Agency for Health Care Administration

AND

Department of Children and Families

Medicaid Redetermination
House Health and Human Services Committee
January 18, 2023

What is Medicaid?

Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low-income children, families, elders, and people with disabilities.

The federal government establishes basic mandatory program requirements.

States choose whether to participate.

Jointly financed: federal and state governments share the cost.

Each state develops a unique Medicaid program based on federal rules – subject to federal Centers for Medicare and Medicaid Services (CMS) approval.

What is Federal Medical Assistance Percentage (FMAP)?

- The Federal Medical Assistance Percentage (FMAP) is the amount of federal matching funds for state Medicaid program expenditures.
  - Varies from state-to-state
  - Updated annually
- Each state's FMAP is based on the state's average per capita income compared to the national per capita income.
  - The lower a state's average per capita income, the higher the FMAP; and vice versa.
  - All states receive at least 50% FMAP.
- The current Florida FMAP is **60.05%**. This means that for every dollar we spend on services, the federal government pays 60.05 cents and the state pays 39.95 cents.

Florida Medicaid Delivery System

- A majority of Florida's Medicaid population receives Medicaid services through a managed care delivery system.

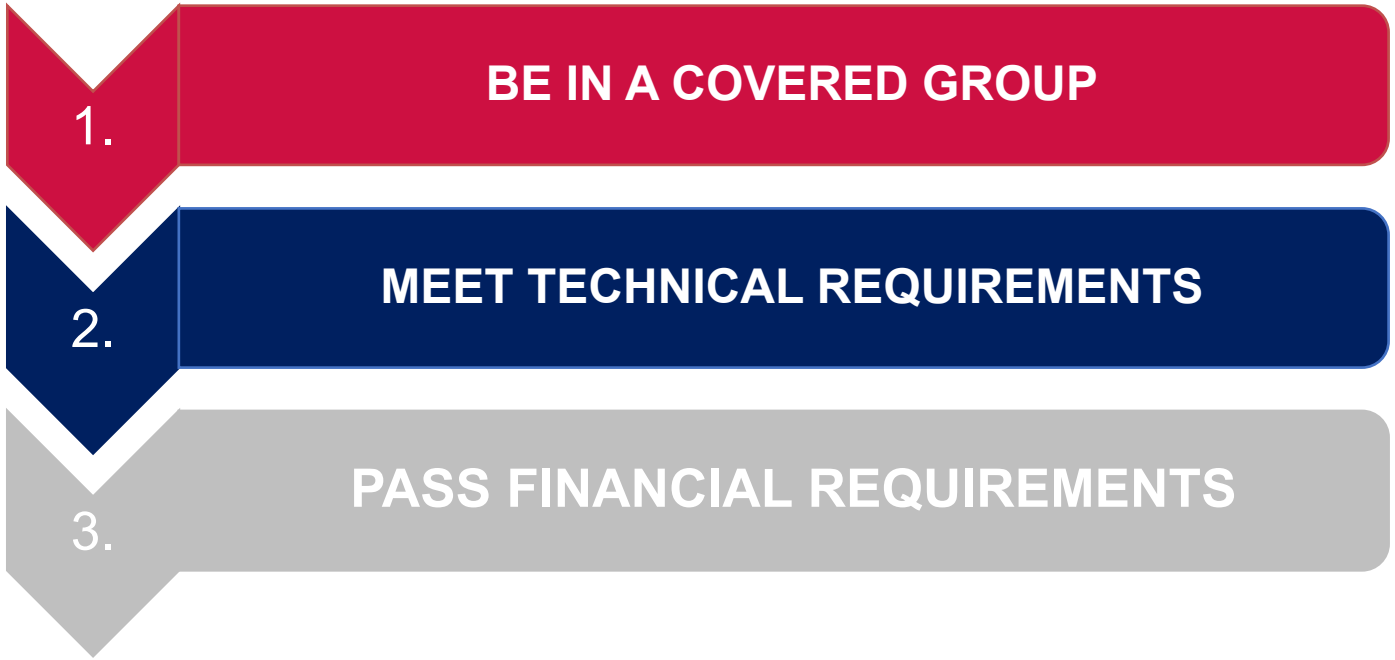
Who does Florida Medicaid Serve?

Medicaid serves more than 5.5 million Floridians.

