Medicaid Impact Conference
Session 2011

ISSUE SUMMARY

Post Conferences
March 1 and 10, 2011

Issue		Action	Proposed Start Date	General Revenue (Annualized)	Trust Fund (Annualized)	Annualized Total	Federal Approval (Y/N)	Type (State Plan / Waiver)
1	Eliminate Optional Service - Adult Dental *	Provide the estimated savings by eliminating coverage for non-emergency adult dental services effective July 1, 2011.	10/1/2011	($6,595,140)	($8,510,108)	($15,105,248)	Y	State Plan
2	Eliminate Optional Service - Adult Vision and Hearing *	Provide the estimated savings by eliminating coverage for adult vision and hearing services effective July 1, 2011.	10/1/2011	($8,298,891)	($10,859,680)	($19,158,571)	Y	State Plan
3	Adult Dental Services *	Savings associated with eliminating partial dentures based on the FY 2011-12 estimate.	10/1/2011	($925,499)	($1,194,227)	($2,119,726)	Y	State Plan
4	Adult Podiatric Services *	Savings associated with eliminating this service based on FY 2011-12 estimate.	10/1/2011	($1,485,450)	($1,902,161)	($3,387,611)	Y	State Plan
5	Adult Chiropractic Services *	Savings associated with eliminating this service based on FY 2011-12 estimate.	10/1/2011	($585,286)	($747,319)	($1,332,605)	Y	State Plan
6	FHK Rate Freeze	Provide an estimate of the savings if FHK capitation rates continue to be frozen at the June 30, 2009, level. Provide a mechanism to calculate the rate freeze.	10/1/2011	($3,364,539)	($7,569,940)	($10,934,479)	N	
7	Freeze Medikids Capitation Rates	Provide an estimate of the savings attributable to the Medikids capitation rates if the Institutional unit cost freeze in Medicaid is continued, subject to actuarial certification at the June 30, 2011, level. Provide a mechanism to calculate the rate freeze.	7/1/2011	($763,524)	($1,715,343)	($2,478,867)	N	

8	Medically Needy Program - Revision of Benefits	Provide an estimate of the savings from limiting the program to physician services only for adults. Analysis should preserve populations that would otherwise still qualify for Medicaid services.	4/1/2012	($359,051,990)	(502,181,833)	($861,233,823)	Y	State Plan
9	Meds AD Program (Defer till we hear from CMS)	Provide an estimate of the savings from not continuing the program in Fiscal Year 2011-2012. Current law sunsets the program effective June 30, 2011. Analysis should preserve and delineate populations that would otherwise still qualify for Medicaid services. In addition, provide an estimate of the savings assuming the institutional unit cost freeze is continued at the June 2011 level.	Deferred					
10	Institutional Unit Cost Freeze - Institutional Providers	Provide an estimate of freezing the unit cost for Hospital Inpatient/Outpatient, County Health Departments (CHD), Intermediate Care for the Developmentally Disabled Facilities (ICF/DD), Nursing Homes (including Hospice impact), and Prepaid Health Plans at the estimated June 2011 level such that rates are established at a level that ensures no increase in statewide expenditures as a result of a change in the unit cost. As part of the analysis, include the amounts and corresponding percentages the units costs are projected to increase for each provider type.	7/1/2011	($137,016,867)	($256,870,828)	($393,887,695)	Y	State Plan

11	Nursing Home/Hospice Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 Nursing Home/Hospice rates by 1%. Provide mechanisms to calculate the reduction assuming the institutional unit cost freeze is not continued and assuming the unit cost freeze is continued at the June 2011 level. Include impact on Hospice rates.	7/1/2011	($13,759,774)	($17,469,851)	($31,229,625)	Y	State Plan
12A	Hospital Inpatient Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.	7/1/2011	($22,696,580)	($29,310,344)	($52,006,924)	Y	State Plan
12B	Hospital Inpatient Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.	7/1/2011	($21,796,219)	($27,834,261)	($49,630,480)	Y	State Plan
13A	Hospital Outpatient Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.	7/1/2011	($6,156,019)	($7,906,806)	($14,062,825)	Y	State Plan
13B	Hospital Outpatient Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.	7/1/2011	($5,819,730)	($7,417,750)	($13,237,480)	Y	State Plan

14A	HMO Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 HMO rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.	9/1/2011	($13,894,157)	($17,993,778)	($31,887,935)	Y	State Plan
14B	HMO Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 HMO rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.	9/1/2011	($13,341,517)	($17,056,327)	($30,397,844)	Y	State Plan
15A	County Health Department Rates	Provide the estimated savings by reducing the FY 2011-12 CHD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.	7/1/2011	($971,813)	($1,244,942)	($2,216,755)	Y	State Plan
15B	County Health Department Rates	Provide the estimated savings by reducing the FY 2011-12 CHD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.	7/1/2011	($929,959)	($1,191,281)	($2,121,240)	Y	State Plan
16	Reduce County Health Department Rates	Provide the estimated savings by reducing the FY 2011-12 CHD rates to the same level as the estimated average rate of FQHC rates. Provide a mechanism to calculate the reduction.	7/1/2011	($26,581,946)	($34,052,774)	($60,634,720)	Y	State Plan
17A	ICF/DD Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 ICF/DD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.	10/1/2011	($1,240,191)	($1,574,587)	($2,814,778)	Y	State Plan

17B	ICF/DD Rate Reduction	Provide the estimated savings by reducing the FY 2011-12 ICF/DD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.	10/1/2011	($1,233,175)	($1,565,678)	($2,798,853)	Y	State Plan
18	Nursing Home Diversion (Defer for wait list)	Provide an estimate of savings associated with increasing nursing home diversion slots by 1,000.	Deferred					
19	Nursing Home - Assets over Eligibility Limits Loopholes	Provide an estimate of savings by closing loopholes associated with Medicaid Estate Planning relating to compensation of family members and promissory notes for emergency Medicaid planning.	unknown	Indeterminate Savings				
20	Medicaid Payments for Incarcerated Eligible Inmates	Provide an estimate of the savings to be gained from leveraging Federal Financial Participation for inpatient services for eligible incarcerated recipients under the control of the Departments of Correction, Juvenile Justice, and Children and Family Services assuming current law, current administration.	unknown	Indeterminate Savings				

21	Acute Care Services for Incarcerated Inmates	Provide an estimate of savings for requesting a waiver to authorize the receipt of federal financial participation for state only (general revenue) funded acute care services provided to incarcerated recipients under the control of the Departments of Corrections and Juvenile Justice while incarcerated. The estimate should assume the incarcerated recipient maintains the eligibility grouping that he/she qualified under upon entry. (SSI and TANF eligibility is maintained). The estimate should assume waiver authority is granted from the accumulated savings under the section 1115 waiver.	unknown	Indeterminate Savings
22	Adult and Children's Community Mental Health and Substance Abuse Services	Provide an estimate of savings for requesting a waiver to authorize the receipt of federal financial participation for state only (general revenue) funded mental health and substance abuse services provided in the community to Medicaid eligible recipients, including out-patient detoxification programs, crisis stabilization units, and residential treatment. The estimate should assume waiver authority granted from the accumulated savings under the section 1115 waiver.	Deleted	

23	Mental Health Treatment Facilities (civil and forensic programs)	Provide an estimate of savings for requesting a waiver to authorize the receipt of federal financial participation for state only (general revenue) funded services provided to persons occupying a civil or forensic bed in a facility under the control of the Department of Children and Family Services. The estimate should assume waiver authority is granted from the accumulated savings under the section 1115 waiver.	N/A	$0	$0	$0	Y	Waiver
24	Payment for Preventable Hospital Errors	Provide an estimate of savings by expanding the policy of no longer reimbursing hospitals for preventable errors to the full Medicare policy.	7/1/2011	($367,643)	($455,135)	($822,778)	Y	State Plan
25	Single Formulary - Preferred Drug List Management	Provide an estimate of savings by the establishment of a single formulary PDL for Fee for Service and Managed Care expenditures. Reference January 2011 PS2 Study by the Florida Senate.	Deleted					
26	Specialty Drug Management	Provide an estimate of savings from outsourcing high-cost injectable medications to reduce inappropriate utilization and to promote preferred products. Reference January 2011 PS2 Study by the Florida Senate.	7/1/2012	($4,151,616)	($5,271,026)	($9,422,642)	N	
27	Pharmacy Formulary - HIV Drugs	Provide an estimate of savings from removing the exclusion of HIV Drugs from the formulary.	7/1/2011	($61,684)	($78,316)	($140,000)	N	

28	Pharmacy - Managed Care Supplemental Rebates	Provide an estimate of savings from requesting a waiver to obtain supplemental rebates for in a managed care environment. (Refer to January 2011 State of Oregon waiver)	N/A			N/A	N	
29	Developmental Disabilities Waiver	Provide an estimate of savings by eliminating eligibility based on "Family of 1" for children.	unknown	Indeterminate Savings				
30	Developmental Disabilities Waiver	Provide an estimate of savings by implementing a parental fee for waiver clients under the age of 18 whose parent's income would not have qualified for Medicaid absent the "Family of one" eligibility category. Analysis should assume a sliding scale fee based on income bands. Reference Minnisota parental fee.	unknown	Indeterminate Savings				
31	Pharmaceutical Expense Assistance	Provide an analysis of estimated savings due to reducing the appropriation for this program to the most recent FY 2011-12 estimate.	7/1/2011			$0	N	
32	Limit Medicaid Behavioral Health Overlay Services to Six Days Per Week for Juvenile Justice and Child Welfare Clients *	Savings associated with limiting behavioral health overlay services for youths in juvenile justice and child welfare settings to six days a week.	1/1/2012	$0	$0	$0	N	

33	Disease Management Contracts	Provide an estimate of savings if the Disease Management Program was eliminated. Include potential impact of cost shifting for those that would be eligible to receive services through other programs.	12/1/2011	($1,939,980)	($2,463,060)	($4,403,040)	Y	Waiver
34	Pharmacy Reimbursement	Provide the estimated savings from lowering the Whosale Acquisition Cost (WAC) pricing component from WAC plus 4.75% to WAC plus 3.75%. Provide a mechanism to calculate the reduction.	7/1/2011	($3,949,200)	($5,033,794)	($8,982,994)	Y	State Plan
34A	Pharmacy Reimbursement	Provide the estimated savings from adjusting the Wholesale Acquisition cost (WAC) pricing component to a cost closer to a budget neutral solution that accounts for the loss of AWP in the pricing methodology. Provide a mechanism to calculate the reduction.	7/1/2011	($13,049,185)	($16,632,968)	($29,682,153)	Y	State Plan
35	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associated with eliminating nursing home bed hold days.	1/1/2012	($6,383,545)	($8,104,756)	($14,488,301)	Y	State Plan
35A	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associated with limiting to four days instead of eight. Current 95% occupancy rate.	1/1/2012	($3,191,773)	($4,052,378)	($7,244,151)	Y	State Plan
35B	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associated with limiting to four days instead of eight. 90% occupancy rate.	1/1/2012	$2,860,774	$3,632,131	$6,492,905	Y	State Plan
35C	Eliminate/Reduce Nursing Home Bed Hold Days	Savings associated with limiting to four days instead of eight. 85% occupancy rate.	1/1/2012	$5,697,905	$7,234,245	$12,932,150	Y	State Plan

36	Eliminate/Reduce ICF-DD Bed Hold Days	Savings associated with eliminating ICF-DD bed hold days or limiting to four days instead of eight. Analysis shows savings at 90% occupancy rates.	10/1/2011	($49,515)	($62,866)	($112,381)	Y	State Plan
36A	Eliminate/Reduce ICF-DD Bed Hold Days	Savings associated with eliminating ICF-DD bed hold days or limiting to four days instead of eight. Analysis shows savings at 85% occupancy rates.	10/1/2011	$82,525	$104,777	$187,302	Y	State Plan
37	Reduce Nurse Staffing Requirements to 2.6 Hours	Savings associated with reducing required nursing staffing ratios to 2.6 hours from the current 2.9 average hours.	**7/1/2012**			N/A	Y	State Plan
38	Increased use of Generic Drugs for Medicaid	Savings assoicated with increasing the use of Generic Drugs for Medicaid beneficiaries. (State of North Carolina Model)	7/1/2011			$0	N	
39	Reduce Medicaid Drug Dispensing Fees	Savings associated with reducing the Medicaid Pharmacy Dispensing Fees by $1.00 and $2.00 respectively.	10/1/2011	($6,154,830)	($7,845,170)	($14,000,000) ($1 reduction)	Y	State Plan
				($12,309,659)	($15,690,341)	($28,000,000) ($2 reduction)	Y	State Plan
40	Generic Drugs	Provide an estimate of the savings, if any, attributable to the competitive procurement of generic prescription drugs.	N/A			$0		
41	Peritoneal Dialysis	Provide an estimate of the savings associated with the provision of peritoneal dialysis for End Stage Renal Disease patients.	7/1/2011	($175,376)	($222,664)	($398,040)	N	
42	ICF/DD Assessment	Provide an estimate of revenue generated by requiring an assessment of net revenue to ICF/DD facilities up to the maximum allowable amount of 5.5%.	10/1/2011			$0	Y	State Plan

43	Nursing Home/Hospice Assessment	Provide an estimate of revenue generated by requiring an assessment of net revenue to Nursing Home/Hospice facilities up to the maximum allowable amount of 5.5%.	7/1/2011			$0	Y	State Plan
44	Contingency Fee contracts (DEFER - not discussed due to time constraints)	Use Contingency fee contracts for audits and reviews of Medicaid claims	Deferred					

Medicaid Impact Conference
Session 2011

ISSUE DETAIL

Post Conferences
March 1 and 10, 2011

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #1

Proposal Name:	Eliminate Optional Service - Adult Dental
Brief Description of Proposal:	Provide the estimated savings by eliminating coverage for non-emergency adult dental services effective July 1, 2011.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	Rule revisions required
Total Cost/(Savings)/{Revenue}:	($11,328,936)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services, Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	• FMMIS programming to capture changes in reimbursement methodology for recipients age 21 and over: 10 to 14 days. • Provider Alert: 60 days • Bulletin article: 90 days • Rule Development: 90 days.
II. Will this proposal require a change in Florida Statute?	Yes	409.906 (1) (b) has “may”.
III. Will this proposal require a State Plan Amendment?	Yes	Revisions to State Plan: 60 days.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing rule would require revisions: 90 days
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Last year Impact Conference 2010
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #1 Cont.**

Lead Analyst:	Mary Cerasoli
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Program Analysis pulled the data from claims submitted for dental services provided to all eligible Medicaid recipients age 21 and above.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	2/4/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($11,328,936)**		**($15,105,248)**
General Revenue:	**($4,946,355)**		**($6,595,140)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($6,280,053)**		**($8,373,404)**
Refugee Assistance Trust Fund:	**($102,528)**		**($136,704)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Adult non-emerg dental
FY 2011-12

	Annualized	9 months
TOTAL COST	($15,105,248)	($11,328,936)
TOTAL GENERAL REVENUE	($6,595,140)	($4,946,355)
TOTAL MEDICAL CARE TRUST FUND	($8,373,404)	($6,280,053)
TOTAL REFUGEE ASSISTANCE TF	($136,704)	($102,528)

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #2

Proposal Name:	Eliminate Optional Service - Adult Vision and Hearing
Brief Description of Proposal:	Provide the estimated savings by eliminating coverage for adult vision and hearing services effective July 1, 2011.
Proposed State Fiscal Year:	2011-12
Proposed Start Date:	10/01/2011
If not July 1, start date; please explain.	FMMIS changes and state plan amendment
Total Cost/(Savings)/{Revenue}:	($14,368,928)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alert and send letter to provider and recipients – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Rule Promulgation for the Optometry Services, Visual Services and Hearing Services Coverage and Limitations Handbooks – 120 +days • Update Optometry & Visual Services Fee Schedules-120 + days • Implementation of necessary FMMIS programming to eliminate reimbursement of Optometry, Hearing and Visual Services for recipient age 21 and older – 30-90 days. • Update Hearing Services Fee Schedule – 120+ days
II. Will this proposal require a change in Florida Statute?	Yes	409.906 Optional Services, (17) Optometry Services and (23) Visual Services
III. Will this proposal require a State Plan Amendment?	Yes	State Plan Amendment: 60 days
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.340 Visual Services, 59G-4.210 Optometry Services, 59G-4.110 Hearing Services and 549G-5.020 Provider Requirements (Provider General Handbook).
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	unknown	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #2 Cont.**

Lead Analyst:	Practitioner Services Unit- Kathryn R. Stephens
Secondary Analyst:	Medicaid Program Analysis- Karen Chang
Assumptions (Data source and methodology):	Program Analysis pulled the data from claims submitted for vision and hearing services provided to all eligible Medicaid recipients age 21 and above.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/04/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($14,368,928)**		**($19,158,571)**
General Revenue:	**($6,224,168)**		**($8,298,891)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,902,404)**		**($10,536,539)**
Refugee Assistance Trust Fund:	**($242,356)**		**($323,141)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Annualized	**Total**	**GR**	**MCTF**	**Refugee TF**
ADULT HEARING	($3,592,897)	($1,583,030)	($2,009,867)	$0
ADULT VISION	($15,565,674)	($6,715,861)	($8,526,672)	($323,141)
TOTAL	($19,158,571)	($8,298,891)	($10,536,539)	($323,141)

9 months	**Total**	**GR**	**MCTF**	**Refugee TF**
ADULT HEARING	($2,694,673)	($1,187,273)	($1,507,400)	$0
ADULT VISION	($11,674,256)	($5,036,896)	($6,395,004)	($242,356)
TOTAL	($14,368,928)	($6,224,168)	($7,902,404)	($242,356)

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #3

Proposal Name:	Adult Dental Services
Brief Description of Proposal:	Savings associated with eliminating partial dentures based on the FY 2011-12 estimates.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	Rule revision requirements
Total Cost/(Savings)/{Revenue}:	($1,589,795)
Bureau(s) Responsible for Administration:	Bureau of Medicaid Services, Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	• FMMIS programming for changes in reimbursement for recipients age 21 and over: 10 to 14 days. • Provider Alert: 60 days • Bulletin article: 90 days • Rule Development: 90 days.
II. Will this proposal require a change in Florida Statute?	Yes	409.906 (1) (b) has “may”.
III. Will this proposal require a State Plan Amendment?	Yes	Revisions to State Plan: 60 days.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing rule would require revisions: 90 days
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Last year Impact Conference 2010
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #3 Cont.**

Lead Analyst:	Mary Cerasoli
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Program Analysis pulled the data according to partial denture codes and the number of adults that received a partial.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	01/31/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($1,589,795)**		**($2,119,726)**
General Revenue:	**($694,124)**		**($925,499)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($881,282)**		**($1,175,043)**
Refugee Assistance Trust Fund:	**($14,388)**		**($19,184)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Medicaid Impact Conference Issues

March 2011

Issue #3 Cont.

