FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 1, 2011

Mr. Richard Jensen, Director
Division of State Demonstrations & Waivers
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Jensen:

Enclosed for your review is a paper to present the concept for a demonstration waiver under section 1115 of the Social Security Act in order to implement newly enacted provisions of Florida law related to the Medically Needy Program. The Agency proposes to request authority needed to provide up to a continuous six-month period of eligibility for Medically Needy recipients. Further, the Agency will request authority to collect a premium in lieu of share of cost. Through this authority, the Agency seeks to simplify the enrollment and eligibility determination process and to implement an income-based premium not to exceed the recipient's share of cost. The objective of the demonstration would be to provide an opportunity for more continuous coverage and improved access and coordination of services for Florida's Medically Needy population.

This request would be submitted as an amendment to the Florida MEDS AD 1115 demonstration (Project No. 11-W-00205/4) to request authority to cover costs not otherwise matchable for this program. Continued eligibility and coverage of the Medically Needy population are important objectives of this proposed demonstration, and the authority outlined in this concept paper would provide access to a greater eligibility period for Medicaid services through a premium that would not exceed the share of cost. The Agency requests additional guidance regarding Maintenance of Effort (MOE) requirements and applicability of 1902(gg) of the Social Security Act for this optional population. In all cases, the proposal would apply no more restrictive eligibility policy; and in most cases criteria would be less restrictive, since the proposed premium will be no more than the share of cost.

The newly enacted legislation provides for competitive procurement of a statewide Provider Service Network (PSN) that will function as the third party administrator for premium operations and care coordination.

Attachment I is the concept paper for the proposed amendment to the Florida MEDS AD 1115 demonstration to add the new Medically Needy program. The Agency does not anticipate that it will request additional budget or propose savings related to this amendment, as it is expected that the existing budget neutrality ceiling can remain unchanged, and that additional costs of the Medically Needy amendment will remain within the aggregate budget neutrality cap. Surplus savings to date for the MEDS AD demonstration are currently more than $5 billion; and aggregate costs of the current demonstration and the Medically Needy demonstration amendment will not exceed the ceiling. The new program will operate only until that population is phased in to the Statewide Medicaid Managed Care Program, beginning with procurement of providers in January 2013 and full implementation by October 2014.

Through this proposal, we wish to initiate a dialogue with CMS to help refine our amendment request. We appreciate your consideration and your efforts in working with our staff on the MEDS AD 1115 waiver. Please contact me with any questions at (850) 412-4007.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/md
Enclosure
Cc: Mark Pahl, CMS CO
Jackie Glaze, CMS CO

ATTACHMENT I

Florida Medically Needy Waiver Demonstration Program

PURPOSE

The purpose of this paper is to present the concept for a demonstration waiver under section 1115 of the Social Security Act in order to implement newly enacted provisions of Florida law related to the Medically Needy Program. The request would be submitted as an amendment to the MEDS AD section 1115 Demonstration (Project No. 11-W-00205/4). The state is seeking a waiver of specified provisions of the Social Security Act in order to provide for costs not otherwise matchable for a continuous six-month period of eligibility. The state would further request waiver of any applicable provisions of the Social Security Act to collect a premium in lieu of share of cost. Under this proposed demonstration, eligibility would not be more restrictive than the current State Plan criteria.

BACKGROUND

The Medically Needy program is currently authorized by the State Plan for people who would be eligible except that their family income exceeds the State Plan income threshold for Medicaid eligibility. In the event that subtracting medical expenses incurred by these individuals from their income would cause their income to fall below the Medically Needy Income Limit (MNIL), these individuals currently become eligible for Medicaid. The Medically Needy Income Limit is currently based on the amount of maximum monthly cash benefit paid to recipients of Temporary Assistance for Needy Families. Eligibility is further restricted to families with low assets, such as savings or property (other than a residence). Under this proposed concept, the current income and asset limits would not change. The current Medically Needy Income Limits and Resource Limits are shown in Table I:

TABLE I

Medically Needy Income Limits and Resource Limits by Family Size

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

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

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

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

Currently, the Medically Needy program serves an average of 40,622 individuals during any month, and provides services for at least one month to more than 250,000 individuals annually.

