the initial determination of eligibility, the recipient would be enrolled in a PSN. Enrollment in the PSN would be mandatory and would provide continuous eligibility for up to six months, without the current program requirement that bills for medical expenses in excess of SOC must be incurred monthly. Beginning the second month of PSN enrollment, enrollees would be billed for a monthly premium, at an amount which is the lesser of their SOC or the monthly per capita capitation benchmark (PCCB) cost that has been actuarially determined for the PSN. Enrollees would receive a 90-day grace period prior to disenrollment for non-payment of the premiums. In all cases, the State will fully comply with federal requirement related to advance notice of adverse action prior to any termination of benefits.

The statewide PSN would be responsible for and be at financial risk for collecting all premium amounts, as well as for claim costs in excess of the actuarially determined risk-based PMPM benchmark. The State's risk would be limited to the aggregate remainder of the risk-based PMPM benchmark amount minus all assessed premium amounts for all months in which recipients were enrolled in the PSN.

In order to meet the objectives of the Medically Needy demonstration program, waiver of the following sections of the Social Security Act is requested in accordance with section 1115 of the Social Security Act.

1. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the State to impose a premium.

2. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).

3. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

In addition, the State requests costs not otherwise matchable for this population and expanded months of coverage that do not meet State Plan criteria. The State of Florida submits that costs of this proposed waiver demonstration amendment, in the aggregate with all costs projected for the waiver, will not exceed the established budget neutrality ceiling.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/md
Enclosures
cc: Angela Garner, CMS/CO
Paul Boben, CMS/RO
Mark Pahl, CMS/RO

ATTACHMENT I

Florida Medically Needy Waiver Demonstration Amendment to the Florida MEDS AD section 1115 Demonstration (Project No. 11-W-00205/4)

I. PURPOSE

This is a request to amend the existing Florida MEDS AD section 1115 Demonstration Waiver (Project No. 11-W-00205/4), approved under section 1115 of the Social Security Act, to include a demonstration to implement provisions of Florida law enacted in 2011 related to the Medically Needy program. Section 409.9122, Florida Statutes, specifies that the time period for this new Medically Needy program ends on October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner. The State is seeking a waiver of specified provisions of the Social Security Act in order to provide for costs not otherwise matchable for continuous eligibility for up to six-months for individuals who become eligible for Medicaid through the Medically Needy program. The State would further request waiver of any applicable provisions of the Social Security Act in order to collect a premium in lieu of share of cost, and not to exceed the share of cost amount. Under this proposed demonstration, the criteria for initial eligibility would not be more restrictive than the current State Plan criteria, and persons who become eligible through the Medically Needy program would receive additional months of eligibility through enrollment in a statewide Provider Service Network (PSN), regardless of whether their incurred bills exceeded the share of cost amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full six additional months of coverage; however enrollees would receive a grace period of ninety days of coverage before being disenrolled from the PSN for non-payment. Services would be delivered through the existing fee-for-service network, with the single (PSN) functioning as a third-party administrator and managing entity for the Medically Needy program in all counties. This contractor would provide care coordination and utilization management in order to achieve more cost-effective services for Medically Needy enrollees, and would be at risk for collection of enrollee premiums as well as for aggregate medical expenditures reimbursed by the State in excess of the Per Capita Capitation Benchmark (PCCB). In addition, after reconciliation of actual expenditures to the benchmark this contractor would share with the State any savings from managing costs below the PCCB.

II. BACKGROUND

The Medically Needy program is currently authorized by the State Plan for persons who would be eligible except that their family income or assets exceeds the State Plan threshold for Medicaid eligibility. Currently, in the event that subtracting the amount of allowable medical expenses incurred by these individuals from their monthly income would cause the remainder to fall below the Medically Needy Income Level (MNIL), these individuals become eligible for Medicaid. The Medically Needy Income Level is currently based on the amount of maximum monthly cash benefit paid to recipients of Temporary Assistance for Needy Families (TANF). (This is the same as the AFDC income limit in effect as of July 12, 1996.) For TANF eligible assistance groups (for example, a household with children), all persons in the assistance group become eligible for Medicaid on the date that incurred medical expenses would cause the assistance group income to fall below the MNIL. For SSI-related individuals and spouses, the eligible individual or eligible couple become eligible when the incurred medical expenses cause the countable income to fall below the MNIL. Eligibility is restricted to individuals or families with low assets, such as savings or property (other than a residence). Under this proposed concept, the current income levels and asset limits would not change. The current Medically Needy Income Limits and Resource Limits are shown in Table I:

TABLE I

Medically Needy Income Limits and Resource Limits by Family Size

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

The difference between the family's income and the Medically Needy Income Level is called the "share of cost" (SOC). Currently, when an individual incurs medical expenses sufficient to reduce available income below the Medically Needy Income Level for that month, he or she meets the share of cost and is eligible from the day the share of cost is met through the end of that month only. Medical expenses incurred *before* the day that share of cost is met are not paid by Medicaid and remain the responsibility of the individual. On the date the share of cost is met, the individual becomes eligible for Medicaid for the balance of the month, and medically necessary expenses are reimbursed by Medicaid.

The Medically Needy program covers all medical services covered by Florida Medicaid except for: long-term care (such as skilled nursing care); services in an Intermediate Care Facility for the Developmentally Disabled; and services under a Home and Community-Based Waiver. Eligibility for the Medically Needy program is determined by the Department of Children and Families (DCF) and payment for provision of services is administered by the Agency for Health Care Administration, the State's designated single State agency under Title XIX.

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

Currently, the Medically Needy program serves an average of 48,158 individuals during any month, and provides services for at least one month to more than 250,000 individuals annually. The total cost for Medicaid services reimbursed for the program for State fiscal year 2010-11 were $897 million, and costs for the program for State fiscal year 2011-12 are estimated to exceed $1.05 billion[1].

III. STATE LAW

Prior to the 2011 legislative session, section 409.904(2)(a), Florida Statutes, authorized the Medically Needy program and provided for the program to expire on June 30, 2011. Thereafter, only children under age 21 and pregnant women would have been eligible for Medically Needy under Florida law, absent further change in the statute.

During the 2011 legislative session, the legislature considered several alternative approaches to the program. In the bills that were enacted, the Medically Needy program was continued and the Agency was directed to seek federal waiver authority to change it to provide additional months of coverage, to implement a premium that would not exceed the share of cost, and to provide care coordination and utilization management to achieve more cost-effective services.

Specifically, two laws were enacted in the 2011 session that made significant changes to the Medically Needy program.[2] This waiver amendment request is specific to House Bill 7109

[1] January 2012 Social Services Estimating Conference projection for total Medically Needy population expenditures is $1,046,134,612.

[2] House Bill 7107 (Chapter 2011-134, Laws of Florida) provides for implementation of a statewide managed medical assistance program and includes persons eligible for the Medically Needy program as mandatory enrollees

(Chapter 2011-135, Laws of Florida), which requires the Agency to seek federal waiver authority to establish a single statewide provider service network to manage the program and requires additional changes described below. The provision of HB 7109 related to Medically Needy amends section 409.9122, F.S., as follows:

> *409.9122(20) Subject to federal approval, the agency shall contract with a single provider service network to function as a third-party administrator and managing entity for the Medically Needy program in all counties. The contractor shall provide care coordination and utilization management in order to achieve more cost-effective services for Medically Needy enrollees. To facilitate the care management functions of the provider service network, enrollment in the network shall be for a continuous 6-month period or until the end of the contract between the provider service network and the agency, whichever is sooner. Beginning the second month after the determination of eligibility, the contractor may collect a monthly premium from each Medically Needy recipient provided the premium does not exceed the enrollee's share of cost as determined by the Department of Children and Family Services. The contractor must provide a 90-day grace period before disenrolling a Medically Needy recipient for failure to pay premiums. The contractor may earn an administrative fee, if the fee is less than any savings determined by the reconciliation process pursuant to s. 409.912(4)(d)1. Premium revenue collected from the recipients shall be deducted from the contractor's earned savings. This subsection expires October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner.*

Separately, provisions of House Bill 7107 require that individuals now in the Medically Needy program will transition to managed care plans concurrent with implementation of the Statewide Medicaid Managed Care program (per Part IV, Chapter 409, Florida Statutes), beginning with procurement of providers in January 2013 and full implementation by October 2014. Please see Appendix A of this document for statutory language pertaining to each program.