	0.5594	
ADULT DENTAL	Total	Partial Dentures
DENTAL SERVICES CASELOAD	880,184	880,184
DENTAL SERVICES UTILIZATION RATE	5.15%	0.36%
DENTAL SERVICES PER MONTH	45,322	3,159
DENTAL SERVICES UNIT COST	$55.92	$55.92
DENTAL SERVICES TOTAL COST	$30,414,646	$2,119,726.00
CROSSOVER CASELOAD	3,046,759	
CROSSOVER UTILIZATION RATE	0.00%	
CROSSOVER SERVICES/MONTH	0	
CROSSOVER UNIT COST	$0.00	
CROSSOVER COST	$0	
TOTAL COST	$30,414,646	$2,119,726.00
TOTAL GENERAL REVENUE	$13,279,416	$925,499
TOTAL MEDICAL CARE TRUST FUND	$16,859,974	$1,175,043.00
TOTAL REFUGEE ASSISTANCE TF	$275,256	$19,184.00
TOTAL TOBACCO SETTLEMENT TF	$0	
TOTAL GRANTS AND DONATIONS TF	$0	

Cut Partial dentures
FY 2011-12

	Annualized	9 months
TOTAL COST	($2,119,726)	($1,589,795)
TOTAL GENERAL REVENUE	($925,499)	($694,124)
TOTAL MEDICAL CARE TRUST FUND	($1,175,043)	($881,282)
TOTAL REFUGEE ASSISTANCE TF	($19,184)	($14,388)
Recipients	**5,127**	

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #4

Proposal Name:	Adult Podiatric Services
Brief Description of Proposal:	Savings associated with eliminating this service based on FY 2011-12 estimates.
Proposed State Fiscal Year: 11/12	2011-12
Proposed Start Date: 07-01-2011	10/01/2011
If not July 1, start date; please explain.	FMMIS changes and state plan amendment
Total Cost/(Savings)/{Revenue}:	($2,540,708)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alert and send provider and recipient letters – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Podiatry Services Coverage and Limitations Handbook Rule Promulgation- 120 +days • Update Podiatry Services Fee Schedule – 120 +days • Implementation of needed FMMIS programming to eliminate reimbursement of Podiatry Services for recipients age 21 and older– 30 to 90 days
II. Will this proposal require a change in Florida Statute?	Yes	409.906 Optional Services, (19) Podiatry Services
III. Will this proposal require a State Plan Amendment?	Yes	State Plan Amendment: 60 days
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?		59G-4.220 Podiatry Services and 59G-5.020 Provider Requirements (Provider General Handbook)
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	Unknown	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #4 Cont.**

Lead Analyst:	Practitioner Services Unit- Kathryn R. Stephens
Secondary Analyst:	Medicaid Program Analysis – Tom Wallace
Assumptions (Data source and methodology):	Program Analysis pulled the data for podiatry services.
FY Impacted by Implementation:	FY 2011/12
Date Analysis Completed:	02/22/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,540,708)**		**($3,387,611)**
General Revenue:	**($1,114,088)**		**($1,485,450)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($1,417,999)**		**($1,890,665)**
Refugee Assistance Trust Fund:	**($8,622)**		**($11,496)**
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Podiatrist	$4,838,817	$2,121,993	$2,700,403	$16,421	29,735
adults	$3,387,611	$1,485,450	$1,890,665	$11,496	23,450
adults (9 months)	$2,540,708	$1,114,088	$1,417,999	$8,622	
children	$1,451,206	$636,543	$809,738	$4,925	6,285
children (9 months)	$1,088,405	$477,407	$607,304	$3,694	

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #5

Proposal Name:	Adult Chiropractic Services
Brief Description of Proposal:	Savings associated with eliminating this service based on FY 2011-12 estimates.
Proposed State Fiscal Year: 11/12	2011-12
Proposed Start Date: 07-01-2011	10/01/2011
If not July 1, start date; please explain.	FMMIS changes and state plan amendment
Total Cost/(Savings)/{Revenue}:	($999,454)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Publish RV Banner and Provider Alerts and mail provider and recipient letters – 60 days • Publish Medicaid Provider Bulletin article – 90 days • Chiropractic Services Coverage and Limitations Handbook Rule Promulgation – 120+ days • Promulgate Chiropractic Services Fee Schedule–120 + days • Update Medicaid State Plan Amendment – 90+ • Implementation of needed FMMIS programming to eliminate reimbursement of Chiropractic Services for recipients age 21 and older – 30 to 90 days
II. Will this proposal require a change in Florida Statute?	No	409.906 Optional Services (7) re: Chiropractic Services does not specify age of recipients served
III. Will this proposal require a State Plan Amendment?	Yes	Optional Groups Other Than The Medically Needy (24), Attachment 2.2-A, page 23d State Plan Amendment: 60 days
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.040 Chiropractic Services and 59G-5.020 Provider Requirements
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	Unknown	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #5 Cont.**

Lead Analyst:	Practitioner Services- Kathryn Stephens
Secondary Analyst:	Medicaid Program Analysis – Tom Wallace
Assumptions (Data source and methodology):	Program Analysis pulled the data for chiropractic services.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($999,454)**		**($1,332,605)**
General Revenue:	**($438,965)**		**($585,286)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($557,097)**		**($742,796)**
Refugee Assistance Trust Fund:	**($3,392)**		**($4,523)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Chiropractor	$1,614,436	$708,906	$900,051	$5,479	11,959
adults	$1,332,605	$585,286	$742,796	$4,523	8,242
adults (9 months)	$999,454	$438,965	$557,097	$3,392	
children	$281,831	$123,620	$157,255	$956	3,717
children (9 months)	$211,373	$92,715	$117,941	$717	

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #6

Proposal Name:	FHK Rate Freeze
Brief Description of Proposal:	Provide an estimate of the savings if FHK capitation rates continue to be frozen at the June 30, 2009, level. Provide a mechanism to calculate the rate freeze.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	FHKC health plan contract on 10/1 – 9/30 contract year
Total Cost/(Savings)/{Revenue}:	($8,200,859)
Bureau(s) Responsible for Administration:	Medicaid Services (manages contract with Florida Healthy Kids Corporation)

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Implementation 10/1/11. FHKC's managed care contracts (and rates) for health plan services are based on an October 1 – September 30 cycle so the effective date of any rate freeze would mean that FHKC would not approve any rate increases for the next health plan contract year, effective 10/1/11.
II. Will this proposal require a change in Florida Statute?	No	Statute change not necessary.
III. Will this proposal require a State Plan Amendment?	No	State Plan Amendment not necessary.
IV. Will this require the Procurement Process?	No	No procurement would be necessary if a rate freeze goes into effect, unless holding the average PMPM rates frozen at the FY 2010-11 average PMPM of $110.08 results in some rates that cannot be actuarially justified, and a current insurer could not continue at that rate and would exit a particular county. In those cases where an existing plan would leave only one or no managed care plan, FHKC would have to procure a new plan or plans for that county, because it is a CHIPRA requirement that families have a choice of at least two plans. Additionally, FHKC can non-renew any or all contracts after receipt of Plan rate adjustment requests (due April 1st). FHKC may re-procure with or without a rate freeze. FHKC has until June 1st to give notice of non-renewal to health plans for 10/1 effective date.
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #6 Cont.**

Lead Analyst:	Scott Ingram with FHKC
Secondary Analyst:	Gail Hansen
Assumptions (Data source and methodology):	Program implementation date 10/1/2011 Projected Florida Healthy Kids enrollment: 217,992 Title XXI Federal Medical Assistance blended rate: 69.23%
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/03/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**12**
Total (Savings) Cost of Proposal:	**($8,200,859)**		**($10,934,479)**
General Revenue:	**($2,523,404)**		**($3,364,539)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($5,677,455)**		**($7,569,940)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Note: The average medical PMPM approved for the freeze year 2010-2011 is used for potential freeze year 2011-12.

Medicaid Impact Conference Issues

March 2011

Work Papers/Notes/Comments: **Issue #6 Cont.**

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

If rates due to rate freeze cannot be actuarially justified then health plans could not continue at that rate.

#6 FHK Rate Freeze

Assumptions:

Program implementation date 10/1/2011.

Projected Florida Healthy Kids 217,992

Title XXI Federal Medical Assistance blended rate 69.23%

Program component.	Avg. Monthly caseload		$PMPM	Total	Federal	State
Florida Healthy Kids						
-Results from February 1, 2011 SSEC		217,992				
Medical			$114.26	$224,169,893		
Cost			$114.26	$224,169,893	$155,192,817	$68,977,076
Florida Healthy Kids						
		217,992				
Medical - adjusted to FY 2010-11 Proviso PMPM			$110.08	$215,969,034		
Cost			$110.08	$215,969,034	$149,515,362	$66,453,672
Total Decrease		217,992				
Medical			($4.18)	($8,200,859)		
Total Savings			($4.18)	($8,200,859)	($5,677,455)	($2,523,404)

Medicaid Impact Conference Issues

March 2011

Health Care Services (68500000)	
Children's Special Health Care Trust Fund (68500100)	
(1000-2) General Revenue (State)	($2,523,404)
(2474-3) Medical Care Trust Fund	($5,677,455)
Total	($8,200,859)

Annualized

Health Care Services (68500000)	
Children's Special Health Care trust Fund (68500100)	
(1000-2) General Revenue (State)	($3,364,539)
(2474-3) Medical Care Trust Fund	($7,569,940)
Total	($10,934,479)

1. The average medical PMPM approved for the freeze year of 2010-11 is used for potential freeze year

2011-12

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #7

Proposal Name:	MediKids Capitation Rates
Brief Description of Proposal:	Provide an estimate of the savings if attributable to the MediKids capitation rates if the institutional unit cost freeze in Medicaid is continued, subject to actuarial certification at the June 30, 2011, level. Provide a mechanism to calculate the rate freeze.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/1/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($2,478,867)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	7/1/2011
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #7 Cont.**

Lead Analyst:	Gail Hansen
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	FHK data; SSEC February 2011.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,478,867)**		**($0)**
General Revenue:	**($763,524)**		**($0)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,715,343)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

MediKids are included in Medicaid managed care plan contracts and the same rates are used for MediKids as Medicaid. An institutional unit cost freeze would have to be applied to Medicaid, then the MediKids rate would be frozen also.

MediKids enrollment as of 2/1/2011 is 33,585. Approximately 80%, or 26,868 children, are enrolled in Medicaid managed care plans that would be impacted by this rate freeze.

Medicaid Impact Conference Issues

March 2011

Based on the February 1, 2011 SSEC

Medikids

Projected Expenditures for SFY 2011-2012

Month	Children	Avg Cost	Total Expenditures	Family Contribution	Net Expenditures	Federal * Title XXI	State Funds	Sources of State Share: General Revenue	Sources of State Share: Tobacco Settlement	Sources of State Share: Local Funds
July 2011	32,827	$122.97	$4,036,736	$288,878	$3,747,859	$2,579,276	$1,168,582		$1,168,582	
Aug	33,153	$123.95	$4,109,314	$291,746	$3,817,568	$2,627,250	$1,190,318		$1,190,318	
Sept	33,479	$124.82	$4,178,849	$294,615	$3,884,234	$2,673,130	$1,211,104		$1,211,104	
Oct	33,805	$125.69	$4,248,950	$297,484	$3,951,466	$2,735,600	$1,215,866		$1,215,866	
Nov	34,131	$126.57	$4,319,961	$300,353	$4,019,608	$2,782,775	$1,236,833		$1,236,833	
Dec	34,457	$127.46	$4,391,889	$303,222	$4,088,668	$2,830,585	$1,258,083	$125,349	$1,132,734	
Jan 2012	34,783	$128.35	$4,464,398	$306,090	$4,158,308	$2,878,796	$1,279,511	$1,279,511		
Feb	35,109	$129.25	$4,537,838	$308,959	$4,228,879	$2,927,653	$1,301,226	$1,301,226		
Mar	35,435	$130.15	$4,611,865	$311,828	$4,300,037	$2,976,916	$1,323,121	$1,323,121		
Apr	35,761	$131.07	$4,687,194	$314,697	$4,372,497	$3,027,080	$1,345,417	$1,345,417		
May	36,087	$131.98	$4,762,762	$317,566	$4,445,197	$3,077,410	$1,367,787	$1,367,787		
June	36,413	$132.91	$4,839,652	$320,434	$4,519,217	$3,128,654	$1,390,563	$1,390,563		
TOTAL	415,440	$128.03	$53,189,410	$3,655,872	$49,533,538	$34,245,124	$15,288,413	$8,132,975	$7,155,438	$0
		(1)								
Average	34,620									
2010-2011 Appropriations	30,659	$120.61	$44,372,232	$3,323,068	$41,049,164	$28,177,270	$12,871,894	$5,716,456	$7,155,438	$0
Surplus/(Deficit)	(3,961)	($7.42)	($8,817,178)	($332,804)	($8,484,374)	($6,067,854)	($2,416,519)	($2,416,519)	$0	$0

* July - Sept EFMAP 68.82%
Oct - June EFMAP 69.23%

Enrollment is projected to increase by 12.0% a year. Source: FHK

PMPM is projected to increase by **6%** a year. Source: AHCA

(1) Average cost is total expenditures divided by total children.

Medicaid Impact Conference Issues

March 2011

Medikids

Projected Expenditures for SFY 2011-2012

Month	Children	Avg Cost	Total Expenditures	Family Contribution	Net Expenditures	Federal * Title XXI	State Funds	Sources of State Share: General Revenue	Sources of State Share: Tobacco Settlement	Sources of State Share: Local Funds
July 2011	32,827	$122.00	$4,004,993	$288,878	$3,716,115	$2,557,431	$1,158,685		$1,158,685	
Aug	33,153	$122.01	$4,045,130	$291,746	$3,753,384	$2,583,079	$1,170,305		$1,170,305	
Sept	33,479	$122.02	$4,085,274	$294,615	$3,790,659	$2,608,732	$1,181,928		$1,181,928	
Oct	33,805	$122.04	$4,125,426	$297,484	$3,827,942	$2,650,084	$1,177,858		$1,177,858	
Nov	34,131	$122.05	$4,165,584	$300,353	$3,865,231	$2,675,900	$1,189,332		$1,189,332	
Dec	34,457	$122.06	$4,205,750	$303,222	$3,902,528	$2,701,720	$1,200,808		$1,200,808	
Jan 2012	34,783	$122.07	$4,245,923	$306,090	$3,939,833	$2,727,546	$1,212,287	$1,135,763	$76,524	
Feb	35,109	$122.08	$4,286,103	$308,959	$3,977,144	$2,753,377	$1,223,767	$1,223,767		
Mar	35,435	$122.09	$4,326,291	$311,828	$4,014,463	$2,779,212	$1,235,250	$1,235,250		
Apr	35,761	$122.10	$4,366,485	$314,697	$4,051,788	$2,805,053	$1,246,735	$1,246,735		
May	36,087	$122.11	$4,406,687	$317,566	$4,089,121	$2,830,899	$1,258,223	$1,258,223		
June	36,413	$122.12	$4,446,896	$320,434	$4,126,462	$2,856,749	$1,269,712	$1,269,712		
TOTAL	415,440	$122.06 (1)	$50,710,543	$3,655,872	$47,054,671	$32,529,782	$14,524,889	$7,369,451	$7,155,438	$0
Average	34,620									
2010-2011 Appropriations	30,659	$120.61	$44,372,232	$3,323,068	$41,049,164	$28,177,270	$12,871,894	$5,716,456	$7,155,438	$0
Surplus/(Deficit)	(3,961)	($1.46)	($6,338,311)	($332,804)	($6,005,507)	($4,352,512)	($1,652,995)	($1,652,995)	($0)	$0

* July - Sept EFMAP 68.82%

Oct - June EFMAP 69.23%

Enrollment is projected to increase by 12.0% a year. Source: FHK

PMPM is projected to increase by **1%** a year. Source: AHCA

(1) Average cost is total expenditures divided by total children.

Medicaid Impact Conference Issues

March 2011

Medikids

Difference for SFY 2011-2012

Month	Children	Avg Cost	Total Expenditures	Family Contribution	Net Expenditures	Federal * Title XXI	State Funds	Sources of State Share: General Revenue	Sources of State Share: Tobacco Settlement	Sources of State Share: Local Funds
TOTAL for Feb 1, 2011 SSEC	415,440	$128.03	$53,189,410	$3,655,872	$49,533,538	$34,245,124	$15,288,413	$8,132,975	$7,155,438	$0
TOTAL for New Calculation	415,440	$122.06	$50,710,543	$3,655,872	$47,054,671	$32,529,782	$14,524,889	$7,369,451	$7,155,438	$0
Difference	0	$5.97	$2,478,867	$0	$2,478,867	$1,715,343	$763,524	$763,525	$0	$0

Total expenditures	$2,478,867
General Revenue	$763,524
Medical Care TF	$1,715,343

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #8

Proposal Name:	Medically Needy Program - Revision of Benefits
Brief Description of Proposal:	Limit covered services for Medically Needy adults to physician services only
Proposed State Fiscal Year:	2011-12
Proposed Start Date:	04/01/2012
If not July 1, start date; please explain.	Time needed to program FMMIS, make administrative rule change, send required notices to recipients; may take longer than 9 months to implement.
Total Cost/(Savings)/{Revenue}:	($215,308,456)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	4/1/2012	• Make changes to FMMIS • Prepare notices for recipients (must notify at least 10 days in advance of effective date of change per 65-2.043, F.A.C.) • Amend provider handbooks (takes approximately 6 months for administrative rule) • Amend State plan (takes 90 – 180 days) • Notify providers of change
II. Will this proposal require a change in Florida Statute?	Yes	409.904(2), 409.904(2)(b)
III. Will this proposal require a State Plan Amendment?	Yes	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Amend: • Medicaid Provider General Handbook • Hospital Handbook • CMS 1500 Handbook • UB 04 handbook • ADA dental claim handbook • Home Health Services handbook
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	Yes	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #8 Cont.**

Lead Analyst:	Martha Crabb
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Program Analysis utilized the latest SSEC caseload and expenditures from February 2011 conference, with analysis of program cost and physician services.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**3**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($215,308,456)**		**($861,233,823)**
General Revenue:	**($89,762,998)**		**($359,051,990)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($108,482,161)**		**($433,928,643)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($17,063,298)**		**($68,253,190)**
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

MEDICALLY NEEDY
FY 2011-12

	TOTAL	LESS PHYSICIAN SERVICES	SAVINGS
TOTAL COST	$971,114,662	$109,880,839	($861,233,823)
TOTAL GENERAL REVENUE	$407,465,488	$48,413,498	($359,051,990)
TOTAL MEDICAL CARE TRUST FUND	$495,395,984	$61,467,341	($433,928,643)
TOTAL REFUGEE ASSISTANCE TF	$0		$0
TOTAL PUBLIC MEDICAL ASSIST TF	$0		$0
TOTAL OTHER STATE FUNDS	$0		$0
TOTAL GRANTS AND DONATIONS TF	$68,253,190		($68,253,190)
TOTAL HEALTH CARE TF	$0		$0
TOTAL TOBACCO SETTLEMENT TF	$0		$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #10

Proposal Name:	Institutional Unit Cost Freeze – Institutional Providers
Brief Description of Proposal:	Provide an estimate of freezing the unit cost for Hospital Inpatient/Outpatient, County Health Departments (CHD), Intermediate Care for the Developmentally Disabled Facilities (ICF/DD), Nursing Homes (including Hospice impact), and Prepaid Health Plans at the estimated June 2011 level such that rates are established at a level that ensures no increase in statewide expenditures as a result of a change in the unit cost. As part of the analysis, include the amounts and corresponding percentages the units costs are projected to increase for each provider type.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($393,887,695)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S. and 409-9124, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Long-Term Care Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #10 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/25/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	
Total (Savings) Cost of Proposal:	**(393,887,695)**		
General Revenue:	**(137,016,867)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**(219,925,441)**		
Refugee Assistance Trust Fund:	**(1,226,741)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**(35,718,646)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

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

Reduction from a Rate Freeze	FY11-12
TOTAL COST	($393,887,695)
TOTAL GENERAL REVENUE	($137,016,867)
TOTAL MEDICAL CARE TRUST FUND	($219,925,441)
TOTAL GRANTS AND DONATIONS TF	($35,718,646)
TOTAL REFUGEE ASSISTANCE TF	($1,226,741)
HOSPITAL INPATIENT SERVICES	
TOTAL COST	($178,040,596)
TOTAL GENERAL REVENUE	($52,784,961)
TOTAL MEDICAL CARE TRUST FUND	($99,436,419)
TOTAL GRANTS AND DONATIONS TF	($25,278,615)

Medicaid Impact Conference Issues

March 2011

TOTAL REFUGEE ASSISTANCE TF	($540,601)
NURSING HOMES	
TOTAL COST	$0
TOTAL GENERAL REVENUE	$0
TOTAL MEDICAL CARE TRUST FUND	$0
HOSPITAL OUTPATIENT SERVICES	
TOTAL COST	($65,232,370)
TOTAL GENERAL REVENUE	($19,198,727)
TOTAL MEDICAL CARE TRUST FUND	($36,461,917)
TOTAL GRANTS AND DONATIONS TF	($9,472,163)
TOTAL REFUGEE ASSISTANCE TF	($99,563)
CLINIC SERVICES	
TOTAL COST	($6,311,172)
TOTAL GENERAL REVENUE	($1,797,467)
TOTAL MEDICAL CARE TRUST FUND	($3,510,961)
TOTAL GRANTS AND DONATIONS TF	($967,868)
TOTAL REFUGEE ASSISTANCE TF	($34,876)
ICF-MR COMMUNITY	
TOTAL COST	($1,581,758)
TOTAL GENERAL REVENUE	($696,923)
TOTAL MEDICAL CARE TRUST FUND	($884,835)
PREPAID HEALTH PLAN	
TOTAL COST	($142,721,799)
TOTAL GENERAL REVENUE	($62,538,789)
TOTAL MEDICAL CARE TRUST FUND	($79,631,309)
TOTAL REFUGEE ASSISTANCE TF	($551,701)
HOSPICE	
TOTAL COST	$0
TOTAL GENERAL REVENUE	$0
TOTAL MEDICAL CARE TRUST FUND	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #11

Proposal Name:	Nursing Home/Hospice Rate Reduction
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 Nursing Home/Hospice rates by 1%. Provide mechanisms to calculate the reduction assuming the institutional unit cost freeze is not continued and assuming the unit cost freeze is continued at the June 2011 level. Include impact on Hospice rates.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($31,229,625)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Long-Term Care Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #11 Cont.**

Lead Analyst:	Steve Russell
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. NH and Hospice rates held flat at 11-12 estimates. Reduction of 1% then applied.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	
Total (Savings) Cost of Proposal:	**($31,229,625)**		
General Revenue:	**($13,759,774)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($17,469,851)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Work Papers/Notes/Comments:

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

Reduce NH Rates
FY 11-12
Includes Effect on Hospice

	1.00%	Reduction
TOTAL COST		($31,229,625)
TOTAL GENERAL REVENUE		($13,759,774)
TOTAL MEDICAL CARE TRUST FUND		($17,469,851)
TOTAL REFUGEE ASSISTANCE TF		$0

Medicaid Impact Conference Issues

March 2011

Issue #11 Cont.

	0.5594			
FY 11-12				
NURSING HOMES		1.00%	Reduction	
	44,742	44,742		0
SKILLED CARE CASELOAD	11,238	11,238		0
SKILLED CARE UNIT COST	$5,462.07	$5,407.45		($54.62)
SKILLED CARE TOTAL COST	$736,592,406	$729,227,077		($7,365,329)
CROSSOVER CASELOAD	554	554		0
CROSSOVER UNIT COST	$1,670.63	$1,670.63		$0.00
CROSSOVER TOTAL COST	$11,106,330	$11,106,330		$0
INTERMEDIATE CARE CASELOAD	32,595	32,595		0
INTERMEDIATE CARE UNIT COST	$5,433.24	$5,378.91		($54.33)
INTERMEDIATE CARE TOTAL COST	$2,125,158,226	$2,103,906,857		($21,251,369)
GENERAL CARE CASELOAD	355	355		0
GENERAL CARE UNIT COST	$5,426.17	$5,371.91		($54.26)
GENERAL CARE TOTAL COST	$23,115,490	$22,884,337		($231,153)
SPECIAL PAYMENTS TO NURSING HOMES	$5,222,992	$5,222,992		$0
TOTAL COST	$2,901,195,444	$2,872,347,593		($28,847,851)
TOTAL GENERAL REVENUE	$648,637,376	$635,927,012		($12,710,364)
TOTAL MEDICAL CARE TRUST FUND	$1,636,428,731	$1,620,291,244		($16,137,487)
TOTAL REFUGEE ASSISTANCE TF	$0	$0		$0
TOTAL TOBACCO SETTLEMENT TF	$270,000,000	$270,000,000		$0
TOTAL GRANTS AND DONATIONS TF	$346,129,337	$346,129,337		$0

Medicaid Impact Conference Issues

March 2011

HOSPICE

MEDICAID CASELOAD	11,580	11,580	0
MEDICAID UNIT COST	$2,414.11	$2,396.97	($17.14)
MEDICAID TOTAL COST	$335,465,045	$333,083,271	($2,381,774)
TOTAL COST	$335,465,045	$333,083,271	($2,381,774)
TOTAL GENERAL REVENUE	$91,074,710	$90,025,300	($1,049,410)
TOTAL MEDICAL CARE TRUST FUND	$187,659,146	$186,326,782	($1,332,364)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$42,000,000	$42,000,000	$0
TOTAL GRANTS AND DONATIONS TF	$14,731,189	$14,731,189	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #12A

Proposal Name:	Inpatient Hospital Rate Reduction (without freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($49,821,458)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #12A Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze not continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($49,821,458)**		**($52,006,924)**
General Revenue:	**($21,737,449)**		**($22,696,580)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($27,923,671)**		**($29,141,558)**
Refugee Assistance Trust Fund:	**($160,338)**		**($168,786)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce Inpatient Rates (Unit Cost Freeze not continuing)
FY 2011-12
Includes effect on HMO rates

	1.00%	FY1112 reduction	Annual Reduction
TOTAL COST		($49,821,458)	($52,006,924)
TOTAL GENERAL REVENUE		($21,737,449)	($22,696,580)
TOTAL MEDICAL CARE TRUST FUND		($27,923,671)	($29,141,558)
TOTAL REFUGEE ASSISTANCE TF		($160,338)	($168,786)

Issue #12A Cont.