The total cost for Medicaid services reimbursed for the program for state fiscal year 2010-11 are expected to be $953 million, and costs for the program for state fiscal year 2011-12 are estimated to exceed $1.16 billion[1].

STATE LAW

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

During the 2011 legislative session, the legislature considered several alternative approaches to the program. In addition to coverage of all services (except long-term care) for pregnant women and children, one proposal allowed coverage of (a) physician services only; or (b) physician and pharmacy services only for specified relatives/parents as well as aged, blind or disabled individuals. In the bills that finally passed, the Medically Needy program was continued but the Agency was directed to seek federal waiver authority to change it to a premium-based program to provide for care coordination and utilization management to achieve more cost-effective services.

Two laws were enacted in the 2011 session that made significant changes to the Medically Needy Program.[2] This concept proposal is specific to House Bill 7109 (Chapter 2011-135, Laws of Florida), which requires the Agency to seek federal waiver authority to establish a single statewide provider service network to manage the program and requires additional changes described below. The provision of HB 7109 related to Medically Needy amends section 409.9122, F.S. as follows:

> *409.9122(20) Subject to federal approval, the agency shall contract with a single provider service network to function as a third-party administrator and managing entity for the Medically Needy program in all counties. The contractor shall provide care coordination and utilization management in order to achieve more cost-effective services for Medically Needy enrollees. To facilitate the care*

[1] February 2011 Social Services Estimating Conference projection for total Medically Needy population expenditures is $1,161,965, 971.

[2] House Bill 7107 (Chapter 2011-134, Laws of Florida) provides for implementation of a statewide managed medical assistance program and includes persons eligible for the Medically Needy program as mandatory enrollees in managed care plans, subject to federal approval. HB 7107 requires the statewide managed medical assistance program to be fully implemented by October 1, 2014. This concept paper relates only to HB 7109, which includes provisions for Medicaid coverage for the Medically Needy population in the interim until implementation of HB 7107 by October 1, 2014.

management functions of the provider service network, enrollment in the network shall be for a continuous 6-month period or until the end of the contract between the provider service network and the agency, whichever is sooner. Beginning the second month after the determination of eligibility, the contractor may collect a monthly premium from each Medically Needy recipient provided the premium does not exceed the enrollee's share of cost as determined by the Department of Children and Family Services. The contractor must provide a 90-day grace period before disenrolling a Medically Needy recipient for failure to pay premiums. The contractor may earn an administrative fee, if the fee is less than any savings determined by the reconciliation process pursuant to s. 409.912(4)(d)1. Premium revenue collected from the recipients shall be deducted from the contractor's earned savings. This subsection expires October 1, 2014, or upon full implementation of the managed medical assistance program, whichever is sooner.

Provisions of House Bill 7107 require that individuals now in the Medically Needy program will transition to managed care plans concurrent with implementation of the Statewide Medicaid Managed Care Program, beginning with procurement of providers in January 2013 and full implementation by October 2014.

STATE PLAN

The Medicaid State Plan currently includes Medically Needy as an optional coverage group. The program provides medical assistance to persons *who otherwise qualify for Medicaid*, except that they have too much income or assets. Families that meet categorical requirements and who are children, disabled, pregnant, or are a parent or caretaker of a Medicaid recipient may become Medicaid eligible upon incurring medical expenses equal or greater than their Share of Cost. Table II below provides a summary of the eligibility groups currently covered and the respective State Plan coverage criteria for income. As previously noted, the state is not seeking to change the eligibility criteria.

TABLE II

Basis of Eligibility	Income Level for Medicaid State Plan Groups*	Medically Needy**
TANF (adults with dependent children)	19% FPL (based on family size)	over 19% FPL
children under 1	200% FPL(based on family size)	over 200% FPL (Above Medicaid State Plan Limits, up to 200% FPL eligible for KidCare)
children age 1up to age6	133% FPL (based on family size)	
children age 6 -19	100% of FPL (based on family size)	
Aged, Blind and Disabled	75% of FPL for individual; 82% for couple ($674; $1011)	above 75% of FPL for individual
		above 82% of FPL for couple

