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

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

Kelly Kevitt, MSN, ARNP, FNP-BC

Sent: Wednesday, October 31, 2012 4:33 AM
To: FLMedicaidManagedCare
Subject: Waiver limits access to care

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

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

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

Cassandra Garcia

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

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

The waiver should be denied until access to full scope Nurse Practitioner care can be guaranteed.

Carolyn Zaumeyer, MSN, ARNP

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

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

Jan Heidel, MSN, NP-C

Sent: Monday, October 29, 2012 11:37 AM
To: FLMedicaidManagedCare;
Subject: Proposed Waiver for the Medically Needy Medicaid Program

The current waiver being considered regarding the "Share of Cost" Medicaid program will result in reduced access to care for at risk patients who are experiencing an increasing need for medical treatment.

This reduced access to medical treatment at the time of increased need will very likely exacerbate these medical conditions and lead to a further increase in cost of care for the state.

This waiver in many cases will lead to poorer health outcomes, increased cost of care and is humanely and fiscally irresponsible. As an Advanced Registered Nurse Practitioner and tax payer, I'm appalled at the disregard for the health care and well being medicaid patients and lack of prudence in managing our government's health care expenditures.

I ask you to deny this waiver program and instead support measures to allow more affordable and humane access to health care in the state of Florida.

Stephanie H. Ford, ARNP, BC

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

The proposed rule change for Medically needy patients for Nurse Practitioners will affect my own practice and will in turn pushed me to lay off my Medical Assistants staff in the office. This rule will make my patients surfer due to reduced access to care that the proposed rule changes will cause.
I am proposing that the rule remains as it is, with expansion authorizing HMOs to open up their panel to Nurse Practitioners without any hindrance. The policy if implemented will swell up the unemployment line with scores of Medical Assistants and office staff laid off. The patient access to care will be jeopardized, the Nurse Practitioners are the bulk of providers for the Medicaid patients.
Thanks in advance for your rethinking on the proposed policy.

Alade Babatunde Afolabi, FNP-C, DNP

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

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

Marcia J. Huszagh, ARNP, FNP-C

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

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

Lesley Bowlus, ARNP-C

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

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

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

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

Rita Smith Pruette, ARNP, MSN

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

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

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

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

Joella Hall ARNP

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

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

Jill Garrett ARNP

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

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

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

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

--
Max Holliday ARNP-C

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

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

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

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

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

Marifrances Gullo, ARNP-BC

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

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

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

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

Please DENY the medically Needy Waiver!!!

Christy Kuhn, RN, BSN, CCRN, PCCN

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

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

Tracey Novak

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

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

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

Dear Sir/Madam,

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

Susan Lynch MSN NP-C

FAHP Florida Association of Health Plans, Inc.
Representing Florida's Health Plans

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

October 24, 2012

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

Dear Deputy Secretary Senior:

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

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

Medically Needy (MN) Waiver

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

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

Issue Detail

1. Managed Care Organization Premium Collection

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

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

2. Premium Amount and Share of Cost

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

3. Premium, AHCA not responsible for SOC premium amount

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

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

4. Enrollment process Continuity of Care out of network

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

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

5. High Risk Population

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

6. Disenrollment, 90-day grace period

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

7. Medically Needy Premiums/Rates

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

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

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Recommendations

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

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

Sincerely,

Michael Garner, Ph.D.
President and CEO

Attachments (3)

Attachment 1

Statutory Language

409.972 Mandatory and voluntary enrollment.

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

409.975 Managed care plan accountability.

(7) MEDICALLY 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.

Attachment 2

Medically Needy Program – Managed Care Waiver

Initial Eligibility

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

Managed Care Plan Premium

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

Managed Care Enrollment

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

Attachment 3

Draft Example

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

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

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

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

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

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

October 30, 2012

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

Dear Mr. Senior:

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

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

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

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

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

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

Sincerely,

Paul Belcher

Paul Belcher
Senior Vice President

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

Florida Renal Coalition
11001 Danka Way North Suite 2
St. Petersburg, FL 33716
Telephone: (727) 954-1336 ■ Fax: (727) 577-1829

June 4, 2012

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

Dear Ms Dudek,

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

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

If approved, would the monthly premium be an option or a requirement for Medicaid beneficiaries to continue their medically needy status? If this is approved, will Medicaid beneficiaries be allowed to continue to submit medical bills as their share of cost in lieu of paying a monthly premium?

Will the current practice of submitting share of costs be maintained, or will beneficiaries have to show that their share of costs were paid in full prior to submitting their medical qualifying expenses?

We are concerned that a premium "equal to the enrollee's share of the cost" would be unaffordable and unrealistic for most Medicaid beneficiaries. A sliding scale based on income may be a better option if a premium is implemented.

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

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premium, and could be a financial burden for Medicaid program as well as the beneficiaries.

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

Sincerely,

Robert P. Loeper, Chairman
Florida Renal Coalition

C: File

November 10, 2012

Mr. Justin Senior
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: Objections to Florida's Proposed Medicaid 1115 Research and Demonstration Waiver (3rd proposal) Requiring Medically Needy Recipients to Pay Premiums in Lieu of Meeting Share of Cost

Dear Mr. Senior:

As provided for in federal regulations, Florida CHAIN submits these comments in response to Florida's proposed 1115 Research and Demonstration Waiver related to the Medically Needy component of Florida's Medicaid program. Joining us in registering these objections is the Florida Center for Fiscal and Economic Policy. Specifically, we once again express our strong objections to the State of Florida's proposal seeking to require Medicaid recipients with catastrophic medical expenses to enroll in a managed care plan and impoverish themselves by paying exorbitant premiums relative to their income. The State aims to win approval for its proposal by peddling what will be for most a false promise of continuous coverage. In reality, State-run scenarios show that monthly premiums could be expected to absorb up to 90% of household income, and actual monthly premium payment amounts could exceed $1,800.