	0.5594		
HOSPITAL INPATIENT SERVICES		1.0%	Reduction
MEDICAID CASELOAD	1,332,029	1,332,029	0
MEDICAID UTILIZATION RATE	2.55%	2.55%	0.00%
MEDICAID ADMISSIONS PER MONTH	33,998	33,998	0
MEDICAID DAYS PER ADMISSION	5.31	5.31	0.00
MEDICAID PER DIEM	$1,794.04	$1,776.10	($17.94)
MEDICAID TOTAL COST	$3,889,412,753	$3,850,518,625	($38,894,128)
AM-SURG CASELOAD	3,046,759	3,046,759	0
AM-SURG UTILIZATION RATE	0.09%	0.09%	0.00%
AM-SURG SERVICES/MONTH	2,798	2,798	0
AM-SURG UNIT COST	$546.70	$546.70	$0.00
AM-SURG TOTAL COST	$18,355,931	$18,355,931	$0
CHILD CASELOAD	1,839,948	1,839,948	0
CHILD UTILIZATION RATE	0.04%	0.04%	0.00%
CHILD SERVICES/MONTH	775	775	0
CHILD UNIT COST	$6,600.31	$6,600.31	$0.00
CHILD TOTAL COST	$61,382,891	$61,382,891	$0
SPECIAL PAYMENTS TO HOSPITALS	$168,300	$168,300	$0
DISPROPORTIONATE SHARE	$0	$0	$0
TOTAL COST	$3,969,319,875	$3,930,425,747	($38,894,128)
TOTAL GENERAL REVENUE	$314,710,624	$297,768,827	($16,941,797)
TOTAL MEDICAL CARE TRUST FUND	$2,213,838,345	$2,192,004,112	($21,834,233)
TOTAL REFUGEE ASSISTANCE TF	$12,052,404	$11,934,306	($118,098)
TOTAL PUBLIC MEDICAL ASSIST TF	$838,100,000	$838,100,000	$0
TOTAL GRANTS AND DONATIONS TF	$563,573,200	$563,573,200	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0
TOTAL OTHER STATE FUNDS	$27,045,302	$27,045,302	$0

Medicaid Impact Conference Issues

March 2011

PREPAID HEALTH PLAN

CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$213.75	$212.87	($0.88)	0.995882966
TOTAL COST	$3,185,009,957	$3,171,897,161	($13,112,796)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,477,889,347	$3,464,776,551	($13,112,796)	($10,927,330)
TOTAL GENERAL REVENUE	$1,060,733,254	$1,054,978,471	($5,754,783)	($4,795,652)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,938,112,072	$1,930,804,747	($7,307,325)	($6,089,438)
TOTAL REFUGEE ASSISTANCE TF	$13,444,021	$13,393,333	($50,688)	($42,240)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #12B

Proposal Name:	Inpatient Hospital Rate Reduction (with freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 Hospital Inpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($47,544,354)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #12B Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($47,544,354)**		**($49,630,480)**
General Revenue:	**($20,880,625)**		**($21,796,219)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($26,510,717)**		**($27,673,185)**
Refugee Assistance Trust Fund:	**($153,012)**		**($161,076)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce IP Rates with Unit Cost Freeze Continuing
FY 11-12
Includes effect on HMO rates

	1.00%	FY1112 reduction	Annual Reduction
TOTAL COST		($47,544,354)	($49,630,480)
TOTAL GENERAL REVENUE		($20,880,625)	($21,796,219)
TOTAL MEDICAL CARE TRUST FUND		($26,510,717)	($27,673,185)
TOTAL REFUGEE ASSISTANCE TF		($153,012)	($161,076)

Medicaid Impact Conference Issues

March 2011

Issue #12B Cont.

	0.5594		
HOSPITAL INPATIENT SERVICES		1.0%	Reduction
MEDICAID CASELOAD	1,332,029	1,332,029	0
MEDICAID UTILIZATION RATE	2.55%	2.55%	0.00%
MEDICAID ADMISSIONS PER MONTH	33,998	33,998	0
MEDICAID DAYS PER ADMISSION	5.31	5.31	0.00
MEDICAID PER DIEM	$1,711.92	$1,694.80	($17.12)
MEDICAID TOTAL COST	$3,711,372,157	$3,674,258,436	($37,113,721)
AM-SURG CASELOAD	3,046,759	3,046,759	0
AM-SURG UTILIZATION RATE	0.09%	0.09%	0.00%
AM-SURG SERVICES/MONTH	2,798	2,798	0
AM-SURG UNIT COST	$546.70	$546.70	$0.00
AM-SURG TOTAL COST	$18,355,931	$18,355,931	$0
CHILD CASELOAD	1,839,948	1,839,948	0
CHILD UTILIZATION RATE	0.04%	0.04%	0.00%
CHILD SERVICES/MONTH	775	775	0
CHILD UNIT COST	$6,600.31	$6,600.31	$0.00
CHILD TOTAL COST	$61,382,891	$61,382,891	$0
SPECIAL PAYMENTS TO HOSPITALS	$168,300	$168,300	$0
DISPROPORTIONATE SHARE	$0	$0	$0
TOTAL COST	$3,791,279,279	$3,754,165,558	($37,113,721)
TOTAL GENERAL REVENUE	$261,925,663	$245,623,010	($16,302,653)
TOTAL MEDICAL CARE TRUST FUND	$2,114,401,926	$2,093,703,550	($20,698,376)
TOTAL REFUGEE ASSISTANCE TF	$11,511,803	$11,399,111	($112,692)
TOTAL PUBLIC MEDICAL ASSIST TF	$838,100,000	$838,100,000	$0
TOTAL GRANTS AND DONATIONS TF	$538,294,585	$538,294,585	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0
TOTAL OTHER STATE FUNDS	$27,045,302	$27,045,302	$0

Medicaid Impact Conference Issues

March 2011

PREPAID HEALTH PLAN

CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$204.17	$203.33	($0.84)	0.995885742
TOTAL COST	$3,042,288,158	$3,029,771,399	($12,516,759)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,335,167,548	$3,322,650,789	($12,516,759)	($10,430,633)
TOTAL GENERAL REVENUE	$998,194,465	$992,700,899	($5,493,566)	($4,577,972)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,858,480,763	$1,851,505,954	($6,974,809)	($5,812,341)
TOTAL REFUGEE ASSISTANCE TF	$12,892,320	$12,843,936	($48,384)	($40,320)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #13A

Proposal Name:	Outpatient Hospital Rate Reduction (without freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($13,419,292)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Outpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #13A Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze not continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($13,419,292)**		**($14,062,825)**
General Revenue:	**($5,873,575)**		**($6,156,019)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,517,708)**		**($7,876,309)**
Refugee Assistance Trust Fund:	**($28,009)**		**($30,497)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce Outpatient Rates (without freeze)
FY 2011-12
Includes effect on HMO rates

	1.00%	FY1112 reduction	Annual Reduction
TOTAL COST		($13,419,292)	($14,062,825)
TOTAL GENERAL REVENUE		($5,873,575)	($6,156,019)
TOTAL MEDICAL CARE TRUST FUND		($7,517,708)	($7,876,309)
TOTAL REFUGEE ASSISTANCE TF		($28,009)	($30,497)

Issue #13A Cont.

	0.5594			
HOSPITAL OUTPATIENT SERVICES		1%		
MEDICAID CASELOAD	1,332,029	1,332,029		
MEDICAID UTILIZATION RATE	78.28%	78.28%		
MEDICAID SERVICES PER MONTH	1,042,668	1,042,668		
MEDICAID UNIT COST	$81.53	$80.72	($1)	
MEDICAID TOTAL COST	$1,020,162,848	$1,009,961,220	($10,201,628)	
CROSSOVER CASELOAD	472,988	472,988		
CROSSOVER UTILIZATION RATE	19.29%	19.29%		
CROSSOVER SERVICES/MONTH	91,256	91,256		
CROSSOVER UNIT COST	$141.24	$141.24		
CROSSOVER TOTAL COST	$154,665,550	$154,665,550		
SPECIAL PAYMENTS	$0	$0		
TOTAL COST	$1,174,828,398	$1,164,626,770	($10,201,628)	($10,201,628)
TOTAL GENERAL REVENUE	$136,220,021	$131,758,669	($4,461,352)	($4,461,352)
TOTAL MEDICAL CARE TRUST FUND	$656,222,556	$650,497,851	($5,724,705)	($5,724,705)
TOTAL REFUGEE ASSISTANCE TF	$1,793,126	$1,777,555	($15,571)	($15,571)
TOTAL PUBLIC MEDICAL ASSIST TF	$210,000,000	$210,000,000	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$170,592,695	$170,592,695	$0	$0

Medicaid Impact Conference Issues

March 2011

PREPAID HEALTH PLAN

CASELOAD	1,241,742	1,241,742		
UNIT COST	$213.75	$213.49	($0.26)	
TOTAL COST	$3,185,009,957	$3,181,148,760		
CASELOAD-MENTAL HEALTH	756,090	756,090		
UNIT COST	$32.28	$32.28		
TOTAL COST	$292,879,390	$292,879,390		
TOTAL COST	$3,477,889,347	$3,474,028,150	($3,861,197)	($3,217,664)
TOTAL GENERAL REVENUE	$1,060,733,254	$1,059,038,700	($1,694,667)	($1,412,223)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,938,112,072	$1,935,960,355	($2,151,604)	($1,793,003)
TOTAL REFUGEE ASSISTANCE TF	$13,444,021	$13,429,095	($14,926)	($12,438)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #13B

Proposal Name:	Outpatient Hospital Rate Reduction (with freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 Hospital Outpatient rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($12,622,784)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Outpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #13B Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($12,622,784)**		**($13,237,480)**
General Revenue:	**($5,549,942)**		**($5,819,730)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($7,046,386)**		**($7,388,918)**
Refugee Assistance Trust Fund:	**($26,456)**		**($28,832)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce OP Rates with Unit Cost Freeze Continuing
FY 2011-12
Includes effect on HMO rates

1.00%	FY1112 reduction	Annual Reduction
TOTAL COST	($12,622,784)	($13,237,480)
TOTAL GENERAL REVENUE	($5,549,942)	($5,819,730)
TOTAL MEDICAL CARE TRUST FUND	($7,046,386)	($7,388,918)
TOTAL REFUGEE ASSISTANCE TF	($26,456)	($28,832)

Issue #13B Cont.

	0.5594			
HOSPITAL OUTPATIENT SERVICES		1%		
MEDICAID CASELOAD	1,332,029	1,332,029		
MEDICAID UTILIZATION RATE	78.28%	78.28%		
MEDICAID SERVICES PER MONTH	1,042,668	1,042,668		
MEDICAID UNIT COST	$76.32	$75.56	($1)	
MEDICAID TOTAL COST	$954,930,478	$945,381,173	($9,549,305)	
CROSSOVER CASELOAD	472,988	472,988		
CROSSOVER UTILIZATION RATE	19.29%	19.29%		
CROSSOVER SERVICES/MONTH	91,256	91,256		
CROSSOVER UNIT COST	$141.24	$141.24		
CROSSOVER TOTAL COST	$154,665,550	$154,665,550		
SPECIAL PAYMENTS	$0	$0		
TOTAL COST	$1,109,596,028	$1,100,046,723	($9,549,305)	($9,549,305)
TOTAL GENERAL REVENUE	$117,021,294	$112,820,292	($4,201,002)	($4,201,002)
TOTAL MEDICAL CARE TRUST FUND	$619,760,639	$614,426,911	($5,333,728)	($5,333,728)
TOTAL REFUGEE ASSISTANCE TF	$1,693,563	$1,678,988	($14,575)	($14,575)
TOTAL PUBLIC MEDICAL ASSIST TF	$210,000,000	$210,000,000	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$161,120,532	$161,120,532	$0	$0

Medicaid Impact Conference Issues

March 2011

PREPAID HEALTH PLAN

CASELOAD	1,241,742	1,241,742		
UNIT COST	$204.17	$203.92	($0.25)	
TOTAL COST	$3,042,288,158	$3,038,599,983		
CASELOAD-MENTAL HEALTH	756,090	756,090		
UNIT COST	$32.28	$32.28		
TOTAL COST	$292,879,390	$292,879,390		
TOTAL COST	$3,335,167,548	$3,331,479,373	($3,688,175)	($3,073,479)
TOTAL GENERAL REVENUE	$998,194,465	$996,575,737	($1,618,728)	($1,348,940)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,858,480,763	$1,856,425,573	($2,055,190)	($1,712,658)
TOTAL REFUGEE ASSISTANCE TF	$12,892,320	$12,878,063	($14,257)	($11,881)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #14A

Proposal Name:	HMO Rate Reduction (without freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 HMO rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	09/01/2011
If not July 1, start date; please explain.	HMO rates effective September 1.
Total Cost/(Savings)/{Revenue}:	($26,573,279)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Rates are set September 1 each year and are subject to actuarial certification.
II. Will this proposal require a change in Florida Statute?	Yes	409-9124, F.S.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #14A Cont.**

Lead Analyst:	Karen Chang
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze not continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**10**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($26,573,279)**		**($31,887,935)**
General Revenue:	**($11,578,464)**		**($13,894,157)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($14,892,094)**		**($17,870,513)**
Refugee Assistance Trust Fund:	**($102,721)**		**($123,265)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce HMO Rates without freeze
FY 11-12

	1.0%	11/12 Reduction	Annual Reduction
TOTAL COST		($26,573,279)	($31,887,935)
TOTAL GENERAL REVENUE		($11,578,464)	($13,894,157)
TOTAL OTHER STATE FUNDS		$0	$0
TOTAL MEDICAL CARE TRUST FUND		($14,892,094)	($17,870,513)
TOTAL REFUGEE ASSISTANCE TF		($102,721)	($123,265)

Medicaid Impact Conference Issues

March 2011

Issue #14A Cont.

	0.5594			
PREPAID HEALTH PLAN		1.0%		
CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$213.75	$211.61	($2.14)	
TOTAL COST	$3,185,009,957	$3,153,122,022	($31,887,935)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,477,889,347	$3,446,001,412	($31,887,935)	($26,573,279)
TOTAL GENERAL REVENUE	$1,060,733,254	$1,046,839,097	($13,894,157)	($11,578,464)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,938,112,072	$1,920,241,559	($17,870,513)	($14,892,094)
TOTAL REFUGEE ASSISTANCE TF	$13,444,021	$13,320,756	($123,265)	($102,721)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #14B

Proposal Name:	HMO Rate Reduction (with freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 HMO rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	09/01/2011
If not July 1, start date; please explain.	HMO rates effective September 1.
Total Cost/(Savings)/{Revenue}:	($25,331,537)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Rates are set September 1 each year and are subject to actuarial certification.
II. Will this proposal require a change in Florida Statute?	Yes	409-9124, F.S.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	Medicaid Impact Conference 2010.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #14B Cont.**

Lead Analyst:	Karen Chang
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**10**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($25,331,537)**		**($30,397,844)**
General Revenue:	**($11,117,931)**		**($13,341,517)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($14,115,685)**		**($16,938,822)**
Refugee Assistance Trust Fund:	**($97,921)**		**($117,505)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce HMO Rates with Unit Cost Freeze Continuing
FY 11-12

1.0%	11/12 Reduction	Annual Reduction
TOTAL COST	($25,331,537)	($30,397,844)
TOTAL GENERAL REVENUE	($11,117,931)	($13,341,517)
TOTAL OTHER STATE FUNDS	$0	$0
TOTAL MEDICAL CARE TRUST FUND	($14,115,685)	($16,938,822)
TOTAL REFUGEE ASSISTANCE TF	($97,921)	($117,505)

Issue #14B Cont.

	0.5594			
PREPAID HEALTH PLAN		1.0%		
CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$204.17	$202.13	($2.04)	
TOTAL COST	$3,042,288,158	$3,011,890,314	($30,397,844)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,335,167,548	$3,304,769,704	($30,397,844)	($25,331,537)
TOTAL GENERAL REVENUE	$998,194,465	$984,852,948	($13,341,517)	($11,117,931)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,858,480,763	$1,841,541,941	($16,938,822)	($14,115,685)
TOTAL REFUGEE ASSISTANCE TF	$12,892,320	$12,774,815	($117,505)	($97,921)
TOTAL TOBACCO SETTLEMENT TF	$465,600,000	$465,600,000	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #15A

Proposal Name:	County Health Department Rates (without freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 CHD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($2,096,236)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #15A Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze not continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,096,236)**		**($2,216,755)**
General Revenue:	**($918,921)**		**($971,813)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,166,732)**		**($1,233,893)**
Refugee Assistance Trust Fund:	**($10,583)**		**($11,049)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce County Health Department Rates (without freeze)
FY 1112
Includes effect on HMO rates

1.00%	11/12 Reduction	Annual Reduction
TOTAL COST	($2,096,236)	($2,216,755)
TOTAL GENERAL REVENUE	($918,921)	($971,813)
TOTAL MEDICAL CARE TRUST FUND	($1,166,732)	($1,233,893)
TOTAL REFUGEE ASSISTANCE TF	($10,583)	($11,049)

Medicaid Impact Conference Issues

March 2011

Issue #15A Cont.

	0.5594			
CLINIC SERVICES		1.00%	Reduction	
MEDICAID CASELOAD	1,332,029	1,332,029	0	
MEDICAID UTILIZATION RATE	5.38%	5.38%	0.00%	
MEDICAID SERVICES PER MONTH	71,643	71,643	0	
MEDICAID UNIT COST	$173.74	$172.00	($1.74)	0.99
MEDICAID TOTAL COST	$149,364,019	$147,870,379	($1,493,640)	
TOTAL COST	$149,364,019	$147,870,379	($1,493,640)	
TOTAL GENERAL REVENUE	$42,539,974	$41,885,513	($654,461)	
TOTAL OTHER STATE FUNDS	$0	$0	$0	
TOTAL MEDICAL CARE TRUST FUND	$83,092,504	$82,261,579	($830,925)	
TOTAL REFUGEE ASSISTANCE TF	$825,400	$817,146	($8,254)	
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	
TOTAL GRANTS AND DONATIONS TF	$22,906,141	$22,906,141	$0	
	$0	$0		
PREPAID HEALTH PLAN				
CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$213.75	$213.70	($0.049)	0.999772963
TOTAL COST	$3,185,009,957	$3,184,286,842	($723,115)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,477,889,347	$3,477,166,232	($723,115)	($602,596)
TOTAL GENERAL REVENUE	$1,060,733,254	$1,060,415,902	($317,352)	($264,460)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,938,112,072	$1,937,709,104	($402,968)	($335,807)
TOTAL REFUGEE ASSISTANCE TF	$13,444,021	$13,441,226	($2,795)	($2,329)
TOTAL HEALTH CARE TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #15B

Proposal Name:	County Health Department Rates (with freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 CHD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($2,006,121)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #15B Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,006,121)**		**($2,121,240)**
General Revenue:	**($879,434)**		**($929,959)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,116,558)**		**($1,180,706)**
Refugee Assistance Trust Fund:	**($10,130)**		**($10,575)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce County Health Department Rates with Unit Cost Freeze Continuing
FY1112
Includes effect on HMO rates

	1.00%	11/12 Reduction	Annual Reduction
TOTAL COST		($2,006,121)	($2,121,240)
TOTAL GENERAL REVENUE		($879,434)	($929,959)
TOTAL MEDICAL CARE TRUST FUND		($1,116,558)	($1,180,706)
TOTAL REFUGEE ASSISTANCE TF		($10,130)	($10,575)

Medicaid Impact Conference Issues

March 2011

Issue #15B Cont.