*Expressed as % of Federal Poverty Level

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

CURRENT PROGRAM AND RECIPIENT PROFILE

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

On Table III and Table IV below, the difference between the average gross income and the average share of cost would include the Medically Needy Income Limit (MNIL), plus any disregard of income that is applicable. The Federal Poverty Level is based on the total number of people in the household, whereas the number of assistance groups and the number of Medically Needy persons is based only on the eligible recipients who are in the Medically Needy program. For example, a family of four might include one Medically Needy adult, one Medically Needy child and two children who are categorically eligible for Medicaid. This would count as *one* Assistance Group; include *two* Medically Needy persons; and the income would be a percentage of the Federal Poverty Level for household size of *four*.

TABLE III

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

TABLE IV

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

Analysis of eligibility patterns show that approximately half of the individuals eligible across a twelve-month period meet the eligibility threshold only for one month, while approximately 10 percent of individuals become eligible for six or more months across a twelve-month period. Based on historical expenditure data, the greatest expense category for these individuals is inpatient and outpatient hospital services. This pattern indicates episodic utilization of high cost care in the most expensive setting. The chart below summarizes utilization by service category for this population for state fiscal year 2009-2010

Hospital Services (all)	$421,047,817.41	67.72%
Physician Services	$87,054,119.56	14.00%
Pharmacy Services	$85,991,654.80	13.83%
All Other Services	$27,692,390.25	4.45%
Total Service Expenditure SFY 2009-2010	$621,785,982.02	100.00%

The Medically Needy group has the highest per member per month cost for any Medicaid-eligible group of recipients. In a recent analysis of Medicaid eligibility groups for state fiscal year 2010 – 2011, the average per member per month cost for individuals eligible under the Medically Needy group was $1,957, compared to just $561 for all other eligibles.[3] Note that long-term care services are included in the overall average, whereas these services are excluded from the Medically Needy program.

Please see Appendices A and B for additional detail on caseload and utilization.

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

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

[3] Source: February 2011 Social Services Estimating Conference

Unintended results of the current program include:

- Incentive exists for potential eligibles to incur a high bill in order to become eligible for Medicaid benefits for a month.
- Accessing services in the most expensive setting, hospital emergency room, is a common way for Medically Needy individuals to incur a large expense and qualify for Medicaid eligibility.
- Hospitals may also admit patients through the emergency room, due to (1) liability concerns if the patient is treated and released; and (2) the hospital may not receive payment for services unless the patient qualifies for Medicaid through Medically Needy eligibility.
- Similarly, surgeons' and hospital bills submitted at usual and customary rates are higher than the Medicaid rate and higher than the reimbursement paid by third party payers, resulting in inflated incurred bills used to meet the share of cost to ensure Medicaid eligibility.
- The result of such practices is that individuals are responsible for higher expenses until the date that their share of cost is met. If the recipient does not pay this obligation, the cost of providing the service may be borne by the county or other public funding entity.
- Given the episodic nature of eligibility, there is lack of coordination of medical care, resulting in inefficient and fragmented service utilization and access to care in the most expensive setting--the hospital emergency room.
- Recipients must prove that their incurred expenses meet the share of cost criteria each month. This places a great administrative workload on the recipient, service providers, and the state. Further, providers are discouraged from serving this population because they must wait for eligibility to be entered to the Medicaid claims system each month or risk not receiving reimbursement for their services.

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

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

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

FLORIDA MEDICALLY NEEDY DEMONSTRATION WAIVER PROPOSAL

Objectives of the proposed demonstration:

1. Provide incentives to providers and recipients for efficient utilization of services. By providing for the ability of continuous eligibility and requiring recipient cost sharing through a premium arrangement not to exceed the current share of cost amount, it is expected that individuals will have access to lower cost and more appropriate care.
2. Require eligibility determination only once each six months rather than meeting share of cost monthly.
3. Providing for eligible PSN enrollees to have a three-month grace period before they can be disenrolled from the network for non-payment of their premiums, to ensure coordination of care and resulting continued control of costs to the state.
4. Coordination of administration of the program and utilization management through a single statewide provider service network (PSN) that acts as an administrator of the program. Cost savings may be shared with this contractor pursuant to the state's existing statutory reconciliation process to provide an incentive for active care management.
5. Providers would be assured that recipients are eligible up to a the six month period, without loss of coverage for several days each month until share of cost is once again met, and eligibility is determined by DCF and entered into the Medicaid claims system.
6. Recipients have access to care coordination, and the emergency room will no longer be the first choice of setting for medical care in order to qualify for eligibility.