This third proposal differs from its predecessors in that it presumably takes the form of a stand-alone application for a Medicaid Section 1115 Research and Demonstration Waiver (Proposed Waiver).[1] The Proposed Waiver includes some improvements over prior versions. Nevertheless, like its predecessors, the Proposed Waiver request is cruel, misleading, and dangerous.

We also note that the Proposed Waiver is structurally different from its predecessors in that seeks to align with the proposed Statewide Medicaid Managed Care (SMMC) initiative. We have previously submitted detailed objections to that broader SMMC proposal (aka, Amendment #1 to Medicaid Reform Waiver) as well, which we reaffirm without restating here.

We have at least **10 specific objections** to the Proposed Waiver, and they are as follows:

1. The Proposed Waiver would require most Medically Needy recipients to pay exorbitant and unsustainable premiums that would put them and their families in financial peril. Specifically, recipients could be required to pay up to 90% of their income on premiums.

The Public Notice Document for the Proposed Waiver provides virtually no information about the range of premiums that Medically Needy recipients would be required to pay, or the percentage of household income that those premiums would absorb. In fact, the only explanation provided is the following vague statement, buried deep in the Public Notice Document:

> The estimated enrollee monthly premiums reflect an average amount with consideration that enrollees will pay the lesser of the premium benchmark or their share of cost, and will not pay a premium during the initial qualifying month. Premium

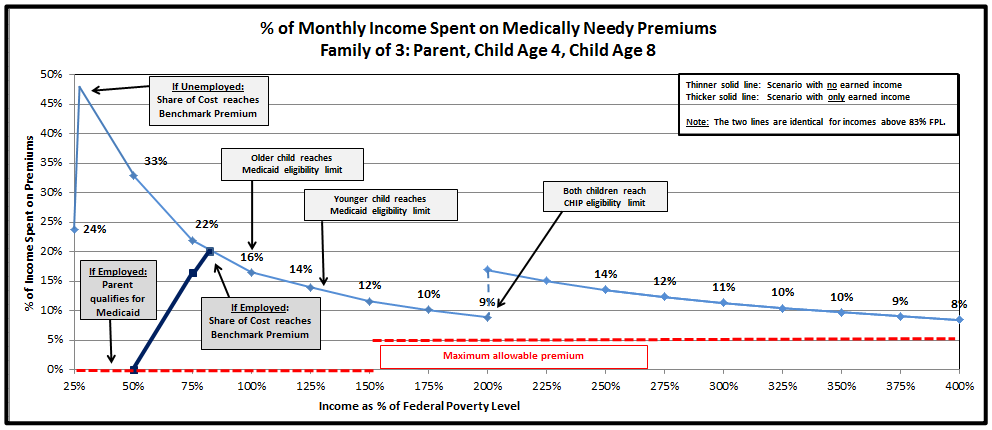
[1] References in these comments to the Proposed Waiver refer to the information provided in the State's Public Notice Document for the Proposed 1115 Research and Demonstration Waiver Florida's re: the Medically Needy Program (Public Notice Document), October 2011.

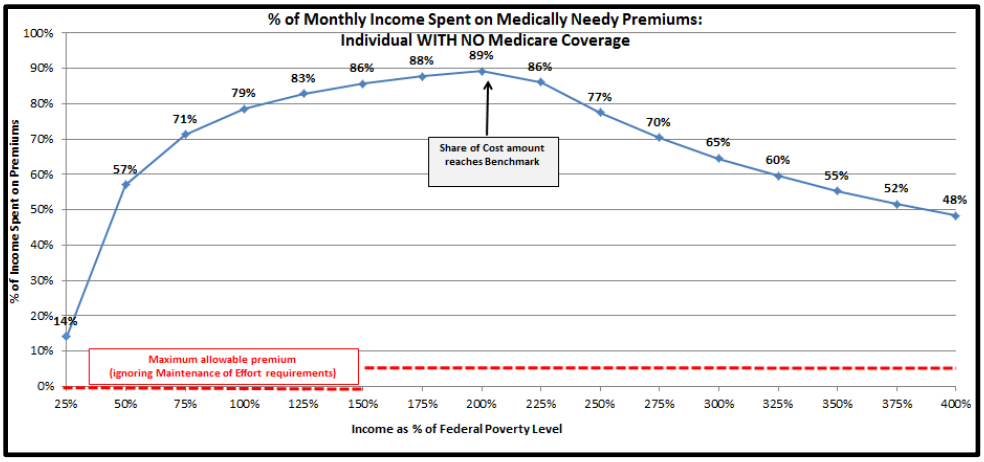
benchmarks will be developed by the Agency's actuaries and based on historical experience of Medically Needy and other similar populations.[2]

The only specific premium payment amount mentioned is a single statistic: an average of $118 per month, a number completely lacking in context. It is unclear how the Proposed Waiver can even be considered complete in the absence of such context.

However, very specific information was provided in the previous version of the State's proposal, including estimated premium benchmarks based on actuarial analysis. Under those assumptions, the State's data shows that monthly premiums could absorb up to 90% of household income, and actual monthly premium payment amounts could exceed $1,800.

A host of examples illustrating the oppressive burden of the premium requirement alone (ignoring consideration of the impact of any copayments) based on the premium benchmark estimates submitted previously can be found in the attached brief issued by the Florida Center for Fiscal and Economic Policy. Two charts from that brief depict the crushing burden the premium requirement would pose across all income levels.





It should also be noted that the State presumably cannot even calculate premium benchmarks for future years, because of uncertainty about the characteristics and health utilization patterns of the population to be served. Share of cost does not increase, but premium benchmarks will, which could make this system even more oppressive over time.