	0.5594			
CLINIC SERVICES		1.00%	Reduction	
MEDICAID CASELOAD	1,332,029	1,332,029	0	
MEDICAID UTILIZATION RATE	5.38%	5.38%	0.00%	
MEDICAID SERVICES PER MONTH	71,643	71,643	0	
MEDICAID UNIT COST	$166.40	$164.73	($1.66)	0.99
MEDICAID TOTAL COST	$143,052,847	$141,622,319	($1,430,528)	
TOTAL COST	$143,052,847	$141,622,319	($1,430,528)	
TOTAL GENERAL REVENUE	$40,742,507	$40,115,699	($626,808)	
TOTAL OTHER STATE FUNDS	$0	$0	$0	
TOTAL MEDICAL CARE TRUST FUND	$79,581,543	$78,785,728	($795,815)	
TOTAL REFUGEE ASSISTANCE TF	$790,524	$782,619	($7,905)	
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	
TOTAL GRANTS AND DONATIONS TF	$21,938,273	$21,938,273	$0	
PREPAID HEALTH PLAN				
CASELOAD	1,241,742	1,241,742	0	
UNIT COST	$204.17	$204.12	($0.046)	0.999772963
TOTAL COST	$3,042,288,158	$3,041,597,446	($690,712)	
CASELOAD-MENTAL HEALTH	756,090	756,090	0	
UNIT COST	$32.28	$32.28	$0.00	
TOTAL COST	$292,879,390	$292,879,390	$0	
TOTAL COST	$3,335,167,548	$3,334,476,836	($690,712)	($575,593)
TOTAL GENERAL REVENUE	$998,194,465	$997,891,314	($303,151)	($252,626)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,858,480,763	$1,858,095,872	($384,891)	($320,743)
TOTAL REFUGEE ASSISTANCE TF	$12,892,320	$12,889,650	($2,670)	($2,225)
TOTAL HEALTH CARE TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #16

Proposal Name:	Reduce County Health Department Rates
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 CHD rates to the same level as the estimated average rate of FQHC rates. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($57,331,686)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX CHD Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #16 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Tom Wallace
Assumptions (Data source and methodology):	SSEC February 2011.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($57,331,686)**		**($60,634,720)**
General Revenue:	**($25,132,351)**		**($26,581,946)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($31,909,938)**		**($33,750,609)**
Refugee Assistance Trust Fund:	**($289,397)**		**($302,165)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce CHD at FQHC unit cost
FY 2011-12

	FQHC Rate FY1112	Annual
TOTAL COST	($57,331,686)	($60,634,720)
TOTAL GENERAL REVENUE	($25,132,351)	($26,581,946)
TOTAL MEDICAL CARE TRUST FUND	($31,909,938)	($33,750,609)
TOTAL REFUGEE ASSISTANCE TF	($289,397)	($302,165)

Medicaid Impact Conference Issues

March 2011

Issue #16 Cont.

CLINIC SERVICES	FQHC Rate			
MEDICAID CASELOAD	1,332,029	1,332,029		
MEDICAID UTILIZATION RATE	5.38%	5.38%		
MEDICAID SERVICES PER MONTH	71,643	71,643		
MEDICAID UNIT COST	$173.74	$126.26	($47.48)	
MEDICAID TOTAL COST	$149,364,019	$108,547,501	($40,816,518)	
TOTAL COST	$149,364,019	$108,547,501	($40,816,518)	($40,816,518)
TOTAL GENERAL REVENUE	$42,539,974	$24,655,596	($17,884,378)	($17,884,378)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$83,092,504	$60,385,920	($22,706,584)	($22,706,584)
TOTAL REFUGEE ASSISTANCE TF	$825,400	$599,844	($225,556)	($225,556)
TOTAL TOBACCO SETTLEMENT TF	$0	$0	$0	$0
TOTAL GRANTS AND DONATIONS TF	$22,906,141	$22,906,141	$0	$0
PREPAID HEALTH PLAN				
CASELOAD	1,241,742	1,241,742		
UNIT COST	$213.75	$212.42	-1.33	
TOTAL COST	$3,185,009,957	$3,165,191,755	($19,818,202)	
CASELOAD-MENTAL HEALTH	756,090	756,090		
UNIT COST	$32.28	$32.28		
TOTAL COST	$292,879,390	$292,879,390		
TOTAL COST	$3,477,889,347	$3,458,071,145	($19,818,202)	($16,515,168)
TOTAL GENERAL REVENUE	$1,060,733,254	$1,052,035,686	($8,697,568)	($7,247,973)
TOTAL OTHER STATE FUNDS	$0	$0	$0	$0
TOTAL MEDICAL CARE TRUST FUND	$1,938,112,072	$1,927,068,047	($11,044,025)	($9,203,354)
TOTAL REFUGEE ASSISTANCE TF	$13,444,021	$13,367,412	($76,609)	($63,841)
TOTAL HEALTH CARE TF	$465,600,000	$465,600,000	$0	$0
TOTAL GRANTS AND DONATIONS TF	$0	$0	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #17A

Proposal Name:	ICF/DD Rate Reduction (without freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 ICF/DD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze NOT continuing.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	Rate setting period is October 1.
Total Cost/(Savings)/{Revenue}:	($2,111,084)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #17A Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze not continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,111,084)**		**($2,814,778)**
General Revenue:	**($930,144)**		**($1,240,191)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,180,940)**		**($1,574,587)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce ICFDD Rates (without freeze)
FY 2011-12

	1.00%	Reduction	Annual Reduction
TOTAL COST		($2,111,084)	($2,814,778)
TOTAL GENERAL REVENUE		($930,144)	($1,240,191)
TOTAL MEDICAL CARE TRUST FUND		($1,180,940)	($1,574,587)

Medicaid Impact Conference Issues

March 2011

Issue #17A Cont.

	0.5594			
ICF-MR COMMUNITY		1.0%	Reduction	Start 10/1/11
	2,029			
CASELOAD PRIVATE	1,179	1,179	0	
UNIT COST	$10,683.31	$10,576.47	($106.84)	
TOTAL COST	$151,147,429	$149,635,898	($1,511,531)	
CASELOAD CLUSTER	624	624	0	
UNIT COST	$14,020.45	$13,880.24	($140.21)	
TOTAL COST	$104,985,115	$103,935,237	($1,049,878)	
CASELOAD SIXBED	226	226	0	
UNIT COST	$9,342.04	$9,248.62	($93.42)	
TOTAL COST	$25,335,626	$25,082,257	($253,369)	
TOTAL COST	$281,468,170	$278,653,392	($2,814,778)	($2,111,084)
TOTAL GENERAL REVENUE	$112,451,194	$111,211,003	($1,240,191)	($930,144)
TOTAL MEDICAL CARE TRUST FUND	$157,453,294	$155,878,707	($1,574,587)	($1,180,940)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$11,563,682	$11,563,682	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #17B

Proposal Name:	ICF/DD Rate Reduction (with freeze)
Brief Description of Proposal:	Provide the estimated savings by reducing the FY 2011-12 ICF/DD rates by 1%. Provide a mechanism to calculate the reduction; unit cost freeze at the June 2011 level.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	Rate setting period is October 1.
Total Cost/(Savings)/{Revenue}:	($2,099,140)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409-908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Rate reduction from previous rate semesters.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #17B Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	SSEC February 2011. Institutional Units cost freeze continuing. 1% reduction.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,099,140)**		**($2,798,853)**
General Revenue:	**($924,881)**		**($1,233,175)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,174,259)**		**($1,565,678)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Work Papers/Notes/Comments:

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

Reduce ICFDD Rates with Unit Cost Freeze Continuing
FY 11-12

	1.00% Reduction	Annual Reduction
TOTAL COST	($2,099,140)	($2,798,853)
TOTAL GENERAL REVENUE	($924,881)	($1,233,175)
TOTAL MEDICAL CARE TRUST FUND	($1,174,259)	($1,565,678)

Medicaid Impact Conference Issues

March 2011

Issue #17B Cont.

	0.5594			
ICF-MR COMMUNITY		1.0%	Reduction	Start 10/1/11
	2,029			
CASELOAD PRIVATE	1,179	1,179	0	
UNIT COST	$11,355.01	$11,241.46	($113.55)	
TOTAL COST	$160,650,712	$159,044,176	($1,606,536)	
CASELOAD CLUSTER	624	624	0	
UNIT COST	$12,887.36	$12,758.49	($128.87)	
TOTAL COST	$96,500,551	$95,535,573	($964,978)	
CASELOAD SIXBED	226	226	0	
UNIT COST	$8,383.17	$8,299.34	($83.83)	
TOTAL COST	$22,735,149	$22,507,810	($227,339)	
TOTAL COST	$279,886,412	$277,087,559	($2,798,853)	($2,099,140)
TOTAL GENERAL REVENUE	$111,754,271	$110,521,096	($1,233,175)	($924,881)
TOTAL MEDICAL CARE TRUST FUND	$156,568,459	$155,002,781	($1,565,678)	($1,174,259)
TOTAL REFUGEE ASSISTANCE TF	$0	$0	$0	$0
TOTAL TOBACCO SETTLEMENT TF	$11,563,682	$11,563,682	$0	$0

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #19

Proposal Name:	Nursing Home - Assets over Eligibility Limits Loopholes
Brief Description of Proposal:	Close loopholes associated with Medicaid Estate Planning relating to compensation of family members and promissory notes
Proposed State Fiscal Year:	unknown
Proposed Start Date: (?)	Proposed start date will have to be provided by DCF
If not July 1, start date; please explain.	The Department of Children and Families (DCF) requires the time to develop policy and make any needed programming changes to their system
Total Cost/(Savings)/{Revenue}:	Indeterminate Savings
Bureau(s) Responsible for Administration:	Department of Children and Families

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	unknown	There are no actions for AHCA; DCF would have to develop the policy, promulgate administrative rules, and make the needed system programming changes.
II. Will this proposal require a change in Florida Statute?	Yes	409.902, F.S.
III. Will this proposal require a State Plan Amendment?	No	May not require a State Plan change; state plan already provides for penalty for transfer of assets; specifics of how state establishes fair market value for a transferred asset is not specifically addressed by the plan
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	DCF, 65A-1.712
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	unknown	May require a federal waiver if proposed statutory changes to close loopholes are more restrictive than SSI policy and the federal statute isn't changed to allow Florida to implement policy more restrictive than SSI; would require waiver to waive Maintenance of Effort provision of Affordable Care Act
VII. Will this proposal require additional staffing?	unknown	AHCA needs no additional staff; not known if DCF requires additional staffing
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Similar bill for personal care contracts in 2005 -
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #19 Cont.**

Lead Analyst:	Martha Crabb
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Based on February 2011 SSEC.
FY Impacted by Implementation:	Unknown
Date Analysis Completed:	03/02/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

There are two primary implementation obstacles:

1. **The maintenance of effort (MOE) provision under the Section 2001 of the Affordable Care Act * prevents states from making changes to eligibility policy for adults until the state's Exchange is deemed operational by the Secretary of HHS. Guidance is needed from the Centers for Medicare and Medicaid Services on whether application of the transfer of assets penalty is considered a more restrictive eligibility policy or procedure; the individual who is in a penalty period is eligible for all Medicaid services except institutional care services, Hospice institutional care services, and Home and Community Based Services. If the transfer of assets penalty is considered to deny eligibility for the long-term care services, the MOE provision is applicable. If the transfer of assets penalty is seen as limiting services and not eligibility, it is possible the MOE provision would not apply. We have not been able to obtain a definitive answer from CMS on this issue.**
2. **The other possible obstacle is the requirement to not use any more restrictive policy than is used by SSI for determining eligibility, unless it is expressly permitted by federal statue or regulation. If any of the actions which DCF needs to take are more restrictive than SSI policy, a waiver from CMS or a federal statutory change would be needed.**

The estimates for number of recipients and average number of penalty months resulting from closing these loopholes will have to be provided by the Department of Children and Families. It is likely that this data is not available; when someone is determined eligible, information on assets the individual no longer owns is not maintained in the DCF system. AHCA would then likely use the average patient responsibility and average cost of nursing facility care to project potential savings.

Elder law attorneys and elder advocates may have concerns with changes to policies affecting elders.

Note: * Pending ruling of the affordable care act.

NUMBER OF RECIPIENTS	NURSING HOME PMPM*	COST AVOIDANCE	GR	MCTF
100	$5,433	$6,519,890	$2,872,664	$3,647,227
500	$5,433	$32,599,451	$14,363,318	$18,236,133
1,000	$5,433	$65,198,902	$28,726,636	$36,472,266
2,000	$5,433	$130,397,805	$57,453,273	$72,944,532

* Nursing Home Intermediate Level of Care FY1011, SSEC Feb. 2011

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #20

Proposal Name:	Medicaid Payments for Incarcerated Inmates
Brief Description of Proposal:	Provide inpatient hospital services for eligible incarcerated recipients under the control of the Departments of Correction, Juvenile Justice, and Children and Family Services assuming current law, current administration.
Proposed State Fiscal Year:	2011-12
Proposed Start Date:	unknown
If not July 1, start date; please explain.	Requires time to complete programming changes in both Department of Children and Families and Florida Medicaid Management Information systems and adopt administrative rules
Total Cost/(Savings)/{Revenue}:	Indeterminate Savings
Bureau(s) Responsible for Administration:	Medicaid Services [Third Party Liability (TPL) has been working on a system change with Medicaid Contract Management and DCF to implement 2008 legislation for suspension of Medicaid coverage for prison inmates who are Medicaid eligible at time of admission and providing Medicaid coverage for their inpatient care, 409.0925, F.S.] (The 2008 legislation did not include DJJ inmates or State Mental Hospital inmates.)

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Begin work May 1, 2011; complete work by 1/1/2012	• complete and test system changes in the DCF automated eligibility determination system – complete by November 1, 2011 • complete changes in Medicaid system to accept DCF data – complete by December 1, 2011 • fix Medicaid system edits to pay inpatient hospital claims for eligible incarcerated recipients – complete by December 1, 2011 • administrative rule promulgation, requires approximately 6 months
		•
II. Will this proposal require a change in Florida Statute?	Yes	409.9025, F.S., Eligibility while an inmate
III. Will this proposal require a State Plan Amendment?	No	AHCA requested guidance from CMS on whether State Plan was required; CMS written reply dated 9/9/2010 stated no State Plan amendment is required

Medicaid Impact Conference Issues

March 2011

Issue #20 Cont.

IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	• AHCA Medicaid Provider General handbook (modify language re: inmates of public institutions) • DCF eligibility rule change may be needed
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	• No additional staffing for AHCA • Impact on DCF not available
VIII. Is there a previous or concurrent Analysis by the Agency?	Previous analysis for similar provision	Analysis for 2008 session for similar provision – implemented 409.0925, F.S. – Eligibility while an inmate (the 2008 bill differs from current proposal; it provided for coverage of inmates in the state's correctional system, in a county detention facility, or in a municipal detention facility; it also provided for continuation of Medicaid benefits to allow for immediate reinstatement of full Medicaid coverage upon release)
IX. Is this proposal included in the current Governors recommendations?		

Lead Analyst:	Martha Crabb
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Data from DOC; DJJ; DCF. Utilization data not readily available.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/02/2011

Issue #20 Cont.

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

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): This proposal would provide federal matching funds for inpatient hospital stays for inmates who could be eligible for Medicaid; the inpatient hospital care is currently funded in full by General Revenue by the responsible department or entity.

The Agency and the Department of Children and Families have been working together to implement 409.9025, F.S., passed in 2008. The following chart provides a comparison between the provisions in the existing statute, 409.9025, F.S. and this impact conference issue (number 19):

Provisions of Existing 409.9025, F.S.	Impact Conference Issue #19 Proposal
Medicaid will cover inpatient hospital services for inmates in: • the state's correctional system • a county or municipal detention facility	Medicaid will cover inpatient hospital services for: • incarcerated recipients under the control of the Department of Corrections • incarcerated recipients under the control of Department of Juvenile Justice • State Mental Hospital residents under the control of DCF
Persons admitted as inmates to above facilities shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished under this chapter for any	Allows Medicaid eligibility to be determined for inmates in the above public institutions and provides for Medicaid coverage of inpatient care

care, services, or supplies provided during such time as the person is an inmate (limited eligibility to inmates eligible at the point of incarceration)	
Provides for automatic reinstatement of full Medicaid benefits at the point of release.	Does not address Medicaid eligibility for inmates at the point of release.

The Agency and the Department of Children and Families recently discovered that Medicaid coverage could not be automatically continued for all inmates who were Medicaid eligible at the time of incarceration; DCF must determine the inmate is eligible for Medicaid in order for inpatient hospital services for the inmate to be eligible for Medicaid funding.

The following chart provides information about the Medicaid eligibility categories and whether the individual could remain eligible for Medicaid in that category.

Current category at time of admission	Income limit	Asset limit	Eligible in this category as inmate in public institution?
SSI (aged, blind and disabled)	$647 for individual	$2,000 for individual	No. Eligibility in this category ends when SSA stops the SSI payment due to incarceration.
MEDS-AD (aged and disabled without Medicare)	88% Federal Poverty Level (FPL)	$5,000 individual	Yes
Aged and Disabled with Medicare in QMB, SLMB or QI1 categories with Medically Needy • For prison inmates, Medicare rarely pays for any care, including inpatient hospital • State cannot pay Medicare premiums for inmates of public institutions	n/a	n/a	Not eligible for Medicare Premium payments under QMB; could be eligible for copayments for crossovers for inpatient hospital care, within prescribed Medicaid reimbursement limits. SLMB and QI1: could remain open on FMMIS with incarceration indicator, but not eligible for payment of the Medicare premium by Medicaid (payment of the Part B premium is the only benefit available for SLMB and QI1 programs)
Family-related groups	TANF limit	$2,000 family	No. (Parent must be living with child to be eligible; children must be living with parent to be eligible in this category)
Children only, poverty level group (ages 6 up to age 19)	100% FPL	No asset limit	Yes (when turn 19, no longer eligible in this group)

Pregnant women	185% Federal Poverty Level	No asset limit	Yes
Medically Needy; Family-related	Spend-down income to TANF limit with medical expenses	$5,000 individual	No. (Parent must be living with child to be eligible; children must be living with parent to be eligible in this category)
Medically Needy: • Aged, blind and disabled • Pregnant women	Spend-down to TANF limit with medical expenses	$5,000 individual	Yes

The biggest implementation obstacle for this impact conference issue is the coordination of eligibility for benefits with DCF ACCESS Florida and assuring the incarceration data (admission date/discharge date) is on the Florida Medicaid Management Information System (FMMIS) for recipients who are inmates of public institutions.

If a different pending proposal to cover only physician services for adults under Medically Needy is adopted, it would affect the anticipated cost savings.

<u>Background information for Medicare coverage of inmates:</u>
For most aged persons and all disabled persons, Medicare Part A is free; Medicare Part B requires a premium payment (the Part B premium amount depends on when the individual began receiving Medicare; the minimum Part B premium is currently $96.40/month but can be more based on enrollment date).

A prison inmate remains enrolled in Medicare A (hospital coverage), but the Medicare record has an indicator that reflects the individual is a prison inmate and Medicare does not pay unless the conditions below are met. In most instances, the prison inmate does not pay the Medicare Part B premium and the Part B is terminated. The Department of Corrections would have to provide information about whether or not Medicare reimbursement would be available based on the criteria provided in this policy from the SSA policy manual:

SSA policy (Program Operations Manual, "HI 00620.070(C) Prisoners): Generally, no payment is made for items or services rendered to prisoners, since the State (or other government component which operates the prison) is responsible for their medical and other needs. For this purpose, the term "prisoner" means a person who is in the custody of the police, penal authorities, or other agency of a governmental entity. This is a rebuttable presumption that may be overcome only at the initiative of the government entity. However, the entity must establish that:

1. ***State or local law requires that individuals in custody repay the cost of the services.***
2. ***The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the***

amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.

The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for by prisoners' medical expenses."

FMMIS will continue to show Medicare coverage so, unless a system change is made, when a hospital submits a Medicaid claim for a dually eligible prison inmate, Medicaid will deny the claim for "Medicare present." The hospital would then have to bill Medicare and if Medicare denies the claim, the hospital would resubmit the claim with the Medicare denial attached so Medicaid would override the "Medicare present" edit and process the claim.

For persons who are inmates of the state mental institution, Medicare and Social Security Title II benefits remain in place, so Medicare continues to cover inpatient hospital care.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #21

Proposal Name:	Acute Care Services for Incarcerated Inmates (1115 demonstration waiver)
Brief Description of Proposal:	Continue Medicaid eligibility for inmates who are Medicaid eligible at the time they enter public institutions under the control of the Departments of Corrections (DOC), Juvenile Justice (DJJ) and Children and Families (DCF) and only allow Medicaid reimbursement of inpatient hospital care
Proposed State Fiscal Year:	unknown
Proposed Start Date:	unknown
If not July 1, start date; please explain.	Requires approval of 1115 demonstration waiver
Total Cost/(Savings)/{Revenue}:	Indeterminate Savings
Bureau(s) Responsible for Administration:	Medicaid Services Third Party Liability (TPL) has been working on a system change with Medicaid Contract Management and DCF to implement 2008 legislation for suspension of Medicaid coverage for prison inmates who are Medicaid eligible at time of admission and providing Medicaid coverage for their inpatient care, 409.0925, F.S. These units and DCF were consulted for this analysis. The 2008 legislation did not include DJJ inmates or State Mental Hospital inmates.

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	One year	• Develop and submit 1115 waiver request (approximately 3 months) • Work with CMS on obtaining approval (can take up to one year) • DCF to develop system to maintain eligibility • FMMIS to accept eligibility periods from DCF, pay inpatient hospital claims for inmates
II. Will this proposal require a change in Florida Statute?	Yes	409.904, F.S. 409.9025, F.S.
III. Will this proposal require a State Plan Amendment?	No	

Issue #21 Cont.

IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	• AHCA Medicaid Provider General handbook (modify language re: inmates of public institutions) • DCF 65A-1, to allow for continued eligibility under 1115 waiver
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Requires an 1115 demonstration waiver
VII. Will this proposal require additional staffing?	Unknown	No additional staffing for AHCA; impact on DCF not known
VIII. Is there a previous or concurrent Analysis by the Agency?	Similar	Analysis for 2008 session for similar provision – implemented 409.0925, F.S. – Eligibility while an inmate (The 2008 bill differs from current proposal; it provided for coverage of inmates in the state's correctional system, in a county detention facility, or in a municipal detention facility; it also provided for continuation of Medicaid benefits to allow for immediate reinstatement of full Medicaid coverage upon release.)
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #21 Cont.**

Lead Analyst:	Martha Crabb
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Data from DOC; DJJ; DCF. Detailed data not readily available.
FY Impacted by Implementation:	2012-13
Date Analysis Completed:	03/02/2011

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

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

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): Federal guidance from the Centers for Medicare and Medicaid Services allows states to provide Medicaid reimbursement for inpatient hospital services for inmates of public institutions who are admitted to the hospital as an inpatient.