IV. STATE PLAN

The Medicaid State Plan currently includes Medically Needy as an optional coverage group. The program provides medical assistance to persons *who otherwise qualify for Medicaid*, except

---

in managed care plans, subject to federal approval. HB 7107 requires the statewide managed medical assistance program to be fully implemented by October 1, 2014. This demonstration request relates only to HB 7109, which includes provisions for Medicaid coverage for the Medically Needy population in the interim until implementation of HB 7107 by October 1, 2014.

that their income or assets exceed specific limits. Members of families that meet categorical requirements and those individuals who are children, disabled, pregnant, or are a parent or caretaker of a Medicaid recipient may become Medicaid eligible upon incurring medical expenses equal to or greater than their share of cost amounts. Table II below provides a summary of the eligibility groups currently covered and the respective State Plan coverage criteria for income. As previously noted, the State is not seeking to change the initial eligibility criteria.

TABLE II

<table>
<tr><th>Basis of Eligibility</th><th>Income Level for Medicaid State Plan Groups*</th><th>Medically Needy**</th></tr>
<tr><td>TANF (adults with dependent children)</td><td>19% FPL (based on family size)</td><td>Over 19% FPL</td></tr>
<tr><td>Children under 1</td><td>200% FPL(based on family size)</td><td rowspan="3">over 200% FPL
(Above Medicaid State Plan Limits, up to 200% FPL eligible for KidCare)</td></tr>
<tr><td>Children age 1up to age 6</td><td>133% FPL (based on family size)</td></tr>
<tr><td>Children age 6 -19</td><td>100% of FPL (based on family size)</td></tr>
<tr><td rowspan="2">Aged, Blind and Disabled</td><td rowspan="2">75% of FPL for individual; 82% for couple ($674; $1011)</td><td>Above 75% of FPL for individual</td></tr>
<tr><td>Above 82% of FPL for couple</td></tr>
</table>

*Expressed as % of Federal Poverty Level

******There are persons who have incomes less than the categorical income limits who are Medically Needy. For example, an aged, blind or disabled individual who has Medicare and who is not SSI eligible can be Medically Needy with a zero share of cost. Other examples include TANF families with assets between the TANF asset limit of $2,000 and the higher Medically Needy asset limit based on family size.

V. CURRENT PROGRAM AND RECIPIENT PROFILE

Based on February 2011 estimates from the State's Social Services Estimating Conference, the average Medically Needy caseload for State fiscal year 2010-2011 was 40,622 individuals monthly. Tables III and IV below detail average income, share of cost, number of Medically Needy Assistance Groups (families) and the number of individuals covered for (a) the Aged, Blind and Disabled categories, and (b) TANF-related categories. The charts provide information about currently eligible persons based on discrete income bands to explain the distribution of currently eligible persons in the Medically Needy program.

On Tables III and Table IV, the difference between the average gross income and the average share of cost would include the Medically Needy Income Limit (MNIL), plus any disregard of income that is applicable. The Federal Poverty Level is based on the total number of people in the household, whereas the number of assistance groups and the number of Medically Needy persons is based only on the eligible recipients who are in the Medically Needy program. For example, a family of four might include one Medically Needy adult, one Medically Needy child

and two children who are categorically eligible for Medicaid. This would count as *one* Assistance Group; include *two* Medically Needy persons; and the income would be a percentage of the Federal Poverty Level for household size of *four*.

TABLE III

Medically Needy - Aged, Blind and Disabled				
January 2011				
Federal Poverty Level	**Average Gross Income**	**Average Share of Cost**	**Number of Assistance Groups**	**Number of Medically Needy Persons**
Under 25%	$24	$2	2,679	2,815
25% to 50%	$347	$103	197	209
50% to 75%	$603	$384	143	150
75% to 100%	$865	$655	1,242	1,282
100% to 125%	$1,059	$847	1,782	1,845
125% to 150%	$1,308	$1,080	1,095	1,139
150% to 175%	$1,590	$1,320	641	670
175% to 200%	$1,920	$1,526	328	348
200% to 225%	$2,191	$1,764	194	203
225% to 250%	$2,497	$1,927	133	139
250% to 275%	$2,831	$2,111	75	79
275% to 300%	$3,218	$2,173	49	52
300% to 400%	$3,652	$2,564	77	80
Over 400%	$5,276	$3,673	22	24
Total	$899	$702	8,657	9,035

TABLE IV

Medically Needy - Family Related Eligibility Groups January 2011				
Federal Poverty Level	**Average Gross Income**	**Average Share of Cost**	**Number of Assistance Groups (month)**	**Number of Medically Needy Persons (month)**
Under 25%	$113	$22	6,441	7,897
25% to 50%	$650	$141	5,559	6,910
50% to 75%	$1,062	$281	5,680	8,018
75% to 100%	$1,423	$460	4,364	6,061
100% to 125%	$1,787	$1,081	2,480	3,542
125% to 150%	$2,128	$1,650	1,272	1,866
150% to 175%	$2,566	$2,083	686	1,024
175% to 200%	$2,901	$2,414	385	580
200% to 225%	$3,370	$2,872	229	345
225% to 250%	$3,616	$3,110	115	162
250% to 275%	$3,984	$3,482	104	147
275% to 300%	$4,866	$4,348	47	74
300% to 400%	$5,362	$4,843	65	93
Over 400%	$7,594	$7,104	25	37
Total	$1,055	$501	27,452	36,756

Analysis of eligibility patterns show that approximately half of the individuals eligible across a twelve-month period meet the eligibility threshold only for one month, while approximately 10 percent of individuals become eligible for six or more months across a twelve-month period.[3] Based on historical expenditure data, the greatest expense category for these individuals is inpatient and outpatient hospital services. The chart below summarizes utilization by service category for all claims for Medically Needy eligible persons for State fiscal year 2010-2011.

Claims by Service Category, State Fiscal Year 2010-2011

Hospital Services (all)	$433,430,249.13
Pharmacy Services	$107,911,709.92
Physician Services	$89,954,902.83
All Other Services	$631,296,861.88

[3] See Appendix B for details. In a three-year sample, from State fiscal year 2008-2009 through 2010-2011, 48.95% of individuals who became eligible were Medically Needy eligible for only one month in a given twelve month period; during the 12 months of State fiscal year 2009-2010, 55.61% of those who became eligible were Medically Needy eligible for only one month.

Please see Appendix B for additional historical detail on recipient months of eligibility in the current Medically Needy program.

Unintended results of the current program include:

1. Incentive exists for potential eligibles to incur a high bill in order to become eligible for Medicaid benefits for a month.
2. Accessing services in the most expensive setting, hospital emergency room, is a common way for Medically Needy individuals to incur a large expense and qualify for Medicaid eligibility.
3. Recipients must prove that their incurred expenses meet the share of cost criteria each month. This places a great administrative workload on the recipient, service providers, and the State. Further, providers are discouraged from serving this population because they must wait for eligibility to be entered to the Medicaid claims system each month or risk not receiving reimbursement for their services.