Over 2.6 million	• Adults - parents, elderly, and disabled
54%	• Children in Florida
54.24%	• Birth deliveries in Florida (CY 2020)
60.26%	• Nursing home days in Florida

Who is Eligible to Enroll in Florida Medicaid?

- Medicaid is an entitlement program, which means that everyone who meets eligibility rules has a right to enroll in Medicaid coverage – states cannot cap their programs.
- In order to be eligible for Medicaid in Florida, a person must:



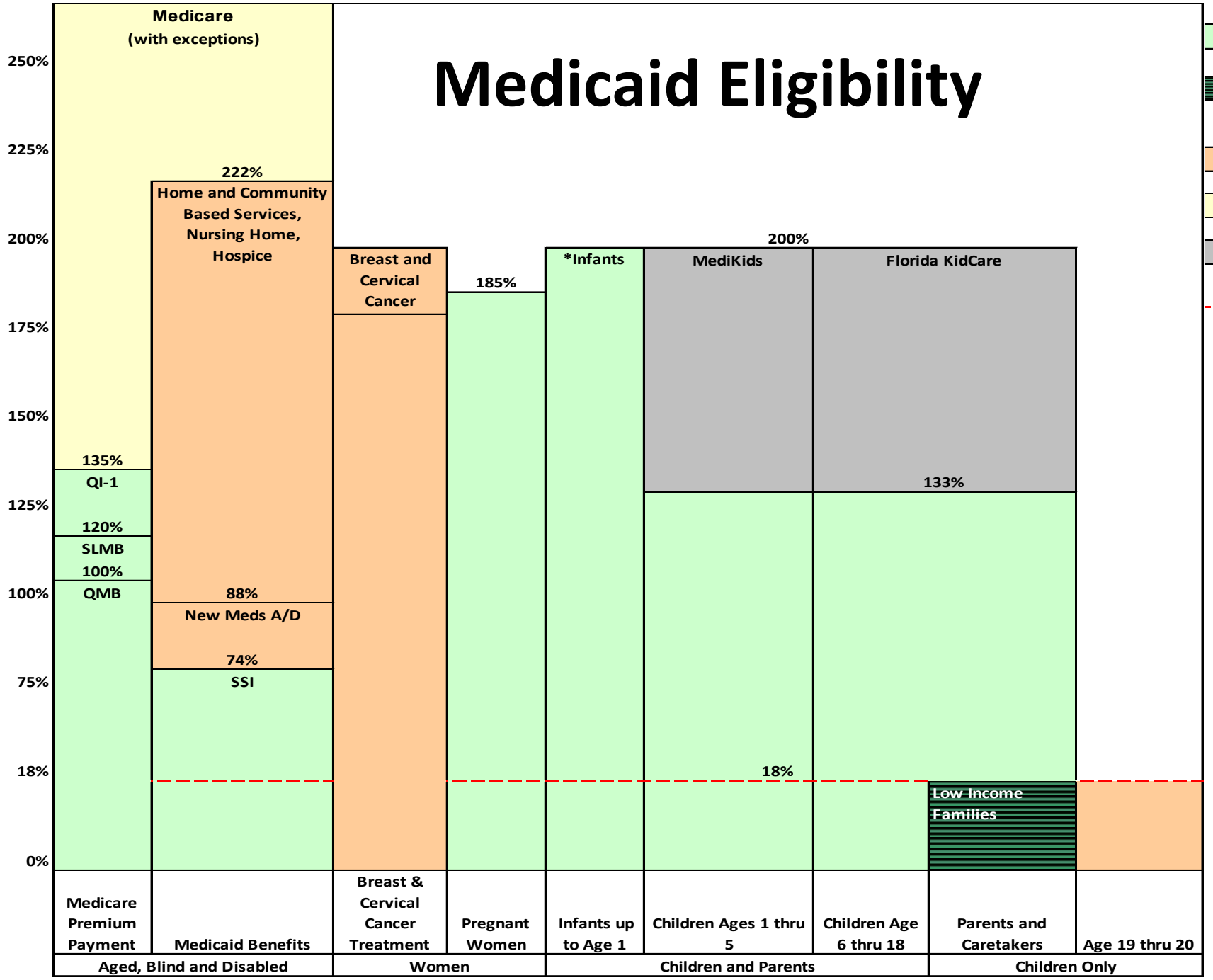
Mandatory and Optional Medicaid Groups

- The federal government requires state Medicaid programs to cover "mandatory groups" and allows for coverage of "optional groups."
  - Mandatory groups: Categories of people that must be covered.
  - Optional groups: States may choose to cover additional federally approved groups.
- The Florida Medicaid program outlines covered groups through its Medicaid state plan and various waivers.