An 1115 Research and Demonstration Waiver is required so that parents and caretaker relatives would be eligible for Medicaid even though they are not living with their children. In addition, since Supplemental Security Income payments for aged and disabled individuals stop when the individual is admitted to a public institution, automatic eligibility as an SSI recipient ends. Without the waiver, the Department of Children and Families would have to complete an eligibility determination and authorize eligibility under either the Medicaid for aged and disabled 88% poverty level group or Medically Needy program. Without the waiver, SSI recipients who have Medicare and lose SSI, could not be eligible for the 88% poverty level income group; they could qualify for Medically Needy only; however, if a proposal that would limit services for Medically Needy to physician services only is adopted, Medicaid would not be able to pay for the inpatient hospital care unless the waiver allowed for payment of inpatient hospital care for Medically Needy inmates only.

If the 1115 demonstration waiver also continues Medically Needy enrollment for adults enrolled in a family-related Medically Needy coverage group or persons with Medicare who qualify for Medically Needy only, in most instances the inmate would be able to meet their share of cost, making Medicaid coverage available for the inpatient hospital service. As noted above, however, if a proposed Medically Needy issue were adopted to limit Medically Needy coverage for adults to only physician services, the waiver would also have to allow payment of inpatient care for Medically Needy inmates only if Medicaid reimbursement for inpatient hospital care were to be available for Medically Needy adult inmates.

The 1115 waiver would reduce the amount of workload for the Department of Children and Families as they would not be required to determine or redetermine eligibility while the individual was an inmate of a public institution. It would also result in additional savings as eligibility would be available to persons who would not otherwise be eligible, as noted above for the family-related groups and for the aged and disabled individuals with Medicare.

It is not clear if this proposal is in addition to impact conference issue number 19 which would allow DCF to determine eligibility at the point of admission to a public institution for persons who were not eligible at the time of admission (for example, children in either Juvenile Detention Centers or in Department of Corrections who didn't qualify for Medicaid due to family income but could qualify for Medicaid while in the custody of the Department of Corrections or Juvenile Justice as they are no longer living with their families and family income could not be counted in determining eligibility for the poverty level children's group).

<u>Impact of Medicare on Medicaid claims for inmates</u>
For most aged persons and all disabled persons, Medicare Part A is free; Medicare Part B requires a premium payment (the Part B premium amount depends on when the individual began receiving Medicare; the minimum Part B premium is currently $96.40/month but can be more based on enrollment date).

Medicaid Impact Conference Issues

March 2011

A prison inmate remains enrolled in Medicare A (for those who have free Part A), but the Medicare record has an indicator that reflects the individual is a prison inmate and Medicare does not pay unless the conditions below are met. In most instances, the prison inmate does not pay the Medicare Part B premium and the Part B is terminated. The Department of Corrections would have to provide information about whether or not Medicare reimbursement would be available based on the following policy from the Social Security policy manual:

SSA policy (Program Operations Manual, "HI 00620.070(C) Prisoners): Generally, no payment is made for items or services rendered to prisoners, since the State (or other government component which operates the prison) is responsible for their medical and other needs. For this purpose, the term "prisoner" means a person who is in the custody of the police, penal authorities, or other agency of a governmental entity. This is a rebuttable presumption that may be overcome only at the initiative of the government entity. However, the entity must establish that:

3. ***State or local law requires that individuals in custody repay the cost of the services.***
4. ***The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.***

The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for by prisoners' medical expenses."

FMMIS will continue to show Medicare coverage. This means that unless a system change is made, when a hospital submits a Medicaid claim for a dually eligible prison inmate, Medicaid will deny the claim for "Medicare present." The hospital would then have to bill Medicare and, if Medicare denies the claim, the hospital would resubmit the claim with the Medicare denial attached so Medicaid would override the "Medicare present" edit and process the Medicaid claim.

For persons who are inmates of the state mental institution, neither Medicare nor Social Security Title II benefits are affected.

Issue #21 Cont.

Eligibility category at time of admission	Income limit	Asset limit	Eligible as inmate in public institution without waiver	With 1115 Waiver to continue eligibility in category person was in at time of admission
SSI (aged, blind and disabled)			No- eligible in this category only when receiving payment. SSA stops the SSI payment for inmates.	Yes – waiver would continue inmate as SSI eligible in FMMIS
MEDS-AD (aged and disabled without Medicare)	88% Federal Poverty Level (FPL)	$5,000 individual	Yes	Yes
Aged and Disabled with Medicare in QMB, SLMB or QI1 categories with Medically Needy • Prison inmates, Medicare usually does not pay for any care, including inpatient; • State cannot pay Medicare premiums for inmates of public institutions	n/a	n/a	Not eligible for Medicare Premium payments under QMB; could be eligible for copayments for crossovers for inpatient hospital care, within prescribed Medicaid reimbursement limits. SLMB and QI1: could remain open on FMMIS with incarceration indicator, but not eligible for payment of the Medicare premium by Medicaid (payment of the Part B premium is the only benefit available for SLMB and QI1 programs)	Only if waiver included QMB; as QMB, only benefit is payment of copayments for inpatient hospital care for incarcerated inmate within prescribed Medicaid limits subject to Medicaid reimbursement rates. Individual would not be eligible for payment of premiums. SLMB and QI1 would not be included in waiver.
Family-related groups	TANF limit	$2,000 family	No-parent must be living with child to be eligible; children must be living with parent to be eligible in this category	Yes – waiver would continue inmate as eligible in family-related group
Children only, poverty level group (ages 6 up to age 19)	100% FPL	No asset limit	Yes (when turn 19, no longer eligible in this group)	Yes
Pregnant women	185% Federal Poverty Level	No asset limit	Yes	Yes
Medically Needy; Family-related	Spend-down income to TANF limit with medical expenses	$5,000 individual	No	Yes
Medically Needy: • Aged, blind and disabled • Pregnant women	Spend-down income to TANF limit with medical expenses	$5,000 individual	Yes	Yes

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #23

Proposal Name:	Mental Health Treatment Facilities (civil and forensic programs)
Brief Description of Proposal:	Provide an estimate of savings for requesting a waiver to authorize the receipt of federal financial participation for state only (general revenue) funded services provided to persons occupying a civil or forensic bed in a facility under the control of the Department of Children and Family Services. The estimate should assume waiver authority is granted from the accumulated savings under the section 1115 waiver.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	n/a
If not July 1, start date; please explain.	CMS is no longer granting waivers for Institutions for Mental Diseases (IMD)
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	n/a

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	n/a	
II. Will this proposal require a change in Florida Statute?	n/a	
III. Will this proposal require a State Plan Amendment?	n/a	
IV. Will this require the Procurement Process?	n/a	
V. Will this proposal require an administrative rule?	n/a	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	CMS will not grant waivers for IMDs.
VII. Will this proposal require additional staffing?	n/a	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	n/a	Unknown

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #23 Cont.**

Lead Analyst:	Bill Hardin
Secondary Analyst:	David Royce
Assumptions (Data source and methodology):	Communicated with DCF on this issue.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/09/2011

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

Medicaid Impact Conference Issues

March 2011

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

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): The Centers for Medicare and Medicaid Services (CMS) will not grant a waiver for residential behavioral health services. As a result of federal reinterpretation of the rationale for initially granting the IMD exclusion waivers, CMS decided that all such waivers had to be phased out upon their current expiration. No further waivers will be granted.

The Department of Children and Families (DCF) expressed some concerns: DCF administrators noted that downward substitutions in capitated arrangements can be made for two reasons: one, a service that meets the recipient's needs but is less expensive; or two, a service that meets the recipient's needs in a less restrictive setting. Because Florida Medicaid limits hospital stays, covering state mental hospitals as a downward substitution cannot be considered as a less expensive option. The Medicaid inpatient coverage for recipients 21 and over is limited to a maximum of 45 days per fiscal year. This State Plan limit caps the cost at about $45,000 to $50,000 per recipient. The length of stay at state mental hospitals averages over one year. Therefore, the state hospitals are more expensive, not less. In addition, under the Medicaid managed care plans, the actual utilization of inpatient is substantially below the 45 days. Also, state mental hospitals are considered to be the most restrictive settings for mental health treatment, so the second reason is clearly not met as well.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #24

Proposal Name:	Payment for Preventable Hospital Errors
Brief Description of Proposal:	Provide an estimate of savings by adopting the Medicare policy of no longer reimbursing hospitals for preventable errors
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($822,778)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis; Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Adopt payment adjustment methodology; amend reimbursement plan; amend contracts as needed
II. Will this proposal require a change in Florida Statute?	Yes	S. 409.905, F.S.; S. 409.908, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	State Plan amendments are required when rule changes are made/
IV. Will this require the Procurement Process?	Yes	When the QIO organization is used, may require amendments to contract. Also may need to amend audit contract.
V. Will this proposal require an administrative rule?	Yes	Amendment to Hospital Inpatient Reimbursement Plan as incorporated into rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Previous analysis was done in FY 2008-2009
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #24 Cont.**

Lead Analyst:	Medicaid Services
Secondary Analyst:	Medicaid Program Analysis
Assumptions (Data source and methodology):	Based on FMMIS claims data and Medicare policy change. This analysis assumes savings would result from denying prior authorization requests for additional hospital days related to treatment for Health Care Acquired Conditions. There is no indicator to indicate hospital acquired conditions. To estimate the impact on Medicaid Reimbursement, the estimated annual savings to Medicare as a percent of annual Medicare Reimbursement for Short Stay Hospitals was applied to Medicaid inpatient hospital reimbursement (excluding SIPP hospitals). Policies and procedures would need to be developed and implemented to allow for appropriate review and denial of claims related to these additional conditions.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/08/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($822,778)**		**($0)**
General Revenue:	**($367,643)**		**($0)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($455,135)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

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

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

Section 5001© of the Deficit Reduction Act of 2005 requires Medicare to identify at least two conditions that are (a) high cost and/or high volume; (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. In August 2007, Medicare published the FY 2008 Inpatient Prospective Payment System (IPPS) Final Rule. The Final Rule included six (6) conditions that when present; trigger a higher payment under Medicare reimbursement methodology. For discharges after October 1, 2008, IPPS hospitals have not received additional payment for cases when one of the selected conditions is acquired during hospitalization (the condition was not present on admission to the hospital). Payment would be made under the Medicare reimbursement methodology as if the secondary diagnosis was not present.

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

Florida pays on a per diem based on Medicaid allowable costs rather than on a DRG methodology. If the policy is adopted to not reimburse hospitals for the hospital acquired conditions adopted by Medicare, a methodology must be developed to adjust the payments to hospitals to reflect the additional cost for the hospital acquired conditions.

Estimated Fiscal Impact for Medicaid if Hospital Acquired Conditions Adopted by HHS for Medicare are adopted for Non Payment by Medicaid

HAC Category	Discharges identified as HAC
Foregin Object	189
Air Embolism	24
Blood Incom.	8
PU	1,316
Falls	5,312
UTI	2,333
Vasc Cath	2,573
Glycemic	395
SSI-Medicast	26
SSI-Ortho	155
SSI-Bariatric	15

DVT-PE	2,335	
Total	**14,681**	
Unduplicated total	**14,621**	
Total discharges	**9,298,503**	
Discharges w/ reassigned MS DRG	3,401	
Changes in Total IPPS payment		$18,779,932

% with HAC = 0.16%
Change per reassigned discharge= $5,522
The data above is national data based on Medicare discharges in Oct. 2008 – Sep. 2009. Data for Atlanta region is also available. Based on that data the % with HACs is also 0.16%. The payment savings data from MS-DRG reassignment is only available for national data. Therefore, we will only use national data.
Data Source: http://www.rti.org/reports/cms/

FLORIDA DATA:
AHCA Data for use in estimating potential HAC savings:
Projections for SFY 2012 for hospital inpatient:
- Medicaid admissions for the year = 407,976
- Total Expenditures for the year = $3,889,412,753

Estimated # discharges with HACs = 0.00157*407,976 = 640
Based on RTI data 23.26% resulted in reassignment of the MS-DRG.
Estimated # with reassigned MS-DRG for FL = 149
Change in payment per reassigned DRG = $5,522
Estimated payment savings for FL = 149*$5,522 = $822,778

LIMITATIONS:
- Assumptions based on Medicare claims data where the identification of HACs is based on POA indicators. The estimates may not be applicable if POA indicators are not available.
- Medicare claims are not paid per diem therefore applying the RTI estimates to a per diem based system is not accurate.
- Available literature on HACs is specific to selected HACs and most articles found are based on NY data.
- Very limited data on FL Medicaid is available at this time

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #26

Proposal Name:	Specialty Drug Management
Brief Description of Proposal:	Provide an estimate of savings from outsourcing high-cost injectable medications to reduce inappropriate utilization and to promote preferred products. The specifics of the proposal referenced in the PS2 Study presented to the Senate did not address all "specialty pharmacy", but described a limited oncology "buy and bill" prepayment review program. Savings with this type of program could possibly be as much as $9.4 million total funds annually (approximately $3.167 million GR), but current system architecture precludes quick implementation.
Proposed State Fiscal Year: 00/00	**2012-13**
Proposed Start Date: 00/00/0000	**07/01/2012**
If not July 1, start date; please explain.	Current system architecture would require significant changes to implement this program.
Total Cost/(Savings)/{Revenue}:	($9,422,642)
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services and Medicaid Contract Management (for extensive fiscal agent system programming)

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Earliest implementation 07/01/12 due to extensive fiscal agent system programming required.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	Yes	Currently any willing provider; this proposal is a “buy and bill” prepayment review and management program.
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	Yes	Pharmacy clinical oversight and contract management functions.
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #26 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Input from Anne Wells, Bureau Chief Pharmacy Services
Assumptions (Data source and methodology):	Proposal from Magellan Health Services iCore Division. Magellan prepared this estimate based upon AHCA claims for certain injectable oncology drugs from Q408 and Q309.
FY Impacted by Implementation:	2012-13
Date Analysis Completed:	02/22/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	
Total (Savings) Cost of Proposal:	**($9,422,642)**		
General Revenue:	**($4,151,616)**		
Administrative Trust Fund:			
Medical Health Care Trust Fund:	**($5,271,026)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

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

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

The specifics of the proposal referenced in the PS2 Study did not address all "specialty pharmacy", but was a limited oncology "buy and bill" prepayment review program. Savings could possibly be as much as $9.4 million total funds annually (approximately $3.167 million GR), but current system architecture precludes quick implementation. The Magellan Health Services estimate for the oncology buy and bill program is summarized in the chart below.

ICORE Initiative	Savings Opportunity	% of Total Spend	Timing
Reimbursement	$5,702,742	10.3%	120 days
Product Mix	$1,120,065	2.2%	120 days
Operational Improvements			
Max Unit Edits	$127,666	0.3%	120 days
Off-Label Use	$700,168	1.6%	120 days
Utilization Management			
Prior Authorization	$1,772,000	7.6%	120 days
Totals	**$9,422,641**	**17.5%**	

Source: Magellan Health Services, Inc.

Regarding other specialty drug management, high cost injectables are already subject to prior authorization, and appropriate utilization is already being controlled. Many of these medications are already being shipped by a variety of specialty pharmacies. These specialty pharmacies are subject to the current reimbursement rates, and are already providing free shipment to recipients or medical providers (for example, providers of drugs for cystic fibrosis already do this voluntarily). Medications that can be self administered are being shipped to recipients. Medications that require administration under the supervision of medical professionals are being shipped to provider offices or medical facilities. Drugs for hemophilia are currently purchased through a competitively procured contract.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #27

Proposal Name:	Pharmacy Formulary HIV Drugs
Brief Description of Proposal:	Review potential savings in soliciting supplemental rebates from manufacturers for PDL inclusion.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/11
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($140,000)
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		
II. Will this proposal require a change in Florida Statute?	Yes	Currently, these drugs are exempt from PDL requirements.
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Handbook incorporated by reference to 59G-4.250 would have to be changed.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #27 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Anne Wells
Assumptions (Data source and methodology):	Estimate provided by the current supplemental rebate negotiation contractor, Provider Synergies (now owned by Magellan Medicaid Management). Estimate was derived using response from manufacturers from other states that have implemented this issue. No manufacturers submitted supplemental rebate offers, and only one product is currently below the statutory minimum in Florida for PDL inclusion. The additional rebate to reach the statutory minimum for this product would be only approximately $140,000 annually.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/22/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($140,000)**		
General Revenue:	**($61,684)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($78,316)**		
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

March 2011

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

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

Drugs used to treat HIV/AIDS have historically been exempt from the statutory requirement to offer a minimum level of combined federal and supplemental rebates as a condition of PDL inclusion, and therefore are exempt from prior authorization requirements.

Currently, manufacturers of all drugs except one in these drug classes have agreed to federal rebates that are in excess of the 29.1 percent combined rebate requirement in Florida statute for PDL inclusion. Rebate revenue from the single existing exception would be less than $140,000 annually for the state. The rebate contractor received no response from manufacturers in a request for bids for supplemental rebates for other states to include these drugs on their PDLs.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #28

Proposal Name:	Pharmacy Managed Care Supplemental Rebates
Brief Description of Proposal:	Provide an estimate of savings from requesting a waiver to obtain supplemental rebates in a managed care environment.
Proposed State Fiscal Year: 00/00	N/A
Proposed Start Date: 00/00/0000	N/A
If not July 1, start date; please explain.	The state already realizes this savings. Supplemental rebates have historically been discounted from MCO rates at the same level as negotiated FFS rebates. Beginning in 2010, capitation rates were set using actual pharmacy encounter data from the MCO plans, and the state will invoice manufacturers directly for the MCO drug rebates. Now at issue is certain manufacturers' refusal to pay supplemental rebates on drugs reimbursed through MCOs. Please see Issue #25 for potential way to continue to realize the impact of these negotiated rebates on expenditures for drugs for individuals in managed care.
Total Cost/(Savings)/{Revenue}:	N/A, see Issue #25 for plan to maintain the current $18.9 million annual level of negotiated rebates for current managed care drug spend.
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

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

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #28 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Anne Wells
Assumptions (Data source and methodology):	Current MCO capitation rate-setting methodology
FY Impacted by Implementation:	N/A
Date Analysis Completed:	02/23/2011

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

Work Papers/Notes/Comments:

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

The state already realizes this savings. Beginning in 2010, capitation rates were set using actual pharmacy encounter data from the MCO plans, and the state will invoice manufacturers directly for the MCO drug rebates. Now at issue is certain manufacturers' refusal to pay supplemental rebates on drugs reimbursed through MCOs. Please see Issue #25 for potential way to continue to realize the impact of these negotiated rebates on expenditures for drugs for individuals in managed care.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #29

Proposal Name:	DD Waivers – Family of 1
Brief Description of Proposal:	Provide an estimate of savings by eliminating eligibility based on "Family of 1" for children.
Proposed State Fiscal Year: 00/00	unknown
Proposed Start Date: 00/00/0000	unknown
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Indeterminate Savings
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		
II. Will this proposal require a change in Florida Statute?	Yes	Medicaid eligibility determination section 409.901 F.S. and subsequent section
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Rule 65A-1.701 F.A.C. and subsequent rules
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Amendments to the four current Developmental Disabilities tier waivers and the proposed Individual Budgeting waiver
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #29 Cont.**

Lead Analyst:	Pamela Kyllonen
Secondary Analyst:	Leigh Meadows
Assumptions (Data source and methodology):	Medicaid eligibility specialist, Florida Administrative Code, Florida Statutes, and Code of Federal Regulation
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/03/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

A total of 2,129 children are currently enrolled in Medicaid in MWA aid category. This category represents children who qualified for Medicaid based on disability and personal income/assets. Because not all of these 2,129 children are enrolled on the Developmental Disabilities waivers; the number of MWA enrolled children in DD waivers would need to be determined.

In conducting Medicaid enrollment, the Department of Children and Families does not collect income information for parents of minor children. Parental income cannot be counted in determining eligibility for Home and Community-Based Services waivers for children per Code of Federal Regulation (42 CFR 435). Since parental income cannot be considered for eligibility determination there is no way to determine how many MWA enrolled children's families would fall under this category. Counting the income of parents in determining the eligibility for children under the Home and Community Based Services waiver eligibility category is not permitted by federal law or regulation.

Under the Affordable Care Act Medicaid Maintenance of Effort (MOE) provision, for purposes of the MOE compliance, the requirement for individuals to pay premiums is considered to be a provision for eligibility. Thus, imposition of new premiums (i.e. parental fees) would be considered a new eligibility requirement and not compliant with the MOE provision. If the Affordable Care Act is not repealed or revised or the decision that is unconstitutional is not upheld, the state of Florida would lose federal funding for any quarter it is found to not be incompliance with the Maintenance of Effort provision.

Therefore, eliminating DD waiver eligibility for children "Family of One" and changing eligibility standards to consider parental income for their eligibility is out of compliance with federal law for determining eligibility for children under the Home and Community Based Services eligibility coverage group. Further, as noted above, it would be considered out of compliance with the Affordable Care Act if the Act is not repealed, revised or found to be constitutional.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #30

Proposal Name:	DD Waivers – Parental fee
Brief Description of Proposal:	Provide an estimate of savings by implementing a parental fee for waiver clients under the age of 18 whose parent's income would not have qualified for Medicaid absent the "Family of one" eligibility category. Analysis should assume a sliding scale fee based on income bands. Reference Minnesota parental fee.
Proposed State Fiscal Year: 00/00	unknown
Proposed Start Date: 00/00/0000	unknown
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	Indeterminate Savings
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		
II. Will this proposal require a change in Florida Statute?	Yes	Medicaid eligibility determination section 409.901 F.S. and subsequent section
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Rule 65A-1.701 F.A.C. and subsequent rules
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	Amendments to the four current Developmental Disabilities tier waivers and the proposed Individual Budgeting waiver
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #30 Cont.**

Lead Analyst:	Pamela Kyllonen
Secondary Analyst:	Leigh Meadows
Assumptions (Data source and methodology):	Medicaid eligibility specialist, Florida Administrative Code, Florida Statutes, and Code of Federal Regulation
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/08/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

A total of 2,129 children are currently enrolled in Medicaid in MWA aid category. Not all 2,129 children are enrolled on the Developmental Disabilities waivers. During Medicaid enrollment, the Department of Children and Families does not collect incomes for parents because it is not used in the eligibility determination thus it is difficult to determine how many of the children's families would fall under this category.