As a result of the inherent inefficiencies that impact recipients and providers, the State seeks to simplify the enrollment and eligibility determination process for recipients, providers, and DCF by addressing these limitations of the current program through creation of an interim premium-based program that provides an opportunity for more continuous coverage and thus enhanced access to services for Florida's Medically Needy population.

Although all individuals who are eligible through the Medically Needy category will be assigned to managed care by October 1, 2014[4], in the interim the State could lower costs by providing care coordination in an integrated health care system through this demonstration.

VI. FLORIDA MEDICALLY NEEDY DEMONSTRATION WAIVER PROPOSAL

As described in the background above, Medicaid applicants who are otherwise eligible for Medicaid, but who do not qualify specifically because their respective incomes exceed the standard level for eligibility cannot receive services reimbursed by Medicaid until share of cost is met and they become eligible. The State seeks to continue to serve this population and reduce costs by (a) removing incentives for individuals to incur inflated medical costs in order to qualify for eligibility; (b) extending eligibility to six month periods rather than recertifying recipients each month; and (c) providing coordinated and appropriate use of medically necessary services reimbursed by Medicaid for this population.

[4] See Appendix C for provisions of HB 7107. Note: This demonstration concept paper concerns only provisions of HB 7109 for the interim period until implementation of HB 7107 requirements on October 1, 2014.

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

A. Specific Objectives of the proposed demonstration:

1. Provide incentives to providers and recipients for efficient utilization of services. By providing for the ability of continuous eligibility and requiring recipient cost sharing through a premium arrangement not to exceed the current share of cost amount, it is expected that individuals will have access to lower cost and more appropriate care.
2. Require eligibility determination only once each six months rather than meeting share of cost monthly. This will remove a significant paperwork burden from beneficiaries and their service providers, as they currently must submit proof of incurred bills each month.
3. Providing for eligible PSN enrollees to have a three-month grace period before they can be disenrolled from the network for non-payment of their premiums, to ensure coordination of care and resulting continued control of costs to the State.
4. Coordination of administration of the program and utilization management through a single statewide provider service network (PSN) that acts as an administrator of the program. Cost savings may be shared with this contractor pursuant to the State's existing statutory reconciliation process to provide an incentive for active care management.[5]
5. Providers would be assured that recipients are eligible for up to a six month period, without loss of coverage for several days each month until share of cost is once again met, and eligibility is determined by DCF and entered into the Medicaid claims system.

---

[5] For statutory requirements of the PSN reconciliation process, see section 409.912(4)(d) 1., Florida Statutes.

(The Agency may contract with) "A provider service network, which may be reimbursed on a fee-for-service or prepaid basis. Prepaid provider service networks shall receive per-member, per-month payments. A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final."

6. Recipients have access to care coordination, and the incentive is removed for the emergency room to be the first choice of setting for medical care in order to qualify for eligibility.

B. Provisions Proposed to be Waived

In order to meet the objectives of the Medically Needy demonstration program, waiver of the following sections of the Social Security Act is requested in accordance with section 1115 of the Social Security Act.

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

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

C. Operation of the Demonstration

1. Initial Eligibility through Medically Needy Program

   Under this proposed demonstration, the criteria for initial eligibility would not change from the current State Plan criteria. Subsequent to the initial month, persons who become eligible through the Medically Needy program would receive additional months of continuous eligibility for up to six months, regardless of whether their incurred bills exceeded the share of cost amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full six additional months of coverage; however enrollees would receive a grace period of ninety days of coverage before being disenrolled for non-payment.

2. Single Statewide Provider Service Network

   In accordance with the new provisions of Florida law, the waiver demonstration would establish a single provider service network (PSN) to function as a third party administrator and managing entity for the Medically Needy program in all counties. Beginning in the calendar month after eligibility is actually determined by the State under the existing eligibility requirements for Medically Needy coverage, enrollment in the network shall be for up to a continuous six month period. In many cases,

eligibility is determined several months after the month in which qualifying criteria were met. PSN enrollment would be effective the first day of the month after the actual determination. For example, if expenses incurred in January exceeded the share of cost, but such eligibility is not known to the State until March, enrollment in the PSN would begin in April. The State will use the appropriate procurement process to contract with the PSN that will function as the third party administrator.

3. Enrollee Premiums

Beginning the second month of enrollment in the PSN, the PSN may collect a monthly premium from each recipient, provided the premium does not exceed the enrollee's share of cost (SOC). The risk-based per-member per-month (PMPM) cost amounts proposed have been actuarially determined based on Medicaid claims data. Enrollees would pay a monthly amount equal to the lesser of their SOC or the risk-based premium amount. Please see the Section VII of this document titled "Premium Design" for a detailed presentation of the proposed premium structure. The PSN must provide a 90 day grace period before disenrolling a Medically Needy recipient for failure to pay premiums. If any premium is paid by the enrollee, the 90 day grace period begins anew. Following the grace period, the PSN must coordinate with DCF to meet all requirements regarding termination of Medicaid benefits to enrollees who are disenrolled.

The six month enrollment period in the PSN is prospective. In the event that DCF determines eligibility after the fact for a span in months past, the first month *after* the month in which the State (DCF) determines that eligibility criteria were met in some prior month, would be the first month of the continuous eligibility period and the PSN could begin to invoice the enrollee for a premium the month after that. Enrollment in the Medically Needy PSN would be limited to individuals who first become eligible for Medicaid through incurring bills that would reduce their family income to the Medically Needy Income Limit under the current eligibility criteria. If an individual is subsequently determined ineligible (for example, due to change in living arrangement or increase in assets), the PSN enrollment would terminate as well, subject to existing client notice requirements and procedures.

Please see section VII. of this document for examples of how enrollment and premium payment would work.

4. Reconciliation of Costs

The statewide PSN would be responsible for:

a. Collection of enrollee premiums; as well as for

b. Results of the reconciliation process pursuant to s. 409.912(4)(d)1, Florida Statutes.

Providers would submit claims for enrollees' services to the PSN or its Third Party Administrator (TPA). The TPA would submit approved claims to the Agency through the standard electronic claims process, and the Agency would remit payment directly to the service providers.

Consistent with current practice in the State Medicaid program, a FFS PSN may be paid a monthly per capita administrative fee for enrollees, according to the reconciliation process described in s.409.912(4)(d)1, F.S. After reconciliation of actual expenditures to the benchmark, this contractor would share with the State any savings from managing costs below the PCCB. The PSN would be responsible for aggregate medical expenditures reimbursed by the State in excess of the Per Capita Capitation Benchmark (PCCB).

Please see Appendix D for detailed information on the development of the risk-based PCCB in the table titled "Florida Medically Needy Waiver Program Cost Benchmark PSN".

D. Anticipated Results of the Demonstration

The anticipated results of the demonstration include:

1. Increased continuity and coordination of care in the most efficient setting in an integrated service delivery system of health care.
2. Reduced utilization of emergency room care.
3. Decreased utilization of inpatient hospital treatment.
4. Significantly decreased per member per month cost for Medically Needy recipients, who would have access to ongoing coverage rather that high-cost episodic care in more expensive settings.

E. Impact to Beneficiaries

The proposed demonstration would increase access to an integrated health care system for the Medically Needy population. Further, it would simplify the eligibility process for individuals and introduce cost sharing in the form of a monthly premium scaled to income that would not exceed the family's share of cost.