Mandatory
Low Income: • Children • Pregnant Women • Parents • Seniors who are Medicaid recipient
Foster Care/former foster care to age 26
SSI recipient

Optional (Examples)
Medically needy
Children 19 and 20
Lawfully residing children during their first 5 years
Breast and Cervical Cancer Program Enrollees
Family Planning Waiver

Medicaid Eligibility



Mandatory Medicaid coverage (entitlement).

Mandatory Medicaid coverage for low-income families using 1996 AFDC income standard

Optional Medicaid coverage (entitlement).

Federal Medicare coverage (entitlement).

Optional child insurance coverage (non-entitlement).

Optional Medically Needy income spend down level (entitlement).

1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$30,680
6	$37,190
7	$41,970
8	$46,630
Each Additional	$4,720

*Coverage for infants up to 200% Federal Poverty Level is required in order for state to receive Title XXI funding.

**Federal Poverty Level as of January 2022

Florida Medicaid Income Limits

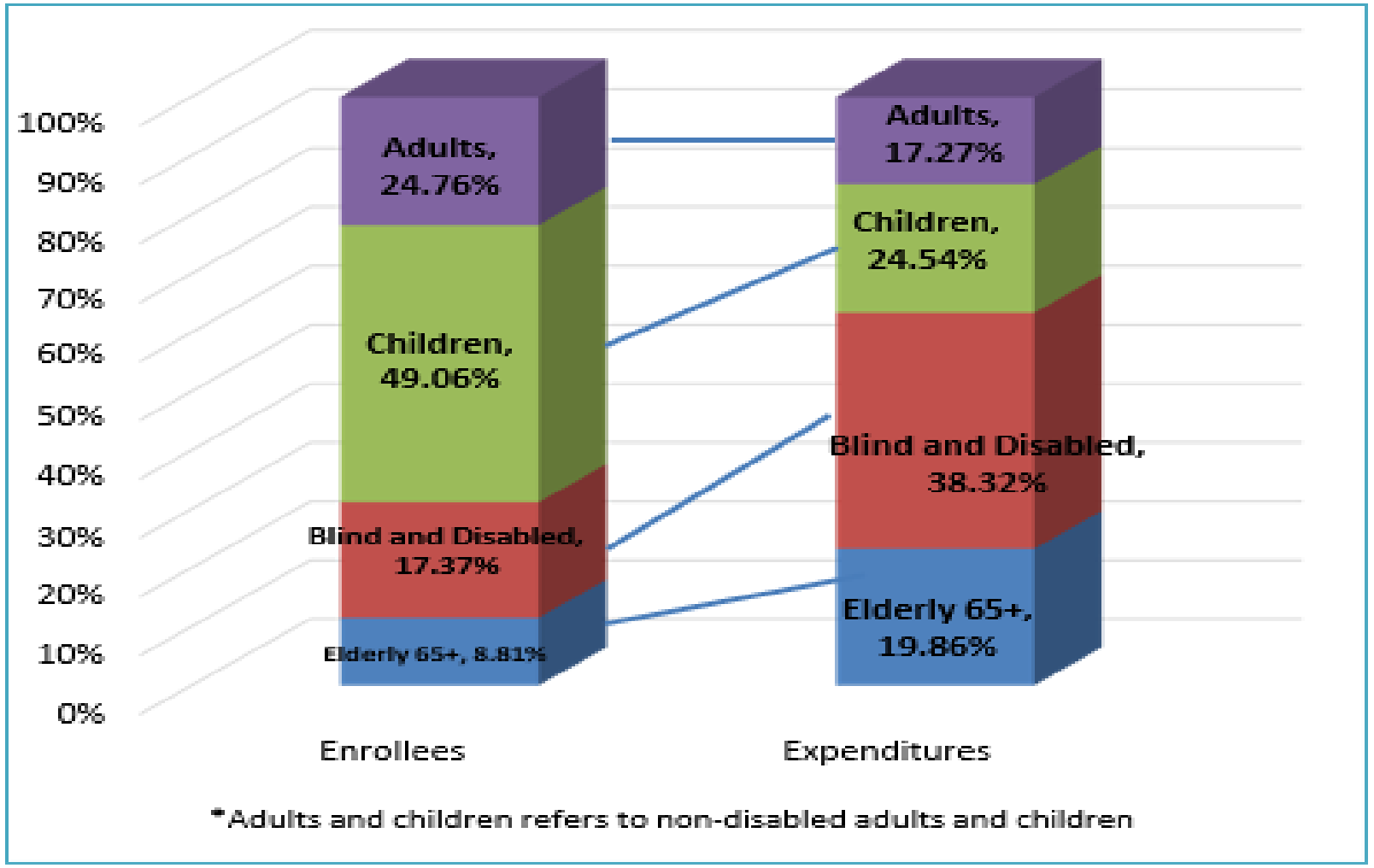
* Income limits do not account for applicable income disregards and are included for comparison to FPL only.