Per Code of Federal Regulation (42 CFR 435), parental income cannot be counted in determining eligibility for Home and Community-Based Services waivers for children.

If payment of the fee were a condition of Medicaid eligibility, the Affordable Care Act Maintenance of Effort provision prohibits the state from imposing more restrictive eligibility policy or procedures on children until October 2019.

If it is imposing coinsurance or copayments, that is permitted. Under Section 1916A of the Social Security Act, state Medicaid programs have additional flexibility for imposing premiums and cost-sharing. The aggregate amount of premiums and cost-sharing for all individuals in the family enrolled in Medicaid cannot exceed 5 percent of the family's income.

Since parental income information is not collected by DCF, the amount of savings cannot currently be predicted.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #31

Proposal Name:	Pharmaceutical Expense Assistance Program
Brief Description of Proposal:	Provide an estimate of estimated savings due to reducing the appropriation for this program to the most recent FY estimate.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services and Medicaid Contract Management

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Implement 07/01/11
II. Will this proposal require a change in Florida Statute?	Possibly	Program mandated in 409.9301, Florida Statutes. This is a state program only.
III. Will this proposal require a State Plan Amendment?	No	This is not a Medicaid program; state GR only.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #31 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Fred Roberson
Assumptions (Data source and methodology):	Paid claims data, Medicaid Program Analysis. SSEC February 2011
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

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

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

Only those 652 individuals who met eligibility requirements as of January 1, 2006, were enrolled in the program. The program included Medicare eligible individuals who were also eligible under the Florida Medicaid Medically Needy program and who had been diagnosed with cancer or were organ transplant recipients. No new enrollees have been added, and the number of individuals who accessed the program during fiscal year 2008-2009 had decreased to 71 through attrition, and further to 59 in 2010-11.

Amounts reimbursed by the state are the Medicare deductible or copayment requirement for the specific drugs covered. After Medicare Part B reimburses the provider for the initial claim, Medicaid pays the "crossover" claim for the residual amount. Based upon paid claims data, annual Expenditures are estimated at approximately $72,000. Current funding is $50,000 annually.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #32

Proposal Name:	Limit Medicaid Behavioral Health Overlay Services to Six Days Per Week for Juvenile Justice and Child Welfare Clients
Brief Description of Proposal:	Savings associated with limiting behavioral health overlay services for youths in juvenile justice and child welfare settings to six days a week.
Proposed State Fiscal Year:	2011-12
Proposed Start Date:	N/A
If not July 1, start date; please explain.	Rule revision will have to be promulgated.
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	1/1/2012	Implementation requires promulgation of a rule revision.
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #32 Cont.**

Lead Analyst:	Bill Hardin
Secondary Analyst:	David Royce
Assumptions (Data source and methodology):	SSEC February 2011. Claims data.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/22/2011

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

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

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles): Providers assert that the current rate is too low. The rate for this bundled service is $32.75 per day. It has remained the same since 1999. Providers will likely assert that they could not continue service delivery if the rate is cut. In the alternative, they could simply admit more children into their BHOS programs to make up for the lost revenue, thus negating any savings.

Also, there may be no reasonable way to implement a six-day-per-week reimbursement limitation in the Florida Medicaid Management Information System (FMMIS). Service delivery can begin on any day of the week so the system would have to constantly track per diem units. Assuming there is a way to adequately program the proposed reimbursement reduction, it would likely take considerable time and effort to design and implement. If such programming is not possible, then Medicaid would have to increase the number of retrospective reviews for these BHOS providers. Increased monitoring would result in a greater fiscal impact on the Agency and burden on the providers with no guaranteed return for the efforts.

And finally, even if this reimbursement reduction could somehow be implemented in the system or enforced through provider monitoring, EPSDT rules may require that the Agency have a service authorization mechanism in place to provide the seventh day of BHOS service. If a Medicaid-enrolled treating practitioner found it medically necessary for a child recipient to receive that seventh day of BHOS service, then federal rules would likely require that Medicaid provide it. Medicaid currently pays a fee to its vendor for every prior authorization of services that exceed the limit. The need for more authorizations would create an additional fiscal impact on the Agency with no guarantee of savings.

Medicaid Impact Conference Issues
March 2011

Proposal: Issue #33

Proposal Name:	Elimination of Disease Management Funding for Integrative Medicine Disease Management program and funding for dual eligible enrollment in HIV/AIDS Disease Management program
Brief Description of Proposal:	Elimination of funding for the Integrative Medicine Disease Management Program (AMI) and eliminating funding for dual eligible enrollment in the HIV/AIDS Disease Management Program.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	12/01/2011
If not July 1, start date; please explain.	A Transition period will be necessary to disenroll recipients from current programs including the federally required 60 day notice to recipients and coordination of care with providers.
Total Cost/(Savings)/{Revenue}:	($2,568,440)
Bureau(s) Responsible for Administration:	Health Systems Development

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	A transition plan will need to be developed and implemented to end the current AMI DM program. It will be necessary to include a federally required 60 day notice of the program ending to recipients currently enrolled in the program. Terminating the AMI DM program will also require coordination of care with the current vendor and providers. A transition plan will need to be developed and implemented to exclude and terminate the dual eligibles from enrollment the HIV/AIDS DM program. The transition plan will require the same 60 day notice period and will require care coordination with providers. 7/1/2011 Effective date of budget reduction 8/1 DM Vendors submit and Agency approves transition plan 1915(b) and 1915(b)(c) waiver amendments submitted to federal CMS 9/1 Transition plan implemented 10/1 Notice mailed to affected recipients 11/1 Transition plan continues 12/1 AMI DM program terminated. Dual eligibles terminated from HIV/AIDS DM program.
II. Will this proposal require a change in Florida Statute?	No	

Medicaid Impact Conference Issues

March 2011

III. Will this proposal require a State Plan Amendment?	No	
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	No	
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	Yes	The 1915(b) waiver would need to be amended to remove the waiver authority for the Integrative Medicine Program. The 1915(b)(c) waiver would have to be amended to update the Medicaid eligibility categories eligible for enrollment in the HIV/AIDS Disease Management Program.
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Schedule VIII-B
IX. Is this proposal included in the current Governors recommendations?		The proposal to eliminate the funding for both Integrated Medicine Disease Management program and the removal of the dual eligibles from the current HIV/AIDS Disease Management program was included in the Schedule VIII-B reductions submitted by the Agency and is included in the Governor's Budget recommendations.

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #33 Cont.**

Lead Analyst:	Tracy Hurd
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Disease Management budget line item funding was used to determine the savings. Eliminating the AMI DM program effective 12/1/2011 – savings projected (300 enrollees effective 12/1/11 with two tier payment mechanism) Eliminating the dual eligible population from the HIV/AIDS DM program (3,000 enrollees @ $90.00PMPM) effective 12/1/2011)
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/07/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**7**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($2,568,440)**		**($4,403,040)**
General Revenue:	**($1,131,655)**		**($1,939,980)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($1,436,785)**		**($2,463,060)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

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

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

The elimination of the funding for the AMI (Integrative Medicine) DM program will result in the elimination of certain waiver services to enrolled recipients including disease state education, nutritional counseling, massage therapy, acupuncture, and durable medical equipment including blood pressure cuffs and weight scales that are useful in self management of chronic disease. These services are not currently covered under the State Plan. The elimination of the AMI DM program funding will not adversely impact a recipients' ability to obtain medical care and Medicaid covered services. Medicaid covered services would continue to be available to the affected recipients and providers will continue to be reimbursed for Medicaid covered services.

If the dual eligible population is removed from the HIV/AIDS DM program Medicare and Medicaid covered services would continue to be available to these recipients and their ability to obtain medical care would not be adversely impacted. These recipients would continue to receive Project AIDS Care (PAC) waiver services as they do currently (dual eligibles must be enrolled in the PAC wavier program to be eligible to enroll in the HIV/AIDS DM program). The majority of medical care cost savings generated by the dual eligible enrollment in the HIV/AIDS DM program is realized by Medicare as Medicaid is responsible for few medical services for this population.

There are current statutory requirements to implement Disease Management and without funding, AHCA could not do so.

The Agency also has Legislative direction to develop and implement a Medical Home pilot within current resources. The Agency has identified the case management line as a source of funding for the pilot project. The Medical Home managed care model as identified in 409.91207, F.S. along with the disease management services as outlined in the proviso above appears to meet the qualifications for a Health Home managed care model from the federal CMS perspective, and as such, the program may be eligible for an enhanced FFP of 90%. If the enhanced FFP is utilized, the program would be able to be implemented statewide without additional GR. The Agency is evaluating the feasibility of creating a program that integrates disease management and medical home objectives in managed care settings.

It should be noted that if the budget currently allocated in the case management – disease management line item is eliminated, the Agency would not have budget authorized to fund the Fee-For-Service Provider Service Network administrative allocation reimbursements as those payments are authorized in this case management line. FY 1112 Disease Management Fee estimate is $73,899,408 (Feb. 2011 SSEC) of which about $44 million is PSN administrative allocation.

Issue #33 Cont.

Disease Management SFY 11-12

Pfizer DM (At Current FFP)

Pfizer Health Solutions	**FY09-10**	**FY10-11**	**FY11-12**
GR	$5,824,469	$6,332,040	$7,930,349
MCTF	$12,174,508	$11,666,937	$10,068,628
Total	$17,998,977	$17,998,977	$17,998,977

Potential Savings

Eliminate the Alternative Therapy DM program

GR	($442,486)
MCTF	($561,794)
Total (Case Management)	($1,004,280)

Evaluation does not support savings generated by this program.

Exclude the dual eligibles from participating in the HIV/AIDS DM program

GR	($1,497,494)
MCTF	($1,901,266)
Total (Case Management)	($3,398,760)

Currently dual eligibles that receive PAC Wavier services are eligible to be enrolled in the HIV/ AIDS DM program. This is the only DM program that allows dual eligibles to enroll, and was begun as a move toward full integration of services for the dual eligible population. As the MA SNP plans are being implemented, Medicaid is moving forward with the federal mandate of full integration of services and therefore this initial step of allowing the dual eligible to be enrolled in DM can be eliminated. Currently there are 3,147 PAC waiver recipients enrolled in the DM program.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #34

Proposal Name:	Pharmacy Reimbursement
Brief Description of Proposal:	Provide the estimated savings from lowering the Wholesale Acquisition cost (WAC) pricing component from WAC plus 4.75% to WAC plus 3.75%. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($8,982,994) **Important Note: After FDB stops reporting AWP in Sept 2011, the pricing logic for branded medications will default to WAC + 4.75%. Allowing the pricing to default to WAC+4.75% will result in a negative fiscal impact of $30.7 million annually. Therefore, the pricing logic based on a WAC+ formula must be revised. The WAC+3.75% will result in a cost of $21.7 million annually. SSEC February 2011 already accounts for the $30.7 million cost.** See range of options below.
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Could be implemented upon enactment.
II. Will this proposal require a change in Florida Statute?	Yes	409.908 and 409.912, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Pharmacy reimbursement must be approved by CMS.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.251, F.A.C. Prescribed Drug Reimbursement Methodology.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Same analysis was provided for FY 10/11 budget cycle. This analysis used and updated claim and price sample.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #34 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Claim data re-priced by Magellan Medicaid Management analysts.
Assumptions (Data source and methodology):	Analysis: Re-price prescriptions from Oct 1 – Dec 31, 2010 as follows: 1. Select prescriptions originally priced according to the AWP – 16.4% + $3.73 2. This sample included 1,041,124 prescriptions totaling $254,726,199 3. Re-price the prescriptions as if the AWP formula no longer exists (WAC + 4.75% + $3.73) and calculate the financial impact. 4. Re-price the same sample of prescriptions at incrementally lower WAC-based formulas, until the analysis achieves parity with the AWP formula. 5. Re-price the same sample of prescriptions at AWP - 17.4% to determine impact.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($8,982,994)**		
General Revenue:	**($3,949,200)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($5,014,031)**		
Refugee Assistance Trust Fund:	**($19,763)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

March 2011

Work Papers/Notes/Comments: **Issue #34 Cont.**

Florida Medicaid Reimbursement Compared to Other States

The "lesser than" pricing logic and $3.73 dispensing fee utilized by Florida Medicaid has resulted in the lowest **overall** pharmacy reimbursement rate in the country. A comparison table of reimbursement by State can be found at the attached link: http://www.cms.gov/Reimbursement/20_StateMedicaidRxReimb.asp#TopOfPage

States are reviewing their reimbursement methodologies to exclude AWP calculations as explained below under "Pricing Issue of Immediate Concern".

With respect to branded prescriptions, California currently uses AWP – 17% in the base calculation, but then allows a dispensing fee of $7.25. The other large Medicaid States (Texas, New York) allow higher reimbursement rates on ingredient cost as well as higher dispensing fees. A few small States (New Hampshire, Rhode Island) support reimbursement rates on branded drugs comparable to Florida, but these are very small State Medicaid Programs.

In January, 2011, the state of Oregon received approval from CMS to change its pharmacy reimbursement from an AWP-based calculation to Average Acquisition Cost (AAC) or the Wholesale Acquisition Cost (WAC) if AAC is not available. Further, their dispensing fee is now tiered based upon annual volume of prescriptions filled by the pharmacy. The dispensing fee for the volume tiers ranges from $9.68 to $14.01.

Pricing Issue of Immediate Concern

First Data Bank reporting of AWP will end as per the terms of a federal legal settlement in September 2011. **Under the current pricing logic, if AWP is no longer reported, then the pricing default for branded pharmaceuticals becomes WAC + 4.75%. There is a significant fiscal impact associated with allowing this default formula to take effect in September 2011.**

The Agency has calculated the fiscal impact that occurs when Average Wholesale Price (AWP) is no longer published, and the default formula for branded pharmaceuticals becomes WAC + 4.75% The Agency took actual paid pharmacy claims from 10/01/2010 through 12/31/2010 that were paid using the AWP methodology and re-priced these prescriptions using various increments of WAC+ pricing methodology.

If AWP had not been available between Oct-Dec 2010, current statutory Medicaid pricing logic would have defaulted to WAC + 4.75%. This would have increased the cost of these drugs to the Florida Medicaid program by $7,679,575.40 for the quarter (annualized $30,718,302 total funds). Based on this claim sample, to achieve parity with the current AWP-based reimbursement, the WAC-based calculation would need to be WAC + 1.5%.

The spreadsheet below shows the calculation comparison using the two pricing methodologies. In addition, the spreadsheet shows the re-pricing of prescribed drugs at incrementally lower WAC-based calculations to bring the cost closer to a budget neutral solution that accounts for the loss of AWP in the pricing methodology. Finally, the spreadsheet also quantifies the impact of AWP – 17.4%, as requested for the conference. At current levels, this would be a reduction in reimbursement to retail pharmacies of $10 million annually.

Medicaid Impact Conference Issues

March 2011

Issue #34 Cont.

Date Range: 10/01/2010 - 12/31/2010						
Current Pricing Formula	**# Claims**	**Actual Paid Amount**				
AWP - 16.4% + $3.73	1,041,124	$ 254,726,199.42				
Less Dispensing Fees		$ (3,883,392.52)				
Current Ingredient Cost		$ 250,842,806.90		check	$ (0.00)	
Re-Pricing Formulas	**# Claims**	**Claim cost calculation based on WAC**	**Ingredient Cost Only**	**Ingredient Cost Difference**	**Annualized**	
WAC + 4.75% + $3.73	1,041,124	$ 262,405,774.82	$ 258,522,382.30	$ 7,679,575.40	$ 30,718,302.00	current statute
WAC + 3.75% + $3.73	1,041,124	$ 260,160,026.40	$ 256,276,633.88	$ 5,433,826.97	$ 21,735,308.00	
WAC + 2.75% + $3.73	1,041,124	$ 257,880,134.42	$ 253,996,741.90	$ 3,153,934.99	$ 12,615,740.00	
WAC + 1.75% + $3.73	1,041,124	$ 255,567,191.99	$ 251,683,799.47	$ 840,992.57	$ 3,363,970.00	
WAC + 1.50% + $3.73	1,041,124	$ 254,985,236.72	$ 251,101,844.20	$ 259,037.30	$ 1,036,149.00	
WAC + 1.00% + 3.73	1,041,124	$ 253,816,993.69	$ 249,933,601.17	$ (909,205.73)	$ (3,636,823.00)	
WAC + $3.73	1,041,124	$ 250,777,015.22	$ 246,893,622.70	$ (3,949,184.21)	$ (15,796,737.00)	
AWP - 17.4%			$ 248,334,378.84	$ (2,508,428.07)	**$ (10,033,712.00)**	Per impact conf request
WAC - 5.00%					**$ (15,359,927.66)**	WAC equivalent

Analysis: Re-price prescriptions from Oct 1 – Dec 31, 2010 as follows:
1. Select prescriptions originally priced according to the AWP – 16.4% + $3.73
2. This sample included 1,041,124 prescriptions totaling $254,726,199
3. Re-price the prescriptions as if the AWP formula no longer exists (WAC + 4.75% + $3.73) and calculate the financial impact.
4. Re-price the same sample of prescriptions at incrementally lower WAC-based formulas, until the analysis achieves parity with the AWP formula.
5. Re-price the same sample of prescriptions at AWP - 17.4% to determine impact.

Conclusion: Eliminating AWP at this time from the prescription pricing logic and allowing the pricing logic for branded medications to default to WAC + 4.75% will increase drug expenditures by $30.7 million annually at current levels. This does not include the ongoing impact of manufacturer price increases or any growth factor. Further, reducing the AWP-based reimbursement calculation to AWP-17.4% would result in ingredient cost reimbursement reduction of $10 million annually at current claim levels.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #34A

Proposal Name:	Pharmacy Reimbursement
Brief Description of Proposal:	Provide the estimated savings from adjusting the Wholesale Acquisition cost (WAC) pricing component to a cost closer to a budget neutral solution that accounts for the loss of AWP in the pricing methodology. Provide a mechanism to calculate the reduction.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($29,682,153) **Important Note: After FDB stops reporting AWP in Sept 2011, the pricing logic for branded medications will default to WAC + 4.75%. Allowing the pricing to default to WAC+4.75% will result in a negative fiscal impact of $30.7 million annually. Therefore, the pricing logic based on a WAC+ formula must be revised. The WAC+1.5% will result in a cost of $1 million annually. SSEC February 2011 already accounts for the $30.7 million cost.**
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Could be implemented upon enactment.
II. Will this proposal require a change in Florida Statute?	Yes	409.908 and 409.912, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Pharmacy reimbursement must be approved by CMS.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	59G-4.251, F.A.C. Prescribed Drug Reimbursement Methodology.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Same analysis was provided for FY 10/11 budget cycle. This analysis used and updated claim and price sample.
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #34A Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Claim data re-priced by Magellan Medicaid Management analysts.
Assumptions (Data source and methodology):	Analysis: Re-price prescriptions from Oct 1 – Dec 31, 2010 as follows: 1. Select prescriptions originally priced according to the AWP – 16.4% + $3.73 2. This sample included 1,041,124 prescriptions totaling $254,726,199 3. Re-price the prescriptions as if the AWP formula no longer exists (WAC + 4.75% + $3.73) and calculate the financial impact. 4. Re-price the same sample of prescriptions at incrementally lower WAC-based formulas, until the analysis achieves parity with the AWP formula. This occurs at WAC+1.5%
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($29,682,153)**		
General Revenue:	**($13,049,185)**		
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($16,567,667)**		
Refugee Assistance Trust Fund:	**($65,301)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

Medicaid Impact Conference Issues

March 2011

Work Papers/Notes/Comments: **Issue #34A Cont.**

Florida Medicaid Reimbursement Compared to Other States

The "lesser than" pricing logic and $3.73 dispensing fee utilized by Florida Medicaid has resulted in the lowest **overall** pharmacy reimbursement rate in the country. A comparison table of reimbursement by State can be found at the attached link: http://www.cms.gov/Reimbursement/20_StateMedicaidRxReimb.asp#TopOfPage

States are reviewing their reimbursement methodologies to exclude AWP calculations as explained below under "Pricing Issue of Immediate Concern".

With respect to branded prescriptions, California currently uses AWP – 17% in the base calculation, but then allows a dispensing fee of $7.25. The other large Medicaid States (Texas, New York) allow higher reimbursement rates on ingredient cost as well as higher dispensing fees. A few small States (New Hampshire, Rhode Island) support reimbursement rates on branded drugs comparable to Florida, but these are very small State Medicaid Programs.

In January, 2011, the state of Oregon received approval from CMS to change its pharmacy reimbursement from an AWP-based calculation to Average Acquisition Cost (AAC) or the Wholesale Acquisition Cost (WAC) if AAC is not available. Further, their dispensing fee is now tiered based upon annual volume of prescriptions filled by the pharmacy. The dispensing fee for the volume tiers ranges from $9.68 to $14.01.

Pricing Issue of Immediate Concern

First Data Bank reporting of AWP will end as per the terms of a federal legal settlement in September 2011. **Under the current pricing logic, if AWP is no longer reported, then the pricing default for branded pharmaceuticals becomes WAC + 4.75%. There is a significant fiscal impact associated with allowing this default formula to take effect in September 2011.**

The Agency has calculated the fiscal impact that occurs when Average Wholesale Price (AWP) is no longer published, and the default formula for branded pharmaceuticals becomes WAC + 4.75% The Agency took actual paid pharmacy claims from 10/01/2010 through 12/31/2010 that were paid using the AWP methodology and re-priced these prescriptions using various increments of WAC+ pricing methodology.