For a comparison of key points of the current Medically Needy program and the proposed demonstration, please see the table in Appendix C.

F. Impact to Providers

Service providers would be ensured that these individuals have Medicaid eligibility for six months at a time without a break in coverage each month; under the current policy, the individual must again incur bills to meet their share of cost before regaining eligibility in a subsequent month. Use of the emergency room and acute care services is expected to decrease when this population has access to care coordination in an integrated health care system.

VII. PREMIUM DESIGN

Under this proposed demonstration, the criteria for initial eligibility would not change from the current State Plan criteria. Subsequent to the initial month, persons who become eligible through the Medically Needy program would receive additional months of continuous eligibility for up to six months, regardless of whether their incurred bills exceeded the share of cost amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full six additional months of coverage; however enrollees would receive a grace period of ninety days of coverage before being disenrolled for non-payment. Item Number 1 below outlines some examples of how the premiums would be assessed. The standard termination and hearing rights procedures would apply, as noted in Number 2 below.

1. Medically Needy PSN Enrollment and Disenrollment Examples

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

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

DCF notifies the statewide Medically Needy Provider Service Network (PSN) to enroll her in the PSN beginning in May, and the benchmark payment amount for the family coverage is $262 (for one adult). She is not assessed a premium for May. May is the first month of a sixth month enrollment period. In May, she will

be advised that she is responsible for paying a premium of $163 per month (her SOC amount) for June and for each subsequent month to the PSN. If she pays the premium, she will receive continuous eligibility through October. If she fails to pay her premium for June, she will receive a notice that she has a 90 day grace period and will be disenrolled on August 31. If she pays the premium for June but subsequently fails to pay the premiums due, she will be disenrolled after 90 days beginning with the month for which no premium payment is made.

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

Example #2 – The family situation and income is the same as in situation #1 except that the applicant applies in April but presents information indicating that qualifying medical expenses were incurred in some prior month.

The DCF eligibility worker determines that she met all eligibility standards in March and that her incurred medical expenses exceeded her SOC as of March 12. In this situation, she would be determined retroactively eligible for the Medicaid fee-for-service program for the period from March 12 through March 31. She would be enrolled in the PSN beginning in May and would begin paying a premium for June. Her six-month continuous eligibility period would begin with May, because it is the first month after her eligibility was determined. If she did not incur medical expenses sufficient to meet her SOC in April, she would not be eligible for any benefits in April, but would begin eligibility in May.

Example #3 – Situation – This is a four person family with net countable income of $3,097. The family consists of one adult and three children, none of whom are eligible for Medicaid except through the Medically Needy program. Their Medically Needy Income Limit is $364 and their SOC is $2,733. In this case, the benchmark payment amount for the family is $679 ($262 for the adult plus $139 for each child), which is less than the SOC amount.

The mother in the family applies for Medicaid in April and presents information showing that she incurred medical expenses that exceeded her SOC as of April 5. The family is determined eligible for April in the Medicaid fee-for-service program, and all are enrolled in the PSN in May. The benchmark payment amount for family coverage is $679. She is advised that the family premium will be $679 per month for June and each subsequent month through October. If no premiums are paid, the family will be disenrolled from the PSN at the end of August.

The PSN would receive the $679 payment from the State for May and would be responsible for collecting the premium of this same amount from the family in the subsequent months.

Example #4 – Situation – A disabled man has who is not categorically eligible for SSI has unearned income of $1,048 of which $1,028 is his net countable income. His Medically Needy Income Limit is $180 and his SOC is $848. The benchmark cost for his coverage is $1,803.

In April he incurs medical expenses and as of April 15, the incurred medical expenses exceed his $848 SOC and he is determined eligible under the Medically Needy fee-for-service Medicaid program beginning on April 15. In May, he is enrolled in the PSN and has no premium assessed for May. In May he is advised that his premium for June is $848 (his SOC), and that amount will be due monthly. If he pays his premium, he will receive continuous PSN enrollment through October. If he fails to pay the premium for June, he will be advised that he will be disenrolled at the end of August.

For May, the PSN would be paid the benchmark payment of $1,803 by the State. For June and subsequent months, the PSN would be paid $955 by the state. This is the benchmark amount minus the premium assessed to the recipient of $848 based on his SOC.

2. Procedure for Termination of Medicaid Benefits

Regardless of when individuals are disenrolled from the PSN, DCF must follow the ex parte procedures for termination of Medicaid coverage. Upon notification of disenrollment from the PSN, DCF will begin the termination procedure. If notice of termination and hearing rights can be given ten or more days prior to the end of a month, Medicaid benefits will end at the end of that month. If notice is given fewer than 10 days before the end of the month, Medicaid benefits will terminate at the end of the following month. In all cases, the State will fully comply with federal requirement related to advance notice of adverse action prior to any termination of benefits.

If recipients request a fair hearing to challenge termination, benefits will continue until the disposition of the hearing, but in no case would Medicaid benefits continue past the end of the original six-month period beginning with the first month of enrollment in the PSN.

VIII. BUDGET NEUTRALITY

This Medically Needy demonstration would increase the number of member months of eligibility by 117 percent, with an estimated 704,701 new member months of coverage in the first full year of implementation. The total incremental cost for these additional months is estimated to be $81,669,558.54 for the first full year of the demonstration. Under the proposed demonstration project, since the statewide PSN is at risk for the full premium amount, Medicaid expenditures for services would be reduced by that amount, regardless of whether the PSN is able to collect the premiums from enrollees. The PSN is also at risk for expenditures that exceed the aggregate PCCB benchmark amount for all months except the first month of enrollment in the PSN. The State would be at risk only for the first month's benchmark amount, plus any amount that the aggregate program benchmark exceeds the total of all enrollee premiums assessed for subsequent months of PSN enrollment.

Enrollment in the PSN is mandatory, however it is unknown how many will actually pay their premiums. Enrollees could be covered by the PSN for up to four months without paying any premium, since they receive a 90 day grace period prior to disenrollment, and they are not billed for a premium until the second month of enrollment. Budget estimates were prepared for a range between two possible scenarios which represent the lower and higher estimates within the likely range of actual payment by recipients. Scenario 1 represents the impact if no enrollees paid any premium. Scenario 2 represents the impact if only those with the lowest SOC/premiums paid premiums.

Since the premium amount is the lesser of the recipient's full share of cost amount or the appropriate PCCB benchmark, the PSN bears a significant risk in the event of non-collection of the premiums. Please see Appendix D for detailed estimates of the impact of the two enrollment and premium payment scenarios.

This Medically Needy project is proposed as an amendment to the Florida MEDS AD section 1115 Demonstration (Project No. 11-W-00205/4), and any related expenditures will not, in the aggregate, exceed the budget neutrality ceiling currently in place for the project. Budget neutrality templates are included for Scenarios 1 and 2 described above in Appendix D.

IX. EVALUATION PLAN

Evaluation Design

The State will work with its contracted evaluation vendor, and anticipates that the evaluation of the demonstration would include these measures:

- Comparison of recipients' perception of access to care
- Utilization patterns, specifically whether more cost effective setting is used when recipients have access to an integrated network through continuous eligibility
- Per-member per-month cost for this group in an integrated health care system compared to the current cost which includes high utilization of hospital services
- Provider acceptance of the continuous coverage model

The State will provide a detailed evaluation plan within 120 days after approval of the proposed demonstration project.

APPENDIX A

As noted, this demonstration proposal concerns only the requirements of HB 7109; the information below is noted only for reference and context. The provisions below will be addressed within the Statewide Medicaid Managed Care authority through the pending Florida Medicaid Reform Section 1115 Demonstration, Number 11-W-00206/4 when approved by CMS.