Certain eligibility categories for the elderly and/or disabled, for example, have final income limits based on other factors including living situation and consideration of assets.

Group	Federal Poverty Level	Annual Income (Family of Four)*
Children Under Age 1	200% FPL	$55,500
Children ages 1 through 18	133% FPL	$30,636
Pregnant Women	185% FPL	$51,348
Parents, Caretakers, Children ages 19-20	Fixed dollar amount	$4,368
Home and Community Based Services, Nursing Home, Hospice	222% FPL	$61,608
Meds A/D	88% FPL	$24.408

Expenditures by Population

- Different populations have different impacts on program expenditures.
- In general, services provided to the elderly and the disabled cost more per person/per month than services provided to children or healthy adults.

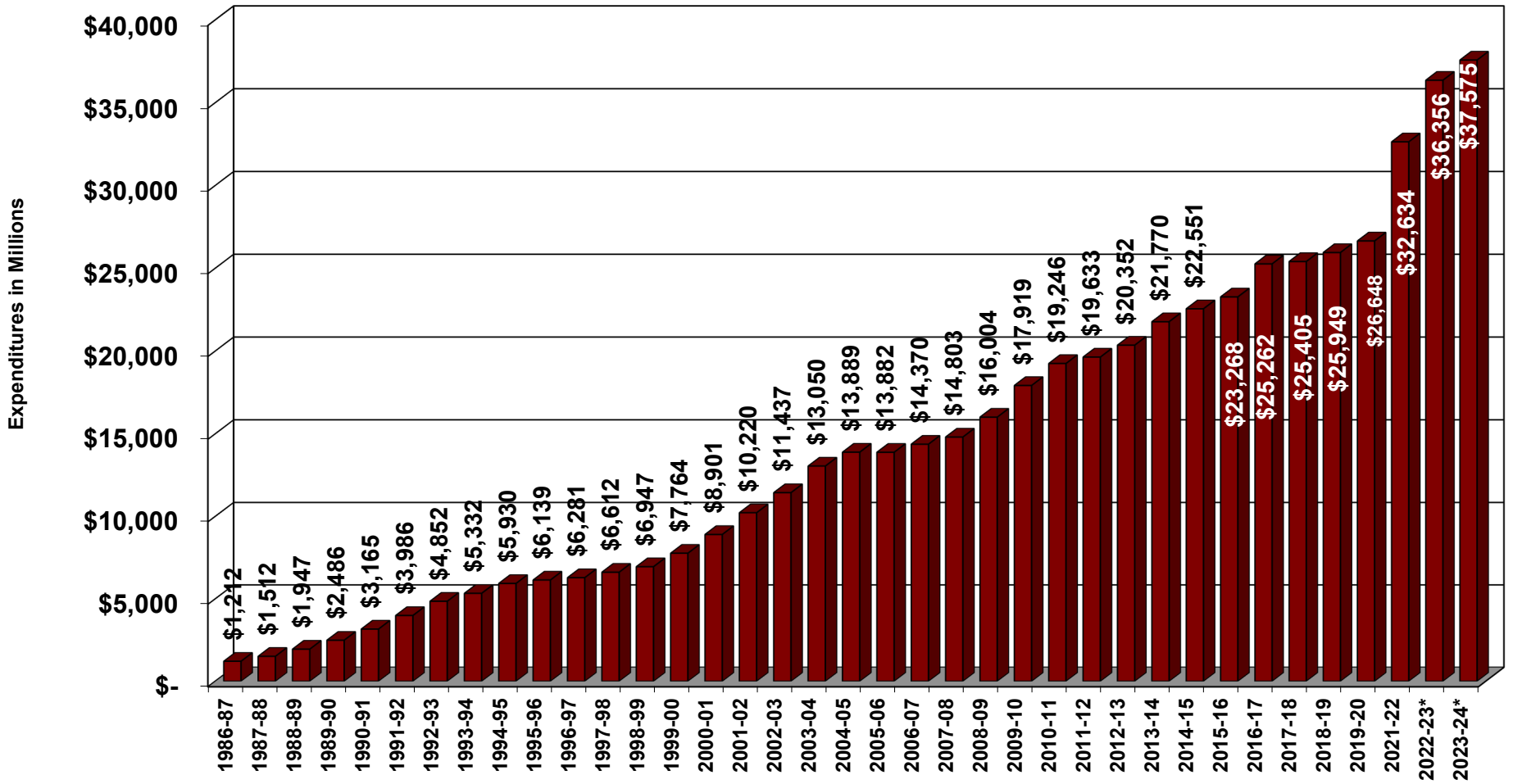


Medicaid Program Costs