[2] Public Notice Document, p.20

2. The burden imposed by the Proposed Waiver is particularly cruel considering the income distribution of the Medically Needy population. The vast majority of Medically Needy recipients live in poverty, and almost all are low-income.

The fact is, almost all Medically Needy patients are already low-income *prior to* incurring catastrophic medical expenses, and virtually none can afford the premiums (which again, the Public Notice Document does not specify or even estimate.) However, the most current data made available by the State, mention of which is notably absent from the Public Notice Document, paints an entirely different picture and puts the $118 average premium statistic in context[3]:

- Among all Medically Needy recipients, 73% have incomes below the poverty level, and 97% are low-income (i.e., below 200% of poverty).

- Among elderly and disabled Medically Needy recipients, the average monthly income was $899, and the average share of cost was $702. If the average corresponded to an actual recipient, (s)he would be left with only $197 per month to survive on after paying the premium.

- Among Medically Needy families with children, average monthly income was $1,055, with an average $501 share of cost. However, even that average is skewed by a small number of middle-income households. More than three out of four Medically Needy families with children live in poverty. For instance, the poorest fifth of Medically Needy families would pay "only" a $22 premium on average, and so would have only $91 left to survive on for the month after paying it.

- Some Medically Needy recipients have household incomes that are in fact lower than some categorically eligible recipients (in other eligibility categories).

3. The Proposed Waiver is contrary to provisions of federal law that cannot be waived.

Under Medicaid Maintenance of Effort (MOE) requirements, which were established by the Affordable Care Act and upheld by the U.S. Supreme Court in *NFIB v. Sebelius*, remain in full effect. Florida cannot tighten or restrict Medicaid eligibility requirements for adults until a Health Insurance Exchange serving Florida is operational or for children until 2019.

Florida currently collects no premiums from Medicaid recipients. Because a recipient who does not pay his or her premium would lose his or her eligibility, the Proposed Waiver would indisputably amount to a tightening of Medicaid eligibility standards, in violation of MOE.

For its part, the State implies that the Proposed Waiver does not run afoul of the Maintenance of Effort requirements because "initial eligibility" is unaffected. "Initial eligibility" is a contrived term specifically created in an effort to justify evasion of the law. CMS has been clear that premium increases (with the exception of already planned automatic adjustments) violate MOE requirements. Postponing such a premium increase - there are no premium requirements at present - until the second month of eligibility changes nothing.

4. The Proposed Waiver is extreme and unyielding.

Astoundingly, among all the premium requirements that the State could have sought to impose, these requirements:

- Apply regardless of any hardship or special circumstance that the recipient may experience.

[3] Summary statistical analysis that follows is based on analysis of data at Conceptual Amendment, p.6

- Apply to children and certain individuals with disabilities who do not control their own finances.
- Apply to every recipient in a family (unless they are eligible for regular Medicaid coverage).[4]

5. Congress has already given states considerable power to levy premiums, and nothing in the Proposed Waiver justifies giving Florida special permission to massively boost that power.

Congress *specifically* addressed the issue of imposing premium payment requirements in the Deficit Reduction Act of 2005 (DRA), allowing states to charge premiums of certain recipients with incomes *above* 150% of the federal poverty level.[5]

It is true that some Medically Needy recipients – albeit fewer than 10%[6] - have household incomes exceeding 150 percent of poverty and so could be charged premiums under the DRA. However, the DRA also imposed a cap of 5% of total income on premiums and out-of-pocket costs.[7]

By contrast, under the Proposed Waiver, virtually every household would be required to pay more than the maximum 5% of income on premiums. Most Medically Needy households with seniors and disabled persons at these "higher" (150%+ FPL) income levels would pay at least half (and up to 90%) of their household income on premiums. Such a system is unsustainable and guarantees that many recipients will lose coverage.

The Proposed Waiver includes no information that justifies the State's extreme approach.

6. The State has consistently misled regarding the ability of Medically Needy recipients to pay premiums and the expected impact of the Proposed Waiver on them upon implementation.

For one, the Florida Senate had insisted throughout the session in which the authorizing legislation was enacted on changing the name of the Medically Needy program to the "non-poverty medical subsidy."[8] Further, in her presentation in legislative committee[9], Florida's Medicaid Director cited an example of a Medically Needy patient with family income of $5,000 per month. She further testified that average family income is $1,944 per month for disabled Medically Needy recipients and $3,027 for families with children.

In reality, based on the data provided to CMS by the State, less than 6 percent of elderly and disabled Medically Needy recipients had incomes at or above the "average" income level cited. Less than ½ percent of Medically Needy families with children have incomes in line with the Medicaid Director's example.

As for the Proposed Waiver itself, the State has described it as a means for ensuring continuous coverage for a group that currently has Medicaid coverage only on a month-to-month basis. The current reality, however, is that recipients need merely *incur* medical expenses equal to their share of cost, as these households have absolutely no ability to pay such an amount from their own resources. Under the Proposed Waiver, by contrast, following the first month of eligibility, recipients would be required to directly remit this amount each month or face eventual disenrollment and

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4 See Section 409.975(7), F.S.

5 CMS, Deficit Reduction Act – Important Facts for State Policymakers, Medicaid Cost-Sharing and Premiums, February 2008, p.1

6 See original "concept for a demonstration waiver" via amendment to Florida MEDS-AD 1115 related to the Medically Needy program, submitted to CMS on August 1, 2011 (Conceptual Amendment), p.6

7 CMS, p.2

8 See Section 22 of CS/CS/CS Senate Bill 1972 (2011)

9 Agency for Health Care Administration (AHCA), Presentation to House Health & Human Services Committee, February 22, 2011

denial of access to care.

Yet the State amazingly describes the changes as singularly beneficial for recipients: "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.[10]"

7. The State has not studied or even estimated the effect of imposing premiums on recipients' access to care or eligibility, reflecting a basic disregard for the well-being of vulnerable patients.