The provisions of HB 7107 added the following language to section 409.972, F.S., to be implemented by October 1, 2014:

> 409.972 Mandatory and voluntary enrollment.—
>
> *(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2)(a) shall enroll in managed care plans. Medically needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.*

HB 7107 also added section 409.975, F.S., which states in part:

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

APPENDIX B

Analysis of Medically Needy Eligible Persons by Number of Months of Eligibility in a 12 Month and Three Year Period

State Fiscal Year 2009 - 2010

Num of months	Count	Percent
1	144,396	55.61%
2	46,859	18.05%
3	21,430	8.25%
4	12,796	4.93%
5	8,738	3.37%
6	6,447	2.48%
7	4,181	1.61%
8	3,300	1.27%
9	2,673	1.03%
10	2,290	0.88%
11	2,197	0.85%
12	4,361	1.68%
	259,668	100.00%

Three Years FY0809 thru FY1011

Num of months	Count	Percent	Cumulative
1	267,421	48.95%	48.95%
2	98,298	17.99%	66.94%
3	49,179	9.00%	75.94%
4	30,050	5.50%	81.44%
5	21,579	3.95%	85.39%
6	17,066	3.12%	88.51%
7	11,958	2.19%	90.70%
8	8,415	1.54%	92.24%
9	6,527	1.19%	93.43%
10	5,381	0.98%	94.42%
11	4,774	0.87%	95.29%
12	4,479	0.82%	96.11%
13	3,755	0.69%	96.80%
14	2,622	0.48%	97.28%
15	1,997	0.37%	97.65%
16	1,672	0.31%	97.95%
17	1,414	0.26%	98.21%
18	1,215	0.22%	98.43%
19	1,046	0.19%	98.62%
20	884	0.16%	98.79%
21	812	0.15%	98.93%
22	708	0.13%	99.06%
23	604	0.11%	99.17%
24	584	0.11%	99.28%
25	441	0.08%	99.36%
26	368	0.07%	99.43%
27	332	0.06%	99.49%
28	293	0.05%	99.54%
29	310	0.06%	99.60%
30	262	0.05%	99.65%
31	227	0.04%	99.69%
32	246	0.05%	99.73%
33	276	0.05%	99.79%
34	256	0.05%	99.83%
35	323	0.06%	99.89%
36	593	0.11%	100.00%
	546,367	100.00%	

APPENDIX C
Recipient Impact of Proposed Waiver Demonstration Compared to Current Program

The following table summarizes the current Medically Needy program and compares the current program to the proposed waiver demonstration program.

Description	Current Program	Proposed Waiver
Groups Covered	• Pregnant women • Children up to age 18 (21 if living with parent/caretaker relative) • Parent/caretaker relatives of dependent children living with them • Aged • Blind • Disabled	Same
Eligibility period	From the date the share of cost is met through the end of that month only.	First month of eligibility same as current program, then beginning the first day of the month after the state determines that share of cost criteria are met, recipient is enrolled in the PSN for up to six full months.
Budget period for share of cost	One month	Same. (Then continuous eligibility and premium for up to six months without having to certify SOC monthly.)
Share of cost (SOC)	Countable monthly income for family or individual minus the Medically Needy Income Limit	Same
Actual cost sharing paid by recipient	Cost of services is paid by Medicaid once recipient is determined eligible for that month. Recipient is responsible for costs incurred prior to meeting the share of cost.	Premium amount, not to exceed SOC**.**
Tracking of incurred bills to determine eligibility	Each month, persons must provide bills showing costs incurred. These amounts are entered into the eligibility determination system. If share of cost is met, eligibility is authorized from that date only through the end of that month.	Following enrollment, the PSN will invoice and track premium payment and coordinate with DCF regarding PSN enrollment spans.
Premium	None	Monthly premium not to exceed the share of cost. Premiums are actuarially determined based on available Medicaid claims data.

APPENDIX D

This Appendix contains the following documents produced by Mercer Government Human Services Consulting actuaries.

1. **Member Month Increase for Medically Needy Waiver Program Enrollment**
   This chart details case months for the existing Medically Needy program and an estimate of the number of additional case months under the demonstration. Subtotals are provided for adults and for children with TANF eligibility, and for dually eligible and non-dually eligible with SSI eligibility.

2. **Florida Medically Needy Waiver Program Cost Benchmark for PSN**
   This chart details the projected increased costs for the additional months, and includes administrative allowance and other factors customarily considered in developing a PSN cost benchmark.

3. **Budget Impact to the State Between:**
   Scenario 1: No Enrollees Pay Premiums
   Scenario 2: Only Lowest SOC Band Eligibles Pay Premiums