If AWP had not been available between Oct-Dec 2010, current statutory Medicaid pricing logic would have defaulted to WAC + 4.75%. This would have increased the cost of these drugs to the Florida Medicaid program by $7,679,575.40 for the quarter (annualized $30,718,302 total funds). Based on this claim sample, to achieve parity with the current AWP-based reimbursement, the WAC-based calculation would need to be WAC + 1.5%.

The spreadsheet below shows the calculation comparison using the two pricing methodologies. In addition, the spreadsheet shows the re-pricing of prescribed drugs at incrementally lower WAC-based calculations to bring the cost closer to a budget neutral solution that accounts for the loss of AWP in the pricing methodology.

Medicaid Impact Conference Issues

March 2011

Issue #34A Cont.

Date Range: 10/01/2010 - 12/31/2010						
Current Pricing Formula	**# Claims**	**Actual Paid Amount**				
AWP - 16.4% + $3.73	1,041,124	$ 254,726,199.42				
Less Dispensing Fees		$ (3,883,392.52)				
Current Ingredient Cost		$ 250,842,806.90		check	$ (0.00)	
Re-Pricing Formulas	**# Claims**	**Claim cost calculation based on WAC**	**Ingredient Cost Only**	**Ingredient Cost Difference**	**Annualized**	
WAC + 4.75% + $3.73	1,041,124	$ 262,405,774.82	$ 258,522,382.30	$ 7,679,575.40	$ 30,718,302.00	current statute
WAC + 3.75% + $3.73	1,041,124	$ 260,160,026.40	$ 256,276,633.88	$ 5,433,826.97	$ 21,735,308.00	
WAC + 2.75% + $3.73	1,041,124	$ 257,880,134.42	$ 253,996,741.90	$ 3,153,934.99	$ 12,615,740.00	
WAC + 1.75% + $3.73	1,041,124	$ 255,567,191.99	$ 251,683,799.47	$ 840,992.57	$ 3,363,970.00	
WAC + 1.50% + $3.73	1,041,124	$ 254,985,236.72	$ 251,101,844.20	$ 259,037.30	$ 1,036,149.00	
WAC + 1.00% + 3.73	1,041,124	$ 253,816,993.69	$ 249,933,601.17	$ (909,205.73)	$ (3,636,823.00)	
WAC + $3.73	1,041,124	$ 250,777,015.22	$ 246,893,622.70	$ (3,949,184.21)	$ (15,796,737.00)	
AWP - 17.4%			$ 248,334,378.84	$ (2,508,428.07)	**$ (10,033,712.00)**	Per impact conf request
WAC - 5.00%					**$ (15,359,927.66)**	WAC equivalent

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #35

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associated with eliminating nursing home bed hold days.
Proposed State Fiscal Year:	2011-12
Proposed Start Date:	01/01/2012
If not July 1, start date; please explain.	Implementation will take one year, refer to response in Key Element I.
Total Cost/(Savings)/{Revenue}:	($7,244,151)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Receive approval for State Plan Amendment • Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook • Modify the Florida Medicaid Management Information System to accommodate reimbursement change • Provider notification
II. Will this proposal require a change in Florida Statute?	No	There is no Florida Statute specifying the maximum number of days a nursing home may be paid for bed hold days.
III. Will this proposal require a State Plan Amendment?		Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This was proposed last year.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #35 Cont.**

Lead Analyst:	Susan Rinaldi, Program Analyst, Bureau of Medicaid Services
Secondary Analyst:	Steve Russell
Assumptions (Data source and methodology):	SSEC February 2011; Occupancy rates.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($7,244,151)**		**($14,488,301)**
General Revenue:	**($3,191,773)**		**($6,383,545)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($4,052,378)**		**($8,104,756)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Medicaid Impact Conference Issues

March 2011

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

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

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

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

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

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

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

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

Medicaid Impact Conference Issues

March 2011

Issue #35 Cont.

FY 1112 SSEC Feb 2011 (Final)

* Current Law: 95% occupancy with 8 hold days

NURSING HOMES	FY1112	Current* Hold Day Costs **	**Eliminate Current** Hold Days
SKILLED CARE CASELOAD	11,238	56	
SKILLED CARE UNIT COST	$5,462.07	$5,462.07	
SKILLED CARE TOTAL COST	$736,592,406	$3,670,509	
CROSSOVER CASELOAD	554	3	
CROSSOVER UNIT COST	$1,670.63	$1,670.63	
CROSSOVER TOTAL COST	$11,106,330	$60,143	
INTERMEDIATE CARE CASELOAD	32,595	163	
INTERMEDIATE CARE UNIT COST	$5,433.24	$5,433.24	
INTERMEDIATE CARE TOTAL COST	$2,125,158,226	$10,627,421	
GENERAL CARE CASELOAD	355	2	
GENERAL CARE UNIT COST	$5,426.17	$5,426.17	
GENERAL CARE TOTAL COST	$23,115,490	$130,228	
SPECIAL PAYMENTS TO NURSING HOMES	$5,222,992	$0	
TOTAL COST	$2,901,195,444	$14,488,301	**($14,488,301)**
TOTAL GENERAL REVENUE	$648,637,376	$6,383,545	**($6,383,545)**
TOTAL MEDICAL CARE TRUST FUND	$1,636,428,731	$8,104,756	**($8,104,756)**
TOTAL REFUGEE ASSISTANCE TF	$0	$0	**$0**
TOTAL HEALTH CARE TF	$270,000,000	$0	**$0**
TOTAL GRANTS AND DONATIONS TF	$346,129,337	$0	**$0**

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #35A

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associated with limiting to four days instead of eight. Current 95% occupancy rate.
Proposed State Fiscal Year: 11/12	2011-12
Proposed Start Date: 08/01/2012	01/01/2012
If not July 1, start date; please explain.	Implementation will take one year, refer to response in Key Element I.
Total Cost/(Savings)/{Revenue}:	($3,622,076)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Receive approval for State Plan Amendment • Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook • Modify the Florida Medicaid Management Information System to accommodate reimbursement change • Provider notification
II. Will this proposal require a change in Florida Statute?	No	There is no Florida Statute specifying the maximum number of days a nursing home may be paid for bed hold days.
III. Will this proposal require a State Plan Amendment?		Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This was proposed last year.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

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

Lead Analyst:	Susan Rinaldi, Program Analyst, Bureau of Medicaid Services
Secondary Analyst:	Steve Russell
Assumptions (Data source and methodology):	SSEC February 2011; Occupancy rates.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($3,622,076)**		**($7,244,151)**
General Revenue:	**($1,595,887)**		**($3,191,773)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($2,026,189)**		**($4,052,378)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Medicaid Impact Conference Issues

March 2011

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

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

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

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

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

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

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

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

Medicaid Impact Conference Issues

March 2011

Issue #35A Cont.

Reduce Bed Hold Days to 4 – at 95% occupancy	Total Savings 6 Months	Total Savings Annualized
Total	($3,622,075)	($7,244,151)
General Revenue	($1,595,886)	($3,191,773)
Medical Care TF	($2,026,189)	($4,052,378)

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #35B

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associated with limiting to four days instead of eight. 90% occupancy rate.
Proposed State Fiscal Year: 11/12	2011-12
Proposed Start Date: 08/01/2012	01/01/2012
If not July 1, start date; please explain.	Implementation will take one year, refer to response in Key Element I.
Total Cost/(Savings)/{Revenue}:	$3,246,453
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Receive approval for State Plan Amendment • Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook • Modify the Florida Medicaid Management Information System to accommodate reimbursement change • Provider notification
II. Will this proposal require a change in Florida Statute?	No	There is no Florida Statute specifying the maximum number of days a nursing home may be paid for bed hold days.
III. Will this proposal require a State Plan Amendment?		Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This was proposed last year.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

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

Lead Analyst:	Susan Rinaldi, Program Analyst, Bureau of Medicaid Services
Secondary Analyst:	Steve Russell
Assumptions (Data source and methodology):	SSEC February 2011; Occupancy rates.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$3,246,453**		**$6,492,905**
General Revenue:	**$1,430,387**		**$2,860,774**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**$1,816,066**		**$3,632,131**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

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

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

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

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

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

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

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

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

Medicaid Impact Conference Issues

March 2011

Issue #35B Cont.

Reduce Bed Hold Days to 4 at 90% Occupancy	Total Savings 6 Months	Total Savings Annualized
Total	$3,246,453	$6,492,905
General Revenue	$1,430,387	$2,860,774
Medical Care TF	$1,816,066	$3,632,131

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #35C

Proposal Name:	Eliminate/Reduce Nursing Home Bed Hold Days
Brief Description of Proposal:	Savings associated with limiting to four days instead of eight. 85% occupancy rate.
Proposed State Fiscal Year: 11/12	2011-12
Proposed Start Date: 08/01/2012	01/01/2012
If not July 1, start date; please explain.	Implementation will take one year, refer to response in Key Element I.
Total Cost/(Savings)/{Revenue}:	$6,466,075
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		• Receive approval for State Plan Amendment • Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook • Modify the Florida Medicaid Management Information System to accommodate reimbursement change • Provider notification
II. Will this proposal require a change in Florida Statute?	No	There is no Florida Statute specifying the maximum number of days a nursing home may be paid for bed hold days.
III. Will this proposal require a State Plan Amendment?		Minimum of 90 days for approval. State Plan Amendment can be made retroactively effective.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Promulgate rule for a revised Nursing Facility Services Coverage and Limitations Handbook, which would take a minimum of 120 days.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	This was proposed last year.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

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

Lead Analyst:	Susan Rinaldi, Program Analyst, Bureau of Medicaid Services
Secondary Analyst:	Steve Russell
Assumptions (Data source and methodology):	SSEC February 2011; Occupancy rates.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**6**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$6,466,075**		**$12,932,150**
General Revenue:	**$2,848,953**		**$5,697,905**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**$3,617,123**		**$7,234,245**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Medicaid Impact Conference Issues

March 2011

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

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

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

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

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

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

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

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

Medicaid Impact Conference Issues

March 2011

Issue #35C Cont.

Reduce Bed Hold Days to 4 at 85% Occupancy	Total Savings 6 Months	Total Savings Annualized
Total	$6,466,075	$12,932,150
General Revenue	$2,848,953	$5,697,905
Medical Care TF	$3,617,123	$7,234,245

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #36

Proposal Name:	Eliminate/Reduce ICF/DD Bed Hold Days
Brief Description of Proposal:	Savings associated with eliminating ICF/DD bed hold days or limiting to four days instead of fifteen (original proposal description stated bed hold days are currently at a maximum of eight days, which is inaccurate). Analysis shows savings at 90 percent occupancy rates.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	ICF rates are established October 1.
Total Cost/(Savings)/{Revenue}:	($84,286)
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	--	• State Plan Amendment: 90-180 days • Adopt revised rules; minimum of 120 days • Provider Notification: 60 days • File Maintenance: FMMIS programming for changes in reimbursement to providers: 30-60 days
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	State Plan Section 4.19 (C) would need to be amended.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing handbook promulgated as rule would need to be amended.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated Feb. 26, 2010
IX. Is this proposal included in the current Governors recommendations?	Unknown	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #36 Cont.**

Lead Analyst:	Rachel Cornwell, Medicaid Services
Secondary Analyst:	Rydell Samuel, Medicaid Program Analysis
Assumptions (Data source and methodology):	SSEC February 2011; ICF-DD rates and occupancy. About 91% of private ICF-DDs have an occupancy of 90% and greater; in addition, about 95% have an occupancy of 85% and greater.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/25/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($84,286)**		**($112,381)**
General Revenue:	**($37,136)**		**($49,515)**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**($47,150)**		**($62,866)**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

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

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

Background

Bed hold days are prescribed in the Code of Federal Regulations at 42 CFR 447.40 and in the State Plan in Section 4.19 (c). A bed hold day is Medicaid paying providers to reserve a bed for up to 15 days for each ICF/DD resident who leaves the facility for a medically necessary hospitalization, including acute care or therapeutic leave. Per the State Plan (the State Medicaid Agency's contract with the Centers for Medicare and Medicaid) and per Florida Rule as promulgated in the ICF/DD handbook, ICF/DDs must reserve temporarily vacant beds for 15 consecutive days unless there is written notification stating that the recipient will not return to the facility. Residents of ICF/DDs quite often require brief absences but intend to return to the ICF in order to maintain continuity of care.

Policy Analysis

From the Medicaid Consumer Perspective:

Some Intermediate Care Facilities have high occupancy rates. If these high occupancy facilities are in areas of the state with few other facility options, the temporarily absent Medicaid recipient would not be provided continued care in the same facility upon their return from treatment. For example, in the county of Okaloosa, there is one ICF/DD facility that accepts females; it currently has only one vacancy. If a female resident were to leave for a medically necessary procedure and then return to the ICF facility and her bed was taken while she was away (and the provider would have an incentive to fill the vacancy right away without bed hold day payments), her only alternative would be institutionalization in a nursing home or another ICF/DD if available, which may or may not be nearby her family or in her community.

If bed hold days were reduced to four days, the same result would occur if the resident required a stay outside of the ICF/DD for treatment or hospitalization that lasted longer than four days; often residents of ICF/DDs have medically complex issues and require longer absences than four days.

Some areas in the state have high vacancy rates, and therefore the impact on Medicaid consumers there would be low to none. There are a total of 71 vacancies in the private ICF/DDs across the state.

From the Provider Perspective:

Decreasing or eliminating bed hold days would impact the providers due to the reduction of reimbursement.

Medicaid Impact Conference Issues

March 2011

Issue #36 Cont.

ICF-MR COMMUNITY

FY 1112 SSEC Feb 2011 (Final)

		**	
CASELOAD PRIVATE	1,179	6	
UNIT COST	$10,683.31	$10,683.31	
TOTAL COST	$151,147,429	$769,198	
CASELOAD CLUSTER	624	3	
UNIT COST	$14,020.45	$14,020.45	
TOTAL COST	$104,985,115	$504,736	
CASELOAD SIXBED	226	1	
UNIT COST	$9,342.04	$9,342.04	
TOTAL COST	$25,335,626	$112,105	
TOTAL COST	$281,468,170	$1,386,039	**($1,386,039)**
TOTAL GENERAL REVENUE	$112,451,194	$610,689	**($610,689)**
TOTAL MEDICAL CARE TRUST FUND	$157,453,294	$775,350	**($775,350)**
TOTAL REFUGEE ASSISTANCE TF	$0	$0	**$0**
TOTAL GRANTS AND DONATIONS TF	$11,563,682	$0	**$0**

ICFDD (annualized)			90%
Total	($1,386,039)	($1,386,039)	($112,381)
General Revenue	($610,689)	($610,689)	($49,515)
MCTF	($775,350)	($775,350)	($62,866)

ICFDD (9 months)			90% Occupancy
Total	($1,039,529)	($1,039,529)	($84,286)
General Revenue	($458,017)	($458,017)	($37,136)
MCTF	($581,513)	($581,513)	($47,150)

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #36A

Proposal Name:	Eliminate/Reduce ICF/DD Bed Hold Days
Brief Description of Proposal:	Savings associated with eliminating ICF/DD bed hold days or limiting to four days instead of fifteen (original proposal description stated bed hold days are currently at a maximum of eight days, which is inaccurate). Analysis shows savings at 85 percent occupancy rates.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	ICF rates are established October 1.
Total Cost/(Savings)/{Revenue}:	$140,477
Bureau(s) Responsible for Administration:	Medicaid Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	--	• State Plan Amendment: 90-180 days • Adopt revised rules; minimum of 120 days • Provider Notification: 60 days • File Maintenance: FMMIS programming for changes in reimbursement to providers: 30-60 days
II. Will this proposal require a change in Florida Statute?	No	
III. Will this proposal require a State Plan Amendment?	Yes	State Plan Section 4.19 (C) would need to be amended.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Existing handbook promulgated as rule would need to be amended.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated Feb. 26, 2010
IX. Is this proposal included in the current Governors recommendations?	Unknown	

Medicaid Impact Conference Issues

March 2011

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

Lead Analyst:	Rachel Cornwell, Medicaid Services
Secondary Analyst:	Rydell Samuel, Medicaid Program Analysis
Assumptions (Data source and methodology):	SSEC February 2011; ICF-DD rates and occupancy. About 91% of private ICF-DDs have an occupancy of 90% and greater; in addition, about 95% have an occupancy of 85% and greater.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/25/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**$140,477**		**$187,302**
General Revenue:	**$61,894**		**$82,525**
Administrative Trust Fund:	**($0)**		
Medical Health Care Trust Fund:	**$78,583**		**$104,777**
Refugee Assistance Trust Fund:	**($0)**		
Tobacco Settlement Trust fund:	**($0)**		
Grants and Donation Trust Fund:	**($0)**		
Public Medical Assistance Trust Fund:	**($0)**		
Other State Funds:	**($0)**		

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

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

Background

Bed hold days are prescribed in the Code of Federal Regulations at 42 CFR 447.40 and in the State Plan in Section 4.19 (c). A bed hold day is Medicaid paying providers to reserve a bed for up to 15 days for each ICF/DD resident who leaves the facility for a medically necessary hospitalization, including acute care or therapeutic leave. Per the State Plan (the State Medicaid Agency's contract with the Centers for Medicare and Medicaid) and per Florida Rule as promulgated in the ICF/DD handbook, ICF/DDs must reserve temporarily vacant beds for 15 consecutive days unless there is written notification stating that the recipient will not return to the facility. Residents of ICF/DDs quite often require brief absences but intend to return to the ICF in order to maintain continuity of care.

Policy Analysis

From the Medicaid Consumer Perspective:

Some Intermediate Care Facilities have high occupancy rates. If these high occupancy facilities are in areas of the state with few other facility options, the temporarily absent Medicaid recipient would not be provided continued care in the same facility upon their return from treatment. For example, in the county of Okaloosa, there is one ICF/DD facility that accepts females; it currently has only one vacancy. If a female resident were to leave for a medically necessary procedure and then return to the ICF facility and her bed was taken while she was away (and the provider would have an incentive to fill the vacancy right away without bed hold day payments), her only alternative would be institutionalization in a nursing home or another ICF/DD if available, which may or may not be nearby her family or in her community.

If bed hold days were reduced to four days, the same result would occur if the resident required a stay outside of the ICF/DD for treatment or hospitalization that lasted longer than four days; often residents of ICF/DDs have medically complex issues and require longer absences than four days.

Some areas in the state have high vacancy rates, and therefore the impact on Medicaid consumers there would be low to none. There are a total of 71 vacancies in the private ICF/DDs across the state.

From the Provider Perspective:

Decreasing or eliminating bed hold days would impact the providers due to the reduction of reimbursement.

Medicaid Impact Conference Issues

March 2011

Issue #36A Cont.

ICF-MR COMMUNITY **FY 1112 SSEC Feb 2011 (Final)**		**)	
CASELOAD PRIVATE	1,179	6	
UNIT COST	$10,683.31	$10,683.31	
TOTAL COST	$151,147,429	$769,198	
CASELOAD CLUSTER	624	3	
UNIT COST	$14,020.45	$14,020.45	
TOTAL COST	$104,985,115	$504,736	
CASELOAD SIXBED	226	1	
UNIT COST	$9,342.04	$9,342.04	
TOTAL COST	$25,335,626	$112,105	
TOTAL COST	$281,468,170	$1,386,039	**($1,386,039)**
TOTAL GENERAL REVENUE	$112,451,194	$610,689	**($610,689)**
TOTAL MEDICAL CARE TRUST FUND	$157,453,294	$775,350	**($775,350)**
TOTAL REFUGEE ASSISTANCE TF	$0	$0	**$0**
TOTAL GRANTS AND DONATIONS TF	$11,563,682	$0	**$0**

ICFDD (annualized)			85%
Total	($1,386,039)	($1,386,039)	$187,302
General Revenue	($610,689)	($610,689)	$82,525
MCTF	($775,350)	($775,350)	$104,777

ICFDD (9 months)			85% Occupancy
Total	($1,039,529)	($1,039,529)	$140,477
General Revenue	($458,017)	($458,017)	$61,894
MCTF	($581,513)	($581,513)	$78,583

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #37

Proposal Name:	Reduce Nurse Staffing Requirements to 2.6 Hours
Brief Description of Proposal:	Savings associated with reducing required nursing staffing ratios to 2.6 hours from the current 2.9 average hours.
Proposed State Fiscal Year: 00/00	**2012-13**
Proposed Start Date: 00/00/0000	07/01/2012
If not July 1, start date; please explain.	Prospective rates set based on prior year cost reports
Total Cost/(Savings)/{Revenue}:	N/A
Bureau(s) Responsible for Administration:	Program Analysis – AHCA

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	N/A	Implement for all providers going forward starting with July 1, 2011.
II. Will this proposal require a change in Florida Statute?	Yes	F.S. 400.23
III. Will this proposal require a State Plan Amendment?	Yes	Florida Title XIX Long-Term Care Reimbursement Plan
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	A rule change is required for this issue. If authority is granted, the policy would be effective July 1, 2011
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Medicaid Impact Conference dated February 23, 2010
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #37 Cont.**

Lead Analyst:	Stephen Russell
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	Data is derived from Medicaid cost reports. Current law HB 5310: *Effective July 1, 2010 a minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.9 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. A minimum certified nursing assistant staffing of 2.7 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.*
FY Impacted by Implementation:	There would be a year delay on any savings due to the nature of the cost reporting and rate setting process where prior period cost reports are used to set prospective rates for Medicaid.
Date Analysis Completed:	02/24/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

Current Situation:

The assumption is that the intended question is moving from 3.9 total staffing to 3.6 total staffing as the 2.9 CNA level to 2.6 CNA is irrelevant due to the approval of last year's HB 5310. If the 3.9 total staffing requirements was reduced to 3.6 total staffing and a minimum RN staffing of 1.0 hour of direct care per resident per day was still required, the savings would correspond to going from the 2.9 CNA requirement to a 2.6 CNA requirement. Therefore, if the total staffing requirement changed from 3.9 hours per resident per day to 3.6 total hours the estimated savings would be (**$57,874,868.76).** Due to the nature of the cost reporting and rate setting process, there would be a year delay on these savings; thus the savings of **($57,874,868.76) would not be realized until FY 12-13** and not FY 11-12.