Provisions Proposed to be Waived

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

1. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the state to impose a premium.
2. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).
3. Section 1902(a)(8) to enable the state to impose a waiting period for coverage under the premium program, to ensure budget neutrality, if necessary.
4. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

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

Operation and Anticipated Results of the Demonstration

In accordance with the provisions of Florida law, the waiver demonstration will establish a single provider service network (PSN) to function as a third party administrator and managing entity for the Medically Needy program in all counties. The month after becoming eligible under the existing eligibility requirements for Medically Needy coverage, enrollment in the network shall be for up to a continuous six month period (or until the end of the contract with the provider service network, if sooner). The state will use the appropriate procurement process to contract with the PSN that will function as the third party administrator.

Beginning the second month after the determination of eligibility, the PSN may collect a monthly premium from each recipient provided the premium does not exceed the enrollee's share of cost. Such a premium would be actuarially determined, scaled to income, and not greater than the family share of cost. (Note Tables III and IV for income ranges.) The PSN must provide a 90 day grace period before disenrolling a Medically Needy recipient for failure to pay premiums.

The six month enrollment period in the PSN is prospective. In the event that DCF determines eligibility after the fact for a span in months past, the first month after the determination of eligibility would be the first month of the continuous eligibility period and the provider service network could begin to collect a premium in the next month. For example, if DCF determines in March that a family became eligible on December 10, enrollment in the PSN would be for April through September, and the PSN could begin to collect a premium in May. (Note: The family would also still be Medicaid eligible for December 10-31.)

Enrollment in the Medically Needy PSN would be limited to individuals who become eligible for Medicaid through incurring bills that would reduce their family income to the Medically Needy Income Limit under the current eligibility criteria. If an individual is subsequently determined ineligible (for example, due to change in living arrangement or increase in assets), the provider service network enrollment would terminate as well, subject to existing client notice requirements and procedures.

The anticipated results of the demonstration include:

1. Increased continuity and coordination of care in the most efficient setting in an integrated service delivery system of health care.
2. Reduced utilization of emergency room care.
3. Decreased utilization of inpatient hospital treatment.
4. Significantly decreased per member per month cost for Medically Needy recipients.

Impact to Beneficiaries

The proposed demonstration would increase access to an integrated health care system for the Medically Needy population. Further, it would simplify the eligibility process and require cost sharing as a monthly premium scaled to income that would not exceed the family's share of cost. The premium structure would be designed to encourage participation in ongoing coverage rather than episodic access to health care.

Impact to Providers

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

Evaluation Design

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

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

DESCRIPTION OF CURRENT PROGRAM COMPARED TO PROPOSED WAIVER DEMONSTRATION

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

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

APPENDIX A

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

State Fiscal Year 2009 - 2010

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

Three Years FY0809 thru FY1011

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

APPENDIX B

Medicaid Eligibility Groups

State Fiscal Year 2010 - 2011

Per Member Per Month Costs

Group	PMPM
Supplemental Security Income (SSI)	$1,476
Temporary Assistance for Needy Families (TANF)	$259
Medically Needy	$1,957
Children < = 100% of Poverty	$139
Children > 100% of Poverty	$171
Children – Medicaid Expansion Under Title XXI	$361
Pregnant Women < = 100% of Poverty	$856
Pregnant Women > 100% of Poverty	$785
Family Planning Waiver	$44
Categorically Eligible	$192
Elderly and Disabled (MEDS AD)	$1,622
Qualified Medicare Beneficiaries (QMB/SLMB/QI)	$150
Refugee General Assistance	$310
Total	$561

Source: AHCA Analysis based on February 2011 Social Services

APPENDIX C

As noted, this concept paper concerns only the requirements of HB 7109; the information below is noted only for reference and context.

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

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

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

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