4. **Budget Neutrality Templates for Each Scenario**

Florida Medically Needy Waiver Program Enrollment Projection

COA	RC			200907	200908	200909	200910	200911	200912	201001	201002	201003	201004	201005	201006	SFY10
MN_SSI	Dual	A	Eligible for New program	4,739	6,492	8,055	9,746	11,311	12,787	9,641	9,282	9,125	10,751	11,027	11,458	114,424
		B	Eligible for New Program and other Medicaid programs	1,568	2,597	3,534	4,477	5,337	6,157	5,104	5,001	4,939	5,219	5,367	5,511	54,811
		C = A-B	Net Enrolled in New Program	3,171	3,895	4,531	5,269	5,974	6,630	4,537	4,281	4,186	5,532	5,660	5,947	59,613
		D	Not yet Enrolled but covered under old rules	2,427	2,281	2,229	2,288	2,034	2,061	3,903	3,932	4,133	2,873	2,815	2,830	33,806
		E = C+D	Total Medically Needy	5,598	6,176	6,760	7,557	8,008	8,691	8,440	8,213	8,319	8,405	8,475	8,777	93,419
		F	If No Change	4,718	4,712	4,782	4,918	4,767	4,893	5,237	5,155	5,336	5,309	5,251	5,352	60,430
		G = E-F	Net Increase	880	1,464	1,978	2,639	3,241	3,798	3,203	3,058	2,983	3,096	3,224	3,425	32,989
		H=C-G	Existing and Enrolled	2,291	2,431	2,553	2,630	2,733	2,832	1,334	1,223	1,203	2,436	2,436	2,522	26,624
MN_SSI	Non-Dual	A	Eligible for New program	3,436	4,773	5,944	7,053	8,043	9,112	6,782	6,429	6,217	7,178	7,667	8,221	80,855
		B	Eligible for New Program and other Medicaid programs	385	618	876	1,142	1,368	1,616	1,088	944	907	1,057	1,180	1,381	12,562
		C = A-B	Net Enrolled in New Program	3,051	4,155	5,068	5,911	6,675	7,496	5,694	5,485	5,310	6,121	6,487	6,840	68,293
		D	Not yet Enrolled but covered under old rules	2,149	1,829	1,840	1,916	1,823	1,820	2,825	3,000	3,440	2,877	2,828	2,615	28,962
		E = C+D	Total Medically Needy	5,200	5,984	6,908	7,827	8,498	9,316	8,519	8,485	8,750	8,998	9,315	9,455	97,255
		F	If No Change	3,954	3,929	4,157	4,387	4,347	4,506	4,873	4,726	5,138	5,195	5,268	5,128	55,408
		G = E-F	Net Increase	1,246	2,055	2,751	3,440	4,151	4,810	3,646	3,759	3,612	3,803	4,047	4,327	41,847
		H=C-G	Existing and Enrolled	1,805	2,100	2,317	2,471	2,524	2,686	1,846	1,726	1,698	2,318	2,440	2,513	26,446
MN_TANF	Adult	A	Eligible for New program	25,967	39,662	51,564	64,105	76,497	88,721	75,028	72,002	70,439	74,397	74,976	77,633	790,991
		B	Eligible for New Program and other Medicaid programs	3,333	5,749	8,178	10,666	13,200	15,808	12,377	11,558	11,480	11,907	12,214	12,712	129,182
		C = A-B	Net Enrolled in New Program	22,634	33,913	43,386	53,439	63,297	72,913	62,651	60,444	58,959	62,490	62,762	64,921	661,809
		D	Not yet Enrolled but covered under old rules	19,622	18,902	18,730	18,710	16,801	16,029	21,843	22,392	25,708	22,822	23,055	22,440	247,054
		E = C+D	Total Medically Needy	42,256	52,815	62,116	72,149	80,098	88,942	84,494	82,836	84,667	85,312	85,817	87,361	908,863
		F	If No Change	30,092	31,395	32,617	33,921	32,412	32,700	33,728	33,408	36,846	36,722	37,632	37,657	409,130
		G = E-F	Net Increase	12,164	21,420	29,499	38,228	47,686	56,242	50,766	49,428	47,821	48,590	48,185	49,704	499,733
		H=C-G	Existing and Enrolled	10,470	12,493	13,887	15,211	15,611	16,671	11,885	11,016	11,138	13,900	14,577	15,217	162,076
MN_TANF	Children	A	Eligible for New program	4,836	8,119	10,945	13,922	17,067	20,679	19,426	19,205	19,474	20,270	20,366	20,568	194,877
		B	Eligible for New Program and other Medicaid programs	866	1,605	2,324	3,206	4,003	4,881	4,424	4,326	4,485	4,628	4,680	4,725	44,153
		C = A-B	Net Enrolled in New Program	3,970	6,514	8,621	10,716	13,064	15,798	15,002	14,879	14,989	15,642	15,686	15,843	150,724
		D	Not yet Enrolled but covered under old rules	4,047	4,158	4,680	4,720	4,170	4,091	4,774	4,686	5,296	4,950	5,150	4,931	55,553
		E = C+D	Total Medically Needy	8,017	10,672	13,301	15,436	17,234	19,889	19,776	19,565	20,285	20,592	20,836	20,774	206,377
		F	If No Change	5,269	5,578	6,270	6,494	5,983	6,162	6,418	6,311	6,977	6,834	7,109	6,842	76,245
		G = E-F	Net Increase	2,748	5,096	7,031	8,942	11,251	13,727	13,358	13,254	13,308	13,758	13,727	13,932	130,132
		H=C-G	Existing and Enrolled	1,222	1,418	1,590	1,774	1,813	2,071	1,644	1,625	1,681	1,884	1,959	1,911	20,592
All	All	A	Eligible for New program	38,978	59,046	76,518	94,826	112,918	131,299	110,877	106,918	105,255	112,596	114,036	117,880	1,181,147
		B	Eligible for New Program and other Medicaid programs	6,152	10,569	14,912	19,491	23,908	28,462	22,993	21,829	21,811	22,611	23,441	24,329	240,708
		C = A-B	Net Enrolled in New Program	32,826	48,477	61,606	75,335	89,010	102,837	87,884	85,089	83,444	89,785	90,595	93,551	940,439
		D	Not yet Enrolled but covered under old rules	28,245	27,170	27,479	27,634	24,828	24,001	33,345	34,010	38,577	33,522	33,848	32,816	365,475
		E = C+D	Total Medically Needy	61,071	75,647	89,085	102,969	113,838	126,838	121,229	119,099	122,021	123,307	124,443	126,367	1,305,914
		F	If No Change	44,033	45,612	47,826	49,720	47,509	48,261	50,056	49,600	54,297	54,080	55,260	54,979	601,213
		G = E-F	Net Increase	17,038	30,035	41,259	53,249	66,329	78,577	71,173	69,499	67,724	69,247	69,183	71,388	704,701
		H=C-G	Existing and Enrolled	15,788	18,442	20,347	22,086	22,681	24,260	16,711	15,590	15,720	20,538	21,412	22,163	235,738

Florida Medically Needy Waiver Program Cost Benchmark_PSN										
COA		MN_SSI				MN_TANF				All
Rate Cell		Dual		Non-Dual		Adult		Children		All
Enrollment		Existing Medically Needy Months	New Medically Needy Months	Existing Medically Needy Months	New Medically Needy Months	Existing Medically Needy Months	New Medically Needy Months	Existing Medically Needy Months	New Medically Needy Months	All
Base Population Used		Historical Medically Needy member months not eligible for other categories	Historical Medically Needy member months eligible for other categories	Historical Medically Needy member months not eligible for other categories	Historical Medically Needy member months eligible for other categories	Historical Medically Needy member months not eligible for other categories	Historical Medically Needy member months eligible for other categories	Historical Medically Needy member months not eligible for other categories	Historical Medically Needy member months eligible for other categories	
Base PMPM net of SOC	A	$ 278.94	$ 177.46	$ 3,789.86	$ 2,106.49	$ 705.78	$ 363.99	$ 589.09	$ 199.19	
Completion factor - IBNR	B	1.0346	1.0269	1.0301	1.0344	1.0173	1.0153	1.0235	1.0174	
Completed Historical PMPM	C=A*B	$ 288.60	$ 182.24	$ 3,904.01	$ 2,178.99	$ 717.97	$ 369.54	$ 602.91	$ 202.66	
Adjustment to Add Back SOC	D	1.0500	1.0000	1.0500	1.0000	1.0500	1.0000	1.0500	1.0000	
Gross Historcal PMPM before SOC	E=C*D	$ 303.03	$ 182.24	$ 4,099.21	$ 2,178.99	$ 753.87	$ 369.54	$ 633.05	$ 202.66	
Adjustment for "clumping"	F	0.8200	1.0000	0.8800	1.0000	0.9200	1.0000	0.9500	1.0000	
Adjusted Gross	G=E*F	$ 248.48	$ 182.24	$ 3,607.30	$ 2,178.99	$ 693.56	$ 369.54	$ 601.40	$ 202.66	
Adjustment for Effect of SOC	H	1.0000	0.3600	1.0000	0.2200	1.0000	0.2600	1.0000	0.2600	
Adjusted Gross	I=G*H	$ 248.48	$ 65.61	$ 3,607.30	$ 479.38	$ 693.56	$ 96.08	$ 601.40	$ 52.69	
Trend factor										
Annualized	J	1.0193	1.0305	1.0043	1.0050	1.0079	1.0133	1.0060	1.0183	
For Period (48 months)	K=J^4.0	1.0793	1.1276	1.0173	1.0202	1.0320	1.0541	1.0242	1.0754	
Trended Gross PMPM	L=I*K	$ 268.19	$ 73.98	$ 3,669.82	$ 489.07	$ 715.75	$ 101.28	$ 615.94	$ 56.66	
Managed care Factor	M	0.9850	0.9850	0.9850	0.9850	0.9800	0.9800	0.9800	0.9800	
Adusted for Managed care	N=L*M	$ 264.16	$ 72.87	$ 3,614.78	$ 481.73	$ 701.44	$ 99.25	$ 603.62	$ 55.53	
Administrative Adjustment as percentage of total benchmark	O	6%	6%	6%	6%	6%	6%	6%	6%	
Adjsuted PMPM including Administration	P=N/(1-O)	$ 281.02	$ 77.52	$ 3,845.51	$ 512.48	$ 746.21	$ 105.59	$ 642.15	$ 59.08	
Projected Member Months	Q	26,624	32,989	26,446	41,847	162,076	499,733	20,592	130,132	940,439
Projected CY 2013 PMPM for all Months in category	R=P weighted by Q		$ 168.41		$ 1,803.17		$ 262.47		$ 138.74	$ 348.56
Projected Member Months	S=Subtotal of Q		59,613		68,293		661,809		150,724	940,439
Annualized Cost	T=S*R		$ 10,039,234.74		$ 123,143,946.91		$ 173,707,576.14		$ 20,910,769.01	$ 327,801,526.80
Florida Medically Needy Waiver Program Projected Costs and Member Months										
Member Months	U=Q for Existing only		26,624		26,446		162,076		20,592	235,738
PMPM	V=C*K		$ 311.48		$ 3,971.67		$ 740.94		$ 617.48	$ 1,044.09
Projected Cost	W=U*V		$ 8,292,886.49		$ 105,034,820.37		$ 120,089,095.56		$ 12,715,165.84	$ 246,131,968.26
Projected cost increase	X=T-W		$ 1,746,348.26		$ 18,109,126.54		$ 53,618,480.57		$ 8,195,603.17	$ 81,669,558.54