Medicaid Impact Conference SFY 2011/12

Estimated Total Savings

Total CNA Cost for all Providers (Including Benefits)		$ 1,092,181,413
Total CNA Hours for all Providers	**/**	71,727,009
Average CNA Cost per Hour		$15.23
Average CNA Cost per day at Current Staffing Requirements (2.9)		$44.16
Average CNA Cost per day at Proposed Staffing Requirements (2.6)	**-**	$39.59
Estimated Savings per Patient Day		$4.57
Total Annualized Patient Days	**X**	24,760,127
Total Cost Savings		$113,106,139.31

Medicaid Impact Conference Issues

March 2011

Estimated Medicaid Savings

Estimated saving to future cost Reimbursement		
Total cost savings		$113,106,139.31
Annualized Total Patient Days	**/**	24760127
Unit cost per day		$4.57
Annualized Medicaid Days	**X**	14905199
Annualized Medicaid Portion		$68,088,080.90
***Assumption for providers held to Targets, Ceilings**	**X**	85%
Annualized Medicaid Savings		$57,874,868.76

***Approximately 15% of providers are held to the direct care ceilings thus we would not recognize a savings for them as they are not being paid for their full cost currently.**

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #38

Proposal Name:	Increased Use of Generic Drugs for Medicaid
Brief Description of Proposal:	Savings associated with increasing the use of generic drugs for beneficiaries (State of North Carolina model).
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

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

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #38 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Magellan Medicaid Management claims analysis
Assumptions (Data source and methodology):	Magellan Medicaid Management review of claims paid 10/1/10-12/31/10. Nearly 90% of prescriptions reimbursed were for generic products. See below for the summary generic utilization rate report. This excludes compound claims, claims for non-drug items, claims for drugs with supplement rebate and drugs that require clinical PA (no generic product exists.) The query used brand class logic that assigns non-innovator multi source brand drug into generic.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

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

Medicaid Impact Conference Issues

March 2011

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

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

The only brand products currently being reimbursed are those for which there is no generic product or for which the net cost after rebates is equivalent to or lower than the generic cost.

Source: Magellan Medicaid Administration

Report: Generic utilization rate for claims with DOS between 10/01/2010 - 12/31/2010
This excldues compound claims, EBA claims, claims for non-drug items, drugs with supplement rebate and drugs that require clinical PA

Month	Total Claims	Generic Claims	% Generic	Brand Claims	% Brand
Oct-10	1,118,824	994,703	88.91%	124,121	11.09%
Nov-10	1,121,223	998,660	89.07%	122,563	10.93%
Dec-10	1,146,075	1,025,046	89.44%	121,029	10.56%

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #39

Proposal Name:	Reduce Medicaid Drug Dispensing Fees by $1 or $2 respectively
Brief Description of Proposal:	Reduce current dispensing fee of $3.73 to $2.73 or $1.73 per prescription
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	CMS approval is required
Total Cost/(Savings)/{Revenue}:	($14,000,000); ($28,000,000) respectively, for current fee-for-service caseload
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.		Could implement upon enactment.
II. Will this proposal require a change in Florida Statute?	Yes	
III. Will this proposal require a State Plan Amendment?	Yes	Unlikely that CMS would approve, given explanation below.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Revision to 59G-4.251 Prescribed Drugs Reimbursement Methodology
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	No	
IX. Is this proposal included in the current Governors recommendations?	No	

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #39 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Anne Wells
Assumptions (Data source and methodology):	The fee-for-service pharmacy program currently reimburses approximately 14 million retail prescriptions per year. Savings below is for a reduction of dispensing fees by $1.00. The amounts are doubled for a $2.00 reduction in dispensing.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/24/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**9**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($10,500,000)**		**($14,000,000)**
General Revenue:	**($4,616,123)**		**($6,154,830)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($5,860,778)**		**($7,814,370)**
Refugee Assistance Trust Fund:	**($23,100)**		**($30,800)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

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

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

Florida Medicaid Reimbursement Compared to Other States

The "lesser than" pricing logic and $3.73 dispensing fee utilized by Florida Medicaid has resulted in the lowest **overall** pharmacy reimbursement rate in the country. A comparison table of reimbursement by State can be found at the attached link: http://www.cms.gov/Reimbursement/20_StateMedicaidRxReimb.asp#TopOfPage

With respect to branded prescriptions, California currently uses AWP – 17% in the base calculation, but then allows a dispensing fee of $7.25. The other large Medicaid States (Texas, New York) allow higher reimbursement rates on ingredient cost as well as higher dispensing fees. A few small States (New Hampshire, Rhode Island) support reimbursement rates on branded drugs comparable to Florida, but these are very small State Medicaid Programs.

In January, 2011, the state of Oregon received approval from CMS to change its pharmacy reimbursement from an AWP-based calculation to Average Acquisition Cost (AAC) or the Wholesale Acquisition Cost (WAC) if AAC is not available. Further, their dispensing fee is now tiered based upon annual volume of prescriptions filled by the pharmacy. The dispensing fee for the volume tiers ranges from $9.68 to $14.01.

Current Situation in Florida and Pricing Considerations

Manufacturers of brand drugs negotiate with the state to provide supplemental rebates in consideration of preferred status on the state's Medicaid drug list. Fewer than 12% of prescriptions are for brand drugs for which there is no generic product, and those on the PDL have negotiated terms that would preclude a reduced dispensing fee for their products. Further, pharmacy providers are reimbursed their actual acquisition cost for generic products due to the state's aggressive state maximum allowable cost reimbursement , and to ensure that Medicaid recipients will continue to be served requires that the pharmacy receive a reasonable dispensing fee to cover its cost of operation and dispensing.

Primary Consideration:

Further reducing the margin for retail pharmacies does not address the issue of rising drug costs. The real issue is the cost of pharmaceuticals at wholesale, not retail. AWP will remain as a pricing index only temporarily. When FDB stops reporting AWP, then the Medicaid reimbursement rate for branded pharmaceuticals will need to default to an equivalent WAC -based pricing strategy. Florida Medicaid reimbursement for branded pharmaceuticals combined with an already aggressive state maximum allowable cost (SMAC) pricing strategy on generic medications will continue to constrain and possibly reduce the retail pharmacy margins, and may create an access problem for Medicaid recipients if some providers cease to serve Medicaid recipients.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #40

Proposal Name:	Competitive Procurement of Generic Drugs
Brief Description of Proposal:	Provide an estimate of the savings, if any, attributable to competitive procurement of generic prescription drugs.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	N/A
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Pharmacy Services

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

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #40 Cont.**

Lead Analyst:	Marie Donnelly
Secondary Analyst:	Anne Wells
Assumptions (Data source and methodology):	Florida Drug Reimbursement Model; Medicaid uses competitive bidding for brands; aggressive control on reimbursement of generics.
FY Impacted by Implementation:	N/A
Date Analysis Completed:	02/24/2011

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

Work Papers/Notes/Comments: **Issue #40 Cont.**

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

Florida Medicaid Drug Reimbursement Model for Brand and Generic Products

Medicaid uses competitive bidding with respect to branded drugs. This is a useful tool to create competition among patented, branded medications – eg products where there are no generics. Aggressive market competition among generic products means that Florida Medicaid pays State Maximum Allowable Cost based upon the lowest available acquisition cost for each generic product. This is an extremely efficient and flexible model, and adapts to rapid changes in the market place, such as price reductions, supply issues from individual manufacturers, etc. For generic products that are produced by several manufacturers, the State MAC program takes advantage of the competition and sets its pricing at the lowest available acquisition cost for pharmacy providers.

The Florida Medicaid program State Maximum Allowable Cost (MAC) for almost all drugs is lower than the Federal Upper Limit (FUL). The Florida Medicaid State MAC program, in coordination with its contractor, maintains aggressive controls on pricing (reimbursement) of generic medications. The program immediately takes advantage of dropping prices in the generic marketplace.

If purchasing of generic products was limited to a single winning bidder, pharmacies (especially independents) may not have access to the winning bidder's product(s). The large chains have their own wholesale companies, and it is likely that the chains will purchase the entire production of the winning bidder's product(s) and create a supply chain problem.

Federal law requires generic manufacturers to submit a 13% rebate on their products reimbursed through state Medicaid programs. All generic manufacturers pay the required federal rebate. A separate state competitive bidding process would have to be designed around a supplemental rebate. Pharmacy reimbursement has no relation to the rebate process. In fact, it's quite possible that the winning bidder could artificially inflate the pharmacy wholesale acquisition cost (WAC) of the winning product(s) to offset the cost of the rebate paid to the State. A process where the state would pay a rebate back to the pharmacy for dispensing the winning bidder's product(s) could create opportunities for price manipulation. A pharmacy could bill the NDC for the winning bidder's product(s), but then actually dispense another product. The current process, state MAC pricing, does not create incentives for fraud because generic medications (specific drug/strength) are uniformly priced and pharmacies my purchase from the manufacturer of their choice.

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #41

Proposal Name:	Peritoneal Dialysis (PD) Initiative
Brief Description of Proposal:	Educate and assess Medicaid ESRD recipients about the availability of PD as an appropriate option for treatment. Encourage physician prescribers to support this initiative and prescribe PD where appropriate.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($398,040)
Bureau(s) Responsible for Administration:	Medicaid Services

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

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #41 Cont.**

Lead Analyst:	Medicaid Services
Secondary Analyst:	Medicaid Program Analysis
Assumptions (Data source and methodology):	SFY 2009-10 Medicaid claims data on dialysis patients. Assume 10% of hemodialysis patients will transfer to peritoneal dialysis.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	03/08/2011

Funding Sources:	**Start Year**	**Additional Year**	**Annualized**
Number of Months in the Analysis:	**12**	**N/A**	**N/A**
Total (Savings) Cost of Proposal:	**($398,040)**		**($0)**
General Revenue:	**($175,376)**		**($0)**
Administrative Trust Fund:	**($0)**		**($0)**
Medical Health Care Trust Fund:	**($222,664)**		**($0)**
Refugee Assistance Trust Fund:	**($0)**		**($0)**
Tobacco Settlement Trust fund:	**($0)**		**($0)**
Grants and Donation Trust Fund:	**($0)**		**($0)**
Public Medical Assistance Trust Fund:	**($0)**		**($0)**
Other State Funds:	**($0)**		**($0)**

Medicaid Impact Conference Issues

March 2011

Work Papers/Notes/Comments: **Issue #41 Cont.**

(i.e. Pros, Cons; Industry Concerns; Implementation obstacles):
The Agency for Health Care Administration supports the dialysis industry's intent to increase awareness of PD (peritoneal dialysis) and we acknowledge PD as an appropriate and effective treatment option for qualified patients. However, due to current work load and impending staff cuts we cannot accept responsibility for educating and assessing all Medicaid patients diagnosed with ESRD.

		Treatment
Number of Recipients	1070	$5,136,000.00
Hemodialysis	107	$513,600.00
Peritoneal dialysis	107	$115,560.00
reduction		($398,040.00)

Treatment:
3 times a week for 16 weeks for hemodialysis
5 times a week for 4 weeks for peritoneal dialysis
Ten percent can transfer to peritoneal

Reduction for encouraging Peritoneal dialysis	
Reduction	($398,040)
GR	($175,376)
MCTF	($222,664)

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #42

Proposal Name:	ICF/DD Assessment
Brief Description of Proposal:	Provide an estimate of revenue generated by requiring an assessment of net revenue to ICF/DD facilities up to the maximum allowable amount of 5.5%.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	10/01/2011
If not July 1, start date; please explain.	Rate setting period is October 1.
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409.9083, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Inpatient Hospital Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Impact Conference 2010.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #42 Cont.**

Lead Analyst:	Rydell Samuel
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	SSEC February 2011. Rate setting and latest Cost reports. Maximum assessment already factored into FY 1112 budget.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

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

Work Papers/Notes/Comments:

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

Medicaid Impact Conference Issues

March 2011

Proposal: Issue #43

Proposal Name:	Nursing Home/Hospice Assessment
Brief Description of Proposal:	Provide an estimate of revenue generated by requiring an assessment of net revenue to Nursing Home/Hospice facilities up to the maximum allowable amount of 5.5%.
Proposed State Fiscal Year: 00/00	2011-12
Proposed Start Date: 00/00/0000	07/01/2011
If not July 1, start date; please explain.	
Total Cost/(Savings)/{Revenue}:	($0)
Bureau(s) Responsible for Administration:	Medicaid Program Analysis

Key Elements:	**Yes;No;N/A**	**Explanation and Time Frame**
I. Anticipated implementation time line and process.	Yes	Notice of Proposed Rule Development in FAW no later than June 16, 2011
II. Will this proposal require a change in Florida Statute?	Yes	409.9082, F.S.
III. Will this proposal require a State Plan Amendment?	Yes	Modify the Title XIX Long-Term Care Reimbursement Plan and submit to CMS no later than September 30, 2011.
IV. Will this require the Procurement Process?	No	
V. Will this proposal require an administrative rule?	Yes	Begin Rulemaking process with publishing a Notice of Rule Development in FAW when Governor signs the budget. AHCA has 90 days to adopt the rule once we file proposed rule.
VI. Will this proposal require a Federal waiver or modification to an existing waiver?	No	
VII. Will this proposal require additional staffing?	No	
VIII. Is there a previous or concurrent Analysis by the Agency?	Yes	Impact Conference 2010.
IX. Is this proposal included in the current Governors recommendations?		

Medicaid Impact Conference Issues

March 2011

Analysis: **Issue #43 Cont.**

Lead Analyst:	Steve Russell
Secondary Analyst:	Karen Chang
Assumptions (Data source and methodology):	SSEC February 2011. Rate setting and latest Cost reports. Maximum assessment already factored into FY 1112 budget.
FY Impacted by Implementation:	2011-12
Date Analysis Completed:	02/23/2011

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

Work Papers/Notes/Comments:

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

MEDICAID SERVICES EXPENDITURES ($Millions)

STATE FISCAL YEAR	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FY 29-30	FY 30-31
TOTAL MEDICAID SERVICES	$22,660.0	$23,615.4	$24,599.3	$25,787.3	$27,024.4	$28,313.2	$29,662.3	$31,081.4	$32,588.3	$34,186.1	$35,872.5	$37,649.8	$39,519.8	$41,479.5	$43,534.3	$45,692.6	$47,960.0	$50,342.3	$52,857.3
	5.7%	4.2%	4.2%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.9%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
FEDERAL SHARE	$12,153.3	$12,803.7	$13,347.8	$13,989.1	$14,657.4	$15,354.8	$16,085.6	$16,855.3	$17,672.3	$18,538.8	$19,454.3	$20,420.1	$21,437.4	$22,505.3	$23,626.7	$24,805.8	$26,045.9	$27,350.1	$28,728.0
	6.5%	5.4%	4.2%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.9%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
TOTAL MEDICAL CARE TRUST FUND	$12,113.2	$12,762.0	$13,304.5	$13,943.6	$14,609.5	$15,304.4	$16,032.7	$16,799.6	$17,613.8	$18,477.3	$19,389.6	$20,352.0	$21,365.9	$22,430.1	$23,547.7	$24,722.8	$25,958.7	$27,258.6	$28,631.8
TOTAL REFUGEE ASSISTANCE TF	$40.1	$41.7	$43.2	$45.6	$47.9	$50.4	$53.0	$55.7	$58.5	$61.5	$64.7	$68.0	$71.5	$75.2	$79.0	$83.0	$87.2	$91.6	$96.2
STATE SHARE	$10,506.7	$10,811.7	$11,251.5	$11,798.2	$12,366.9	$12,958.4	$13,576.7	$14,226.1	$14,916.0	$15,647.3	$16,418.3	$17,229.7	$18,082.4	$18,974.2	$19,907.6	$20,886.7	$21,914.1	$22,992.2	$24,129.2
	4.8%	2.9%	4.1%	4.9%	4.8%	4.8%	4.8%	4.8%	4.8%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%	4.9%
TOTAL GENERAL REVENUE	$5,783.1	$6,065.5	$6,423.3	$6,840.1	$7,275.8	$7,731.2	$8,209.1	$8,712.8	$9,249.2	$9,819.0	$10,421.5	$11,057.5	$11,727.9	$12,431.4	$13,170.1	$13,947.4	$14,765.3	$15,626.0	$16,536.0
TOTAL PUBLIC MEDICAL ASSIST TF	$623.6	$642.3	$661.6	$681.4	$701.8	$722.9	$744.6	$766.9	$789.9	$813.6	$838.0	$863.2	$889.1	$915.7	$943.2	$971.5	$1,000.7	$1,030.7	$1,061.6
TOTAL OTHER STATE FUNDS	$677.1	$667.8	$668.4	$670.2	$672.1	$674.1	$676.2	$678.3	$680.6	$682.9	$685.3	$687.8	$690.4	$693.2	$696.0	$698.9	$702.0	$705.2	$708.5
TOTAL GRANTS & DONATIONS TF	$2,487.9	$2,501.1	$2,563.3	$2,657.9	$2,755.9	$2,857.1	$2,962.3	$3,072.1	$3,189.0	$3,312.7	$3,442.6	$3,578.6	$3,720.8	$3,868.2	$4,021.3	$4,180.9	$4,347.3	$4,520.8	$4,702.9
TOTAL HEALTH CARE TF	$884.8	$884.8	$884.8	$898.4	$911.0	$922.9	$934.3	$945.6	$957.1	$968.8	$980.6	$992.4	$1,004.0	$1,015.5	$1,026.7	$1,037.8	$1,048.6	$1,059.3	$1,070.0
TOTAL TOBACCO SETTLEMENT TF	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2

CALENDAR YEAR	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	CY 2028	CY 2029	CY 2030
TOTAL MEDICAID SERVICES	$23,137.7	$24,107.3	$25,193.3	$26,405.8	$27,668.8	$28,987.8	$30,371.9	$31,834.8	$33,387.2	$35,029.3	$36,761.1	$38,584.8	$40,499.7	$42,506.9	$44,613.4	$46,826.3	$49,151.1	$51,599.8
	7.9%	6.4%	6.7%	7.3%	7.3%	7.3%	7.3%	7.3%	7.4%	7.5%	7.5%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%
FEDERAL SHARE	$12,478.5	$13,075.7	$13,668.4	$14,323.3	$15,006.1	$15,720.2	$16,470.4	$17,263.8	$18,105.5	$18,996.5	$19,937.2	$20,928.7	$21,971.4	$23,066.0	$24,216.3	$25,425.9	$26,698.0	$28,039.1
	9.3%	7.6%	6.8%	7.3%	7.3%	7.3%	7.3%	7.3%	7.4%	7.5%	7.5%	7.6%	7.6%	7.6%	7.6%	7.6%	7.6%	7.7%
TOTAL MEDICAL CARE TRUST FUND	$12,437.6	$13,033.3	$13,624.0	$14,276.5	$14,956.9	$15,668.5	$16,416.1	$17,206.7	$18,045.5	$18,933.4	$19,870.8	$20,859.0	$21,898.0	$22,988.9	$24,135.3	$25,340.8	$26,608.6	$27,945.2	
TOTAL REFUGEE ASSISTANCE TF	$40.9	$42.5	$44.4	$46.7	$49.2	$51.7	$54.3	$57.1	$60.0	$63.1	$66.4	$69.8	$73.4	$77.1	$81.0	$85.1	$89.4	$93.9	
STATE SHARE	$10,659.2	$11,031.6	$11,524.9	$12,082.6	$12,662.7	$13,267.6	$13,901.4	$14,571.1	$15,281.7	$16,032.8	$16,824.0	$17,656.1	$18,528.3	$19,440.9	$20,397.1	$21,400.4	$22,453.1	$23,560.7	
	6.4%	5.0%	6.6%	7.4%	7.3%	7.3%	7.3%	7.3%	7.4%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	
TOTAL GENERAL REVENUE	$5,924.3	$6,244.4	$6,631.7	$7,057.9	$7,503.5	$7,970.2	$8,461.0	$8,981.0	$9,534.1	$10,120.3	$10,739.5	$11,392.7	$12,079.6	$12,800.7	$13,558.7	$14,356.3	$15,195.7	$16,081.0	
TOTAL PUBLIC MEDICAL ASSIST TF	$632.9	$651.9	$671.5	$691.6	$712.4	$733.7	$755.8	$778.4	$801.8	$825.8	$850.6	$876.1	$902.4	$929.5	$957.4	$986.1	$1,015.7	$1,046.1	
TOTAL OTHER STATE FUNDS	$672.4	$668.1	$669.3	$671.2	$673.1	$675.2	$677.3	$679.5	$681.7	$684.1	$686.6	$689.1	$691.8	$694.6	$697.5	$700.4	$703.6	$706.8	
TOTAL GRANTS & DONATIONS TF	$2,494.5	$2,532.2	$2,610.6	$2,706.9	$2,806.5	$2,909.7	$3,017.2	$3,130.6	$3,250.9	$3,377.7	$3,510.6	$3,649.7	$3,794.5	$3,944.7	$4,101.1	$4,264.1	$4,434.0	$4,611.9	
TOTAL HEALTH CARE TF	$884.8	$884.8	$891.6	$904.7	$916.9	$928.6	$940.0	$951.4	$963.0	$974.7	$986.5	$998.2	$1,009.8	$1,021.1	$1,032.3	$1,043.2	$1,054.0	$1,064.7	
TOTAL TOBACCO SETTLEMENT TF	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	$50.2	

NOTE: This forecast does not include any additional costs to the Medicaid program that may result from the passage of The Patient Protection and Affordable Care Act.