Current gross Per Member Per Month cost for the Medicaid program is $6,783.

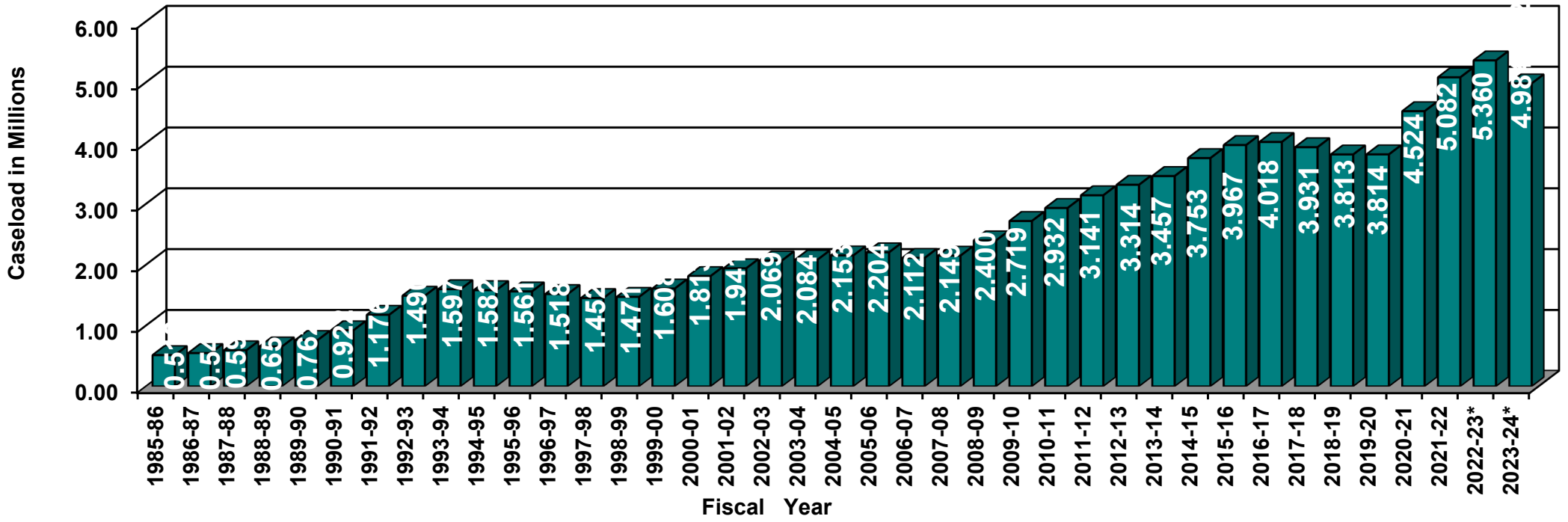
- This does not represent cost of actual average amount of medical services provided to each Medicaid enrollee.
- This is calculated using total Medicaid program costs divided by total Medicaid program enrollees.
- This includes all Medicaid program expenditures, including those not linked to direct service provision. Examples include:
    - Hospital and other provider supplemental funding programs
    - Payments to the federal government for Medicare Part D claw back
    - Mandatory expenditures to cover cost sharing for low-income Medicare recipients
- This does not include adjustments for money repaid by Medicaid plans in the Achieved Savings Rebate program.

Growth in Service Expenditures