											Scenario 2 - only those in the lowest SOC band pay premium						
COA	RC	Elig and Enrollment Type	Member Months	Gross PMPM Benchmark	Premium	Net PMPM	Total Cost Paid By State to PSN	Total Cost Paid By State Under FFS	Total Cost Paid By State		Member Months	Gross PMPM Benchmark	Premium	Net PMPM	Total Cost Paid By State to PSN	Total Cost Paid By State Under FFS	Total Cost Paid By State
SSI	Dual	Net Enrolled in New Program_PSN Month 1	13,262	$ 168.41	$ -	$ 168.41	$ 2,233,411.02	$ -	$ 2,233,411.02		13,262	$ 168.41	$ -	$ 168.41	$ 2,233,411.02	$ -	$ 2,233,411.02
		Net Enrolled in New Program_PSN Month 2-4	31,260	$ 168.41	$ 50.67	$ 117.74	$ 3,680,601.50	$ -	$ 3,680,601.50		31,260	$ 168.41	$ 50.67	$ 117.74	$ 3,680,601.50	$ -	$ 3,680,601.50
		Net Enrolled in New Program_FFS Month 5-6	15,091	$ 160.71	$ -	$ 160.71	$ -	$ 2,425,321.26	$ 2,425,321.26		4,484	$ 160.71	$ -	$ 160.71		$ 720,647.90	$ 720,647.90
		Net Enrolled in New Program_PSN Month 5-6									10,607	$ 168.41	$ 3.10	$ 165.31	$ 1,753,438.43	$ -	$ 1,753,438.43
		Net Enrolled in New Program_Month 1-6	59,613				$ 5,914,012.52	$ 2,425,321.26	$ 8,339,333.78		59,613				$ 7,667,450.95	$ 720,647.90	$ 8,388,098.85
		Not yet Enrolled but covered under old rules	33,806	$ 311.48	$ -	$ 311.48	$ -	$ 10,529,947.44	$ 10,529,947.44		33,806			$ 311.48	$ -	$ 10,529,947.44	$ 10,529,947.44
		Total Medically Needy	93,419				$ 5,914,012.52	$ 12,955,268.69	$ 18,869,281.22		93,419				$ 7,667,450.95	$ 11,250,595.33	$ 18,918,046.29
		If No Change	60,430	$ 311.48	$ -	$ 311.48	$ -	$ 18,822,833.92	$ 18,822,833.92		60,430			$ 311.48	$ -	$ 18,822,833.92	$ 18,822,833.92
		Net Increase	32,989						$ 46,447.30		32,989						$ 95,212.36
SSI	Non-Dual	Net Enrolled in New Program_PSN Month 1	15,249	$ 1,803.17	$ -	$ 1,803.17	$ 27,496,552.30	$ -	$ 27,496,552.30		15,249	$ 1,803.17	$ -	$ 1,803.17	$ 27,496,552.30	$ -	$ 27,496,552.30
		Net Enrolled in New Program_PSN Month 2-4	35,683	$ 1,803.17	$ 835.81	$ 967.36	$ 34,518,217.35	$ -	$ 34,518,217.35		35,683	$ 1,803.17	$ 835.81	$ 967.36	$ 34,518,217.35	$ -	$ 34,518,217.35
		Net Enrolled in New Program_FFS Month 5-6	17,361	$ 1,720.79	$ -	$ 1,720.79	$ -	$ 29,874,678.37	$ 29,874,678.37		15,372	$ 1,720.79	$ -	$ 1,720.79		$ 26,452,756.81	$ 26,452,756.81
		Net Enrolled in New Program_PSN Month 5-6									1,989	$ 1,803.17	$ 12.06	$ 1,791.11	$ 3,561,753.90	$ -	$ 3,561,753.90
		Net Enrolled in New Program_Month 1-6	68,293				$ 62,014,769.66	$ 29,874,678.37	$ 91,889,448.03		68,293				$ 65,576,523.56	$ 26,452,756.81	$ 92,029,280.37
		Not yet Enrolled but covered under old rules	28,962	$ 3,971.67	$ -	$ 3,971.67	$ -	$ 115,027,545.48	$ 115,027,545.48		28,962			$ 3,971.67	$ -	$ 115,027,545.48	$ 115,027,545.48
		Total Medically Needy	97,255				$ 62,014,769.66	$ 144,902,223.84	$ 206,916,993.50		97,255				$ 65,576,523.56	$ 141,480,302.29	$ 207,056,826.85
		If No Change	55,408	$ 3,971.67	$ -	$ 3,971.67	$ -	$ 220,062,365.85	$ 220,062,365.85		55,408			$ 3,971.67	$ -	$ 220,062,365.85	$ 220,062,365.85
		Net Increase	41,847						$ (13,145,372.35)		41,847						$ (13,005,540.01)
TANF	Adults and Children	Net Enrolled in New Program_PSN Month 1	181,189	$ 239.52	$ -	$ 239.52	$ 43,398,487.62	$ -	$ 43,398,487.62		181,189	$ 239.52	$ -	$ 239.52	$ 43,398,487.62	$ -	$ 43,398,487.62
		Net Enrolled in New Program_PSN Month 2-4	424,422	$ 239.52	$ 130.77	$ 108.76	$ 46,158,186.66	$ -	$ 46,158,186.66		424,422	$ 239.52	$ 130.77	$ 108.76	$ 46,158,186.66	$ -	$ 46,158,186.66
		Net Enrolled in New Program_FFS Month 5-6	206,922	$ 229.74	$ -	$ 229.74	$ -	$ 47,539,128.12	$ 47,539,128.12		125,296	$ 229.74	$ -	$ 229.74		$ 28,786,041.85	$ 28,786,041.85
		Net Enrolled in New Program_PSN Month 5-6									81,626	$ 239.52	$ 17.11	$ 222.41	$ 18,154,742.38	$ -	$ 18,154,742.38
		Net Enrolled in New Program_Month 1-6	812,533				$ 89,556,674.28	$ 47,539,128.12	$ 137,095,802.40		812,533				$ 107,711,416.66	$ 28,786,041.85	$ 136,497,458.51
		Not yet Enrolled but covered under old rules	302,707	$ 718.24	$ -	$ 718.24	$ -	$ 217,417,621.42	$ 217,417,621.42		302,707			$ 718.24	$ -	$ 217,417,621.42	$ 217,417,621.42
		Total Medically Needy	1,115,240				$ 89,556,674.28	$ 264,956,749.54	$ 354,513,423.81		1,115,240				$ 107,711,416.66	$ 246,203,663.27	$ 353,915,079.93
		If No Change	485,375	$ 721.55	$ -	$ 721.55	$ -	$ 350,221,882.82	$ 350,221,882.82		485,375			$ 721.55	$ -	$ 350,221,882.82	$ 350,221,882.82
		Net Increase	629,865						$ 4,291,540.98		629,865						$ 3,693,197.11
All	All	Net Enrolled in New Program_PSN Month 1	209,700				$ 73,128,450.94	$ -	$ 73,128,450.94		209,700				$ 73,128,450.94	$ -	$ 73,128,450.94
		Net Enrolled in New Program_PSN Month 2-4	491,365				$ 84,357,005.52	$ -	$ 84,357,005.52		491,365				$ 84,357,005.52	$ -	$ 84,357,005.52
		Net Enrolled in New Program_FFS Month 5-6	239,374				$ -	$ 79,839,127.75	$ 79,839,127.75		145,183				$ -	$ 55,959,446.57	$ 55,959,446.57
		Net Enrolled in New Program_PSN Month 5-6									94,221				$ 23,469,934.71	$ -	$ 23,469,934.71
		Net Enrolled in New Program_Month 1-6	940,439				$ 157,485,456.46	$ 79,839,127.75	$ 237,324,584.20		940,439				$ 180,955,391.17	$ 55,959,446.57	$ 236,914,837.73
		Not yet Enrolled but covered under old rules	365,475				$ -	$ 342,975,114.33	$ 342,975,114.33		365,475				$ -	$ 342,975,114.33	$ 342,975,114.33
		Total Medically Needy	1,305,914				$ 157,485,456.46	$ 422,814,242.08	$ 580,299,698.54		1,305,914				$ 180,955,391.17	$ 398,934,560.90	$ 579,889,952.06
		If No Change	601,213				$ -	$ 589,107,082.59	$ 589,107,082.59		601,213				$ -	$ 589,107,082.59	$ 589,107,082.59
		Net Increase	704,701						$ (8,807,384.06)		704,701						$ (9,217,130.53)