It is well-established that the imposition of premium requirements impedes participation in Medicaid, but the State has taken no steps to assess the impact of the Proposed Waiver on Florida's Medicaid population. Evaluation is slated to occur after approval and implementation, but that is too late. This demonstration will have caused irreparable harm to the subjects of the experimentation by the time the analysis is complete.

Furthermore, the Proposed Waiver is entirely silent on the mechanics of premium payment. Medicaid recipients in particular are underserved by financial institutions, and many would face logistical and financial barriers associated with making payment. It is also unclear what statements, reminders or warnings recipients would receive, or whether they would receive any such notification at all. Such omissions serve to further highlight the State's pervasive failure to consider the plight of Medicaid recipients. Indeed, it is difficult to envision <u>any</u> circumstance in which a recipient who is homeless, relocating due to domestic abuse or temporarily hospitalized, to name a few, could successfully meet the premium payment requirement. The Proposed Waiver is even more dangerous in that regard than its predecessors, in that Medically Needy recipients would pay premiums directly to managed care plans, which will be mostly for-profit Medicaid HMOs, who have a financial disincentive to keep unprofitable recipients enrolled.

8. The Amendment seeks to create a program that operates entirely outside of the Medically Needy framework. The State is in fact attempting to create an entirely new program for which there is no sound basis and for which the potential risks far outweigh any potential benefits.

In particular, the regulations governing the determination of eligibility for the Medically Needy program state that the Medically Needy program must determine eligibility based on incurred medical expenses.[11]

The State is seeking to disallow the use of incurred medical expenses in the determination of eligibility for the Medically Needy program, and requiring that a Medically Needy recipient *pay* a premium out-of-pocket in an amount up to his or her share of cost. That amount could even exceed the total medical expenses incurred in a month.

The detrimental effect of disallowing incurred expenses in the calculation cannot be overstated. Payment for expenses that have been incurred are in fact due from the patient, unless paid by an intervening third party. Absent unreliable and limited access to charity care, a patient denied access to the Medically Needy program will face ruined credit, untenable choices among necessities of life, threat of bankruptcy, and reduced access to care in the future. The requirement that a prospective Medically Needy recipient pay an exorbitant premium is no less onerous than requiring payment of medical bills in precisely the same amount.

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[10] Proposed Medically Needy-related Amendment to Florida MEDS AD Waiver (i.e. previous proposal), April 2012, p.12

[11] 42 CFR § 435.831(d)

9. Most of the Medically Needy would qualify for regular Medicaid under the expansion called for in the Affordable Care Act, and State participation in Medicaid expansion would serve patients far better.

The adverse impact of the proposal on recipients would at least be softened in 2014 if Florida participated in Medicaid expansion under the Affordable Care Act, as it would make most Floridians up to 138 percent of poverty eligible for continuous coverage under regular Medicaid with no premiums. The State would also save money.

10. A**llowing managed care plans to vary the amount, duration, and scope of benefits based on medical sufficiency and actuarial equivalence standards derived separately for the Medically Needy population, as is seemingly called for in the Proposed Waiver, could have adverse but avoidable consequences for recipients and their access to benefits.**

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Thank you for your consideration of these important matters and their potential impact on vulnerable Floridians with catastrophic medical expenses. For all the reasons above, we urge you to withdraw the Proposed Waiver and, failing that, we urge CMS to reject it.

Sincerely,
Florida CHAIN
Florida Center for Fiscal and Economic Policy (FCFEP)

cc: U.S. Centers for Medicare and Medicaid Services

Attachment: FCFEP Issue Brief

FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

Issue Brief **June 2012**

Medically Needy to Medically Needier:
Pushing the Medically Needy Into Managed Care Will Push Most Out of Coverage Completely

The Medically Needy component of the Medicaid program provides short-term coverage to Floridians who are over income for regular Medicaid but have catastrophic medical expenses. On April 26, the state requested federal permission to require, for the first time, that all Medically Needy participants enroll in a managed care plan and pay monthly premiums, purportedly to ensure their access to continuous coverage. However, failure to pay those premiums, which could absorb up to 90 percent of a participant's household income, would end their eligibility for Medicaid altogether. Virtually no Medically Needy participants would be able to afford the premiums, and the inevitable result would be loss of access to Medicaid and harm to hundreds of thousands of the most vulnerable Floridians.

Under the state's plan, virtually no Medically Needy participants would be able to afford the premiums, and the inevitable result would be loss of access to Medicaid and harm to hundreds of thousands of the most vulnerable Floridians.

About the Current Medically Needy Program:

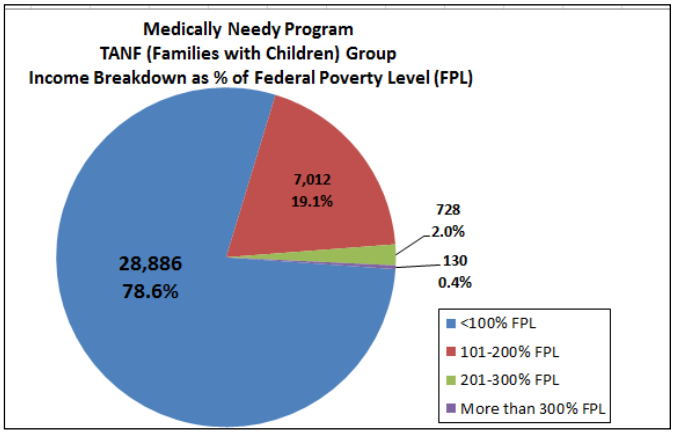
Under the Medically Needy program as it operates currently, participants meet all eligibility criteria for Medicaid coverage except that they have household income or assets above the regular Medicaid limit. As a result, Medically Needy participants do not have regular, ongoing Medicaid coverage. Rather, they are only covered by Medicaid on a short-term basis during months in which they have catastrophic medical expenses. More specifically, participants qualify by meeting what is known as their "Share of Cost." Share of Cost is met by incurring medical expenses that, if paid directly by the participant, would reduce his or her family income to a destitution-level 19 percent of the Federal Poverty Level (FPL).

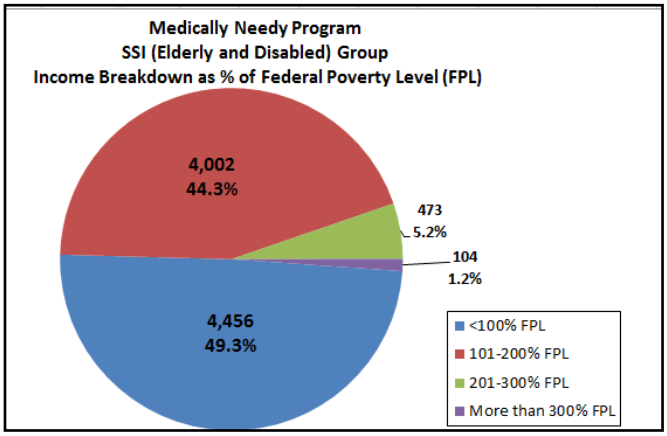
However, an essential characteristic of the current Medically Needy program is that participants are not required to pay the entire Share of Cost directly out of their own pockets. Instead, on the date that a participant can document medical bills for the month – paid or unpaid – that equal or exceed that Share of Cost amount, full Medicaid coverage is activated as of that day and for the remainder of the month.

About Current Medically Needy Participants:

Participants qualify by meeting what is known as their "Share of Cost." Share of Cost is met by incurring medical expenses that, if paid directly by the participant, would reduce his or her family income to a destitution-level 19 percent of the Federal Poverty Level.

Through the Medically Needy program, more than 546,000 Floridians were covered by Medicaid during at least one month between July 2008 and June 2011.[1] In terms of a snapshot, the average Medically Needy caseload for 2010-2011 was 40,622 individuals.[2] Medically Needy participants fall into two main eligibility categories: 1) children and families (often called the TANF group) and 2) elderly and disabled (often called the SSI group). Because Medicaid income eligibility limits are so stringent in Florida, even though Medically Needy participants have incomes (or assets) above the regular Medicaid income limit, the preponderance are nevertheless low-income, with the majority living in poverty. In fact, only 1 in 40 participants in the TANF group and 1 in 16 in the SSI group had household incomes above 200 percent of the poverty level.[3] The distribution of participants by income level for the two groups is shown in the figures below:





Note: The federal poverty level in 2012 is $11,170 for a single individual and $19,090 for a family of three.

About the Proposed Medically Needy Program:

The proposed changes to Florida's Medically Needy program are just one component of the overall Statewide Medicaid Managed Care (SMMC) initiative approved by the Florida Legislature in 2011.[4] Under that legislation, virtually all Florida Medicaid recipients would be required to enroll in capitated, mostly for-profit managed care plans. However, federal Center for Medicaid and Medicare Services (CMS) must first sign off on Florida's plan, most of which was submitted last August. CMS has in fact already rejected two other parts of the initiative calling for punitive measures that could not be granted under federal law. The Medically Needy proposal is the final piece to be submitted, although the proposed amendment is technically not part of the SMMC initiative, and pertains to the Medically Needy program prior to the full implementation of SMMC, in which the Medically Needy population

would be mandatory participants.[5] It follows up on a "concept paper" submitted to CMS earlier that included many of the same ideas.[6]

The stated aim of the proposal, namely to provide continuous coverage to patients who would otherwise cycle on and off of short-term Medicaid coverage, has significant merit. The problem, however, is that in return for continuous coverage, Medically Needy participants would be required to pay extremely unaffordable premiums – absorbing up to 90 percent of monthly income.

The stated aim of the proposal, namely to provide continuous coverage to patients who would otherwise cycle on and off of short-term Medicaid coverage, has significant merit. The problem, however, is that in return for continuous coverage, Medically Needy participants would be required to pay extremely unaffordable premiums – absorbing up to 90 percent of monthly income – in order to remain eligible.

For their first month of eligibility, participants would meet their Share of Cost requirement in precisely the same manner as with the current Medically Needy program. As of the first day of the following month, however, he or she would be enrolled in a managed care plan for six months, provided the participant pays the monthly premiums. However, if the full premium amount is not paid after three months, the participant would be disenrolled from the plan and lose Medicaid eligibility altogether, regardless of medical condition or hardship.[7]

Monthly premiums for 2013 would be set as the lesser of the individual participant's Share of Cost and a "per capita capitation benchmark" amount based on the actuarial (i.e., average expected) value of the care provided to participants in the same eligibility category:

Monthly "Benchmark" Premiums by Medically Needy Subgroup[8]	
Medically Needy Eligibility Category	**Benchmark Premium Amount**
Elderly and Disabled (not dually eligible for Medicare)	$1,803
Elderly and Disabled (dually eligible for Medicare)	$168
Children	$139
Adult (must have child in household)	$262
Overall Average	**$349**

Untenable Burden of Proposed Premium Requirements:

The actual distribution of premiums to be paid among all Medically Needy participants is difficult to estimate, as many variables are involved.[9] However, we can assess the burden created by these premiums in individual scenarios, such as those shown in the table below:

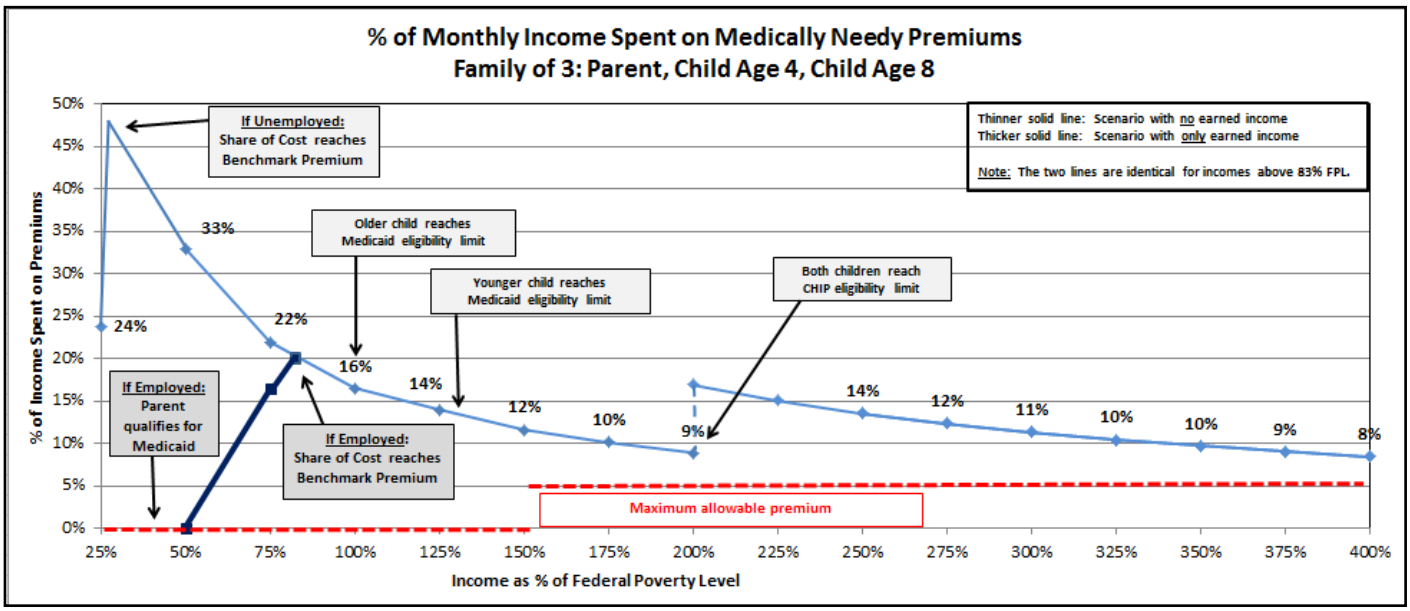
Burden of Medically Needy Premiums - Selected Examples (Detailed calculations are provided in the Appendix)		
Scenario	**Total Monthly Premiums**	**Percent of Income Absorbed by Monthly Premiums**
Unemployed single parent with two children, ages 4 and 8 (Income at 25% of poverty level)	$95	24%
Unemployed single parent with two children, ages 4 and 8 (Income at 125% of poverty level)	$277	14%
Unemployed single parent with two children, ages 4 and 8 (Income at 225% of poverty level)	$538	15%
Single disabled individual WITH Medicare coverage (Income at 100% of poverty level)	$168	18%
Single disabled individual WITH Medicare coverage (Income at 200% of poverty level	$308	17%
Single disabled individual WITHOUT Medicare coverage (Income at 100% of poverty level)	$731	79%
Single disabled individual WITHOUT Medicare coverage (Income at 200% of poverty level)	$1,662	88%

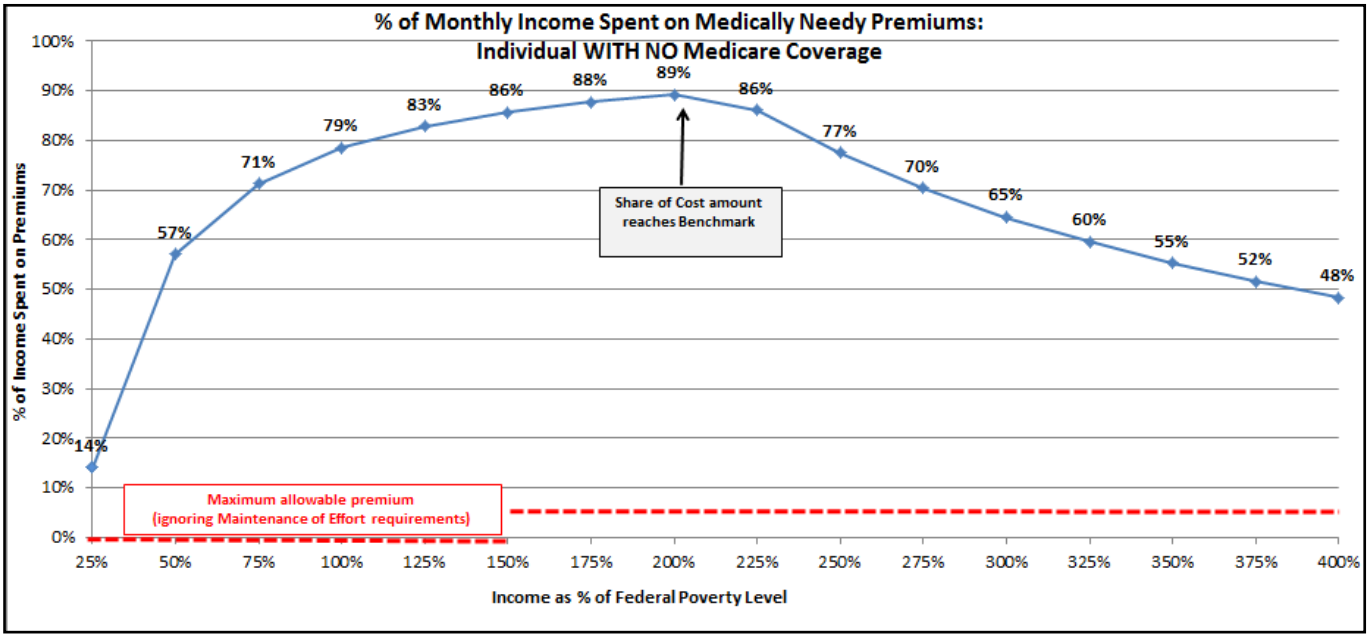
In short, the proposed premium requirements will prove unaffordable to virtually all Medically Needy participants, and pose a significant threat to health and well-being to most.