	Scenario 1: No Enrollees Pay Premium							
	Budget Neutrality - Template							
	Florida MEDS AD Demonstration							
	DEMO YEAR	**Quarter Ended**	**WW Expenditures**	**WW Expenditures Cumulative Total**	**WOW (Target) Expenditures**	**WOW Expend Total**	**Difference**	**Cumulative Difference**
Mar 06		Q1	51,696,950		507,710,894		456,013,944	
Jun 06		Q2	132,235,096		507,710,894		375,475,798	
Sep 06		Q3	105,271,113		507,710,894		402,439,781	
Dec 06	DY1	Q4	146,356,839	435,559,998	507,710,894	2,030,843,575	361,354,055	1,595,283,577
		Q5	69,927,763		460,700,626		390,772,863	
		Q6	79,047,475		460,700,626		381,653,151	
		Q7	87,567,517		460,700,626		373,133,109	
Dec 07	DY2	Q8	90,210,963	762,313,716	460,700,626	3,873,646,079	370,489,663	3,111,332,363
		Q9	93,882,619		455,999,599		362,116,980	
		Q10	103,108,178		455,999,599		352,891,421	
		Q11	95,761,142		455,999,599		360,238,457	
Dec 08	DY3	Q12	96,128,169	1,151,193,824	455,999,599	5,697,644,476	359,871,430	4,546,450,652
		Q13	107,727,900		465,401,653		357,673,753	
		Q14	106,365,677		465,401,653		359,035,976	
		Q15	120,849,499		465,401,653		344,552,154	
Dec 09	DY4	Q16	133,665,863	1,619,802,762	465,401,653	7,559,251,086	331,735,790	5,939,448,324
		Q17	138,153,082		460,700,626		322,547,544	
		Q18	144,229,555		460,700,626		316,471,071	
		Q19	134,966,909		460,700,626		325,733,717	
Dec 10	DY5	Q20	148,599,566	2,185,751,874	460,700,626	9,402,053,590	312,101,060	7,216,301,716
		Q21	154,004,876		-		-	
		Q22	146,340,361		-		-	
		Q23	155,268,617		-		-	
Dec 11	DY6	Q24	174,319,090	2,815,684,818	-	9,402,053,590	-	6,586,368,772
		Q25	206,054,411		-		-	
		Q26	206,054,411		-		-	
		Q27	206,054,411		-		-	
Dec 12	DY7	Q28	206,054,411	3,639,902,460	-	9,402,053,590	-	5,762,151,130
		Q29	241,365,397		-		-	
		Q30	241,365,397		-		-	
		Q31	241,365,397		-		-	
Dec 13	DY8	Q32	241,365,397	4,605,364,046	-	9,402,053,590	-	4,796,689,544

	Scenario 2: Only Lowest SOC Band Enrollees Pay Premium							
	Budget Neutrality - Template							
	Florida MEDS AD Demonstration							
	DEMO YEAR	**Quarter Ended**	**WW Expenditures**	**WW Expenditures Cumulative Total**	**WOW (Target) Expenditures**	**WOW Expend Total**	**Difference**	**Cumulative Difference**
Mar 06		Q1	51,696,950		507,710,894		456,013,944	
Jun 06		Q2	132,235,096		507,710,894		375,475,798	
Sep 06		Q3	105,271,113		507,710,894		402,439,781	
Dec 06	DY1	Q4	146,356,839	435,559,998	507,710,894	2,030,843,575	361,354,055	1,595,283,577
		Q5	69,927,763		460,700,626		390,772,863	
		Q6	79,047,475		460,700,626		381,653,151	
		Q7	87,567,517		460,700,626		373,133,109	
Dec 07	DY2	Q8	90,210,963	762,313,716	460,700,626	3,873,646,079	370,489,663	3,111,332,363
		Q9	93,882,619		455,999,599		362,116,980	
		Q10	103,108,178		455,999,599		352,891,421	
		Q11	95,761,142		455,999,599		360,238,457	
Dec 08	DY3	Q12	96,128,169	1,151,193,824	455,999,599	5,697,644,476	359,871,430	4,546,450,652
		Q13	107,727,900		465,401,653		357,673,753	
		Q14	106,365,677		465,401,653		359,035,976	
		Q15	120,849,499		465,401,653		344,552,154	
Dec 09	DY4	Q16	133,665,863	1,619,802,762	465,401,653	7,559,251,086	331,735,790	5,939,448,324
		Q17	138,153,082		460,700,626		322,547,544	
		Q18	144,229,555		460,700,626		316,471,071	
		Q19	134,966,909		460,700,626		325,733,717	
Dec 10	DY5	Q20	148,599,566	2,185,751,874	460,700,626	9,402,053,590	312,101,060	7,216,301,716
		Q21	154,004,876		-		-	
		Q22	146,340,361		-		-	
		Q23	155,268,617		-		-	
Dec 11	DY6	Q24	174,319,090	2,815,684,818	-	9,402,053,590	-	6,586,368,772
		Q25	206,054,411		-		-	
		Q26	206,054,411		-		-	
		Q27	206,054,411		-		-	
Dec 12	DY7	Q28	206,054,411	3,639,902,460	-	9,402,053,590	-	5,762,151,130
		Q29	241,262,960		-		-	
		Q30	241,262,960		-		-	
		Q31	241,262,960		-		-	
Dec 13	DY8	Q32	241,262,960	4,604,954,299	-	9,402,053,590	-	4,797,099,291