Most Basic Problem with Medically Needy Proposal:

In addition to the devastating impact the proposal would have on Floridians with catastrophic medical needs, an even more fundamental problem with the proposal is that it appears to be in direct conflict with federal law. CMS has the authority to grant waivers from certain federal requirements, but cannot override basic provisions of the Medicaid program set by Congress. In fact, the Medically Needy proposal is far more extreme than Florida's request to charge most recipients $10 monthly premiums throughout Medicaid, which was denied in February.[10]

Congress directly addressed the question of the circumstances under which states may impose premiums and other cost sharing requirements on Medicaid recipients through the Deficit Reduction Act of 2005 (DRA). In particular, states are in general permitted to require recipients with incomes above 150 percent of the federal poverty level (FPL) to pay premiums as a condition of eligibility.[11] More than 9 out of 10 Medically Needy participants have incomes below that level and so would be exempt. However, even for those above 150 percent FPL, the DRA specifies that total premiums and cost sharing may not exceed 5 percent of family income.[12] Expected premiums for fewer than 1 in 100 Medically Needy participants would meet this standard. Most would be expected to pay premiums many times that rate, as illustrated by the examples shown in the figures below:





In addition, the Affordable Care Act's "Maintenance of Effort" requirement prohibits tightening eligibility standards for Medicaid for adults until 2014 and for children until 2019. This specifically includes a ban on any new requirement that recipients pay premiums in order to remain eligible.[13]

Evasion of Transparency

Finally, the state's efforts to evade transparency requirements in its submission provide important insight into the nature of the Medically Needy proposal itself. The state submitted the proposal to CMS on April 26. On April 27, the next day, new federal transparency regulations[14] went into effect that likely[15] would have required the state to operate within public view as well as specifically seek and respond to public input. For more than two weeks, until the story was reported in the media, the state neither posted the proposal online nor mentioned it in any public setting.

Appendix

Examples with Calculations Illustrating Burden of Proposed Medically Needy Premium Requirements

Example 1A: Unemployed single parent with two children, ages 4 and 8 (@ 25% of poverty level)

At one end of the income spectrum, about one in five Medically Needy recipients in the children and families group lives in such deep poverty that their household incomes fall below 25 percent of the federal poverty level. That amount is just above the level at which an unemployed parent would quality for regular Medicaid, although both children would qualify.

Description of Amount	Amount	Calculation
Household Monthly Income (25% FPL)	$398	A
Monthly Income Limit for Regular Medicaid	$303	B
Income Disregarded	$0	C
Share of Cost	$95	D = A - B - C
Benchmark Premium for Parent	$262	E
Benchmark Premium for EACH Child	$138	F
Actual Premium for Parent	$95	G = Lesser of D & E
Actual Premium for Child #1	N/A (Qualifies for Full Medicaid)	H = Lesser of F & (D-G)
Actual Premium for Child #2	N/A (Qualifies for Full Medicaid)	I = Lesser of F & (D-G-H)
Total Monthly Premiums	**$95**	J = G + H + I
Premiums as % of Monthly Income	**24%**	K = J ÷ A

Although the premiums for those in deepest poverty would be lowest, they would be least able to afford them. In this example, the parent could obtain Medicaid coverage for $95 per month, but that would absorb a massive 24 percent of the total $303 dollars they have available for the month.

Example 1B: Employed single parent with two children, ages 4 and 8 (@ 125% of poverty level)

Description of Amount	Amount	Calculation
Household Monthly Income (125% FPL)	$1,989	A
Monthly Income Limit for Regular Medicaid	$303	B
Income Disregarded	$90	C
Share of Cost	$1,596	D = A - B - C
Benchmark Premium for Parent	$262	E
Benchmark Premium for EACH Child	$138	F
Actual Premium for Parent	$262	G = Lesser of D & E
Actual Premium for Child #1	N/A (Qualifies for Full Medicaid)	H = Lesser of F & (D-G)
Actual Premium for Child #2	$15 (Qualifies for FL Healthy Kids[16])	I = Lesser of F & (D-G-H)
Total Monthly Premiums	**$277**	J = G + H + I
Premiums as % of Monthly Income	**14%**	K = J ÷ A

Example 1C: Employed single parent with two children, ages 4 and 8 (@ 225% of poverty level)

Description of Amount	Amount	Calculation
Monthly Income (225% FPL)	$3,580	A
Monthly Income Limit for Regular Medicaid	$303	B
Income Disregarded	$90	C
Share of Cost	$3,187	D = A - B - C
Benchmark Premium for Parent	$262	E
Benchmark Premium for EACH Child	$138	F
Actual Premium for Parent	$262	G = Lesser of D & E
Actual Premium for Child #1	$138	H = Lesser of F & (D-G)
Actual Premium for Child #2	$138	I = Lesser of F & (D-G-H)
Total Monthly Premiums	**$538**	J = G + H + I
Premiums as % of Monthly Income	**15%**	K = J ÷ A

The elderly and disabled persons in the SSI group can be divided further into two very different subgroups for the purpose of calculating premiums: those with Medicare coverage and those with no coverage:

Example 2A: Single disabled individual WITH Medicare coverage (@ 100% of poverty level)

Most elderly individuals, as well as disabled, non-elderly individuals above the SSI payment level, qualify for Medicare, though disabled individuals generally must wait 29 months after their disability

determination to qualify for coverage. Although the medical needs of this "dually eligible" subgroup are significant, Medicare coverage will address a number of them. In this example, the individual likely qualifies for the Qualified Medicare Beneficiary (QMB) program, which pays applicable Medicare premiums for individuals at or below 100 percent FPL. It is also essential to note that non-elderly individuals with incomes less than 138 percent FPL will qualify for Medicaid with no Share of Cost, effective January 1, 2014.

Description of Amount	Amount	Calculation
Monthly Income (100% FPL)	$931	A
Monthly Income Limit for Regular Medicaid	$180	B
Income Disregarded	$20	C
Share of Cost	$731	D = A - B - C
Benchmark Medically Needy Premium	$168	E
Actual Medically Needy Premium	$168	F = Lesser of D & E
Medicare-Related Premiums	$0	G
Total Monthly Premium	**$168**	H = F + G
Premiums as % of Monthly Income	**18%**	I = H ÷ A

Example 2B: Single disabled individual WITH Medicare coverage (@ 200% of poverty level)
In this example, the individual does not qualify for any of the Medicare Savings Programs like QMB, and so must pay all Medicare-related premiums as well. A wide variety of Medicare coverage options exists, and particularly with Part D prescription drug coverage, lower premiums are often offset by higher out-of-pocket costs. Also, non-elderly individuals at this income level should qualify for subsidized coverage through the Health Insurance Exchange as of January 1, 2014, but the extent to which a gap in catastrophic coverage will remain for chronically ill individuals is still unclear.

Description of Amount	Amount	Calculation
Monthly Income (200% FPL)	$1,862	A
Monthly Income Limit for Regular Medicaid	$180	B
Income Disregarded	$20	C
Share of Cost	$1,682	D = A - B - C
Benchmark Medically Needy Premium	$168	E
Actual Medically Needy Premium	$168	F = Lesser of D & E
Medicare-Related Premiums	$140	G
Total Monthly Premium	**$308**	H = F + G
Premiums as % of Monthly Income	**17%**	I = H ÷ A

Example 3A: Single disabled individual WITHOUT Medicare coverage (@ 100% of poverty level)
Disabled individuals who do not have access to Medicare or regular Medicaid rely on the Medically Needy program as their sole protection from health-related and financial catastrophe. These are the individuals who will find the premium requirements utterly prohibitive. However, again, it should be

noted that many of these individuals (non-elderly with incomes less than 138 percent FPL) will qualify for some form of regular Medicaid without a Share of Cost, effective January 1, 2014.

Description of Amount	Amount	Calculation
Monthly Income (100% FPL)	$931	A
Monthly Income Limit	$180	B
Income Disregarded	$20	C
Share of Cost	$731	D = A - B - C
Benchmark Premium	$1,803	E
Actual Monthly Premium	**$731**	F = Lesser of D & E
Premium as % of Monthly Income	**79%**	G

Example 3B: Single disabled individual WITHOUT Medicare coverage (@ 200% of poverty level)
Increased income would be of no benefit to individuals in this subgroup, but rather only to the managed care plan to which he or she would pay an increasingly higher premium. Specifically, under the state's proposal, every dollar of income above the $200 limit would be owed to the managed care plan, at least until his or her income reached $2,003. In other words, the lowest-income and most vulnerable Floridians would be required turn over all but $200 per month – up to 90 percent of their monthly income – to a managed care plan or lose access to coverage.

Description of Amount	Amount	Calculation
Monthly Income (200% FPL)	$1,862	A
Monthly Income Limit	$180	B
Income Disregarded	$20	C
Share of Cost	$1,662	D = A - B - C
Benchmark Premium	$1,803	E
Actual Monthly Premium	**$1,662**	F = Lesser of D & E
Premium as % of Monthly Income	**88%**	G

This report was researched and written by Greg Mellowe. The report and its findings do not necessarily reflect the views of the FCFEP Board of Directors.

Endnotes

[1] Florida Agency for Health Care Administration (AHCA), Florida Medically Needy Waiver Demonstration Amendment
to the Florida MEDS AD section 1115 Demonstration (Waiver Amendment), April 2012, p.19

[2] AHCA, Waiver Amendment, p.5

[3] AHCA, Waiver Amendment, pp. 6-7

[4] Part IV, Chapter 409, Florida Statutes (F.S.)

[5] Section 409.9122(20), F.S.

[6] AHCA, Florida Medically Needy Waiver Demonstration Program – Concept Paper, August 2011.

[7] AHCA, Waiver Amendment, p. 9

[8] AHCA, Waiver Amendment, p. 23

[9] In particular, AHCA only provides a breakdown of the January 2011 Medically Needy population, but premiums are based in part on the demographic characteristics of the 2013 Medically Needy population. To maximize the relevance of the income-to-premium comparisons, we chose to use current (2012) federal poverty guidelines.

[10] U.S. Centers for Medicare and Medicaid Services (CMS), Untitled Letter to AHCA, February 2012, p.1

[11] CMS, Deficit Reduction Act (DRA): Important Facts for State Policymakers, February 2008, p.1

[12] DRA, Section 6041(b)(2)(A)

[13] CMS, State Medicaid Director Letter #11-01, pp. 10-11, February 2011

[14] 42 CFR Part 431, Subpart G (77 FR 11696-11699)

[15] The proposal submitted took the form of a proposed amendment to an already federally approved Medicaid waiver that allows Florida to operate the MEDS-AD program, which extends full Medicaid coverage to certain elderly and disabled individuals with incomes below 88 percent of the poverty level but who do not receive SSI. The Medically Needy and MEDS-AD populations and programs are completely different. Thus, the Medically Needy proposal will likely be considered as a new waiver rather than an amendment to an existing one, triggering applicability of the new regulations.

[16] Florida Healthy Kids is a component of Florida KidCare, funded under the federal Children's Health Insurance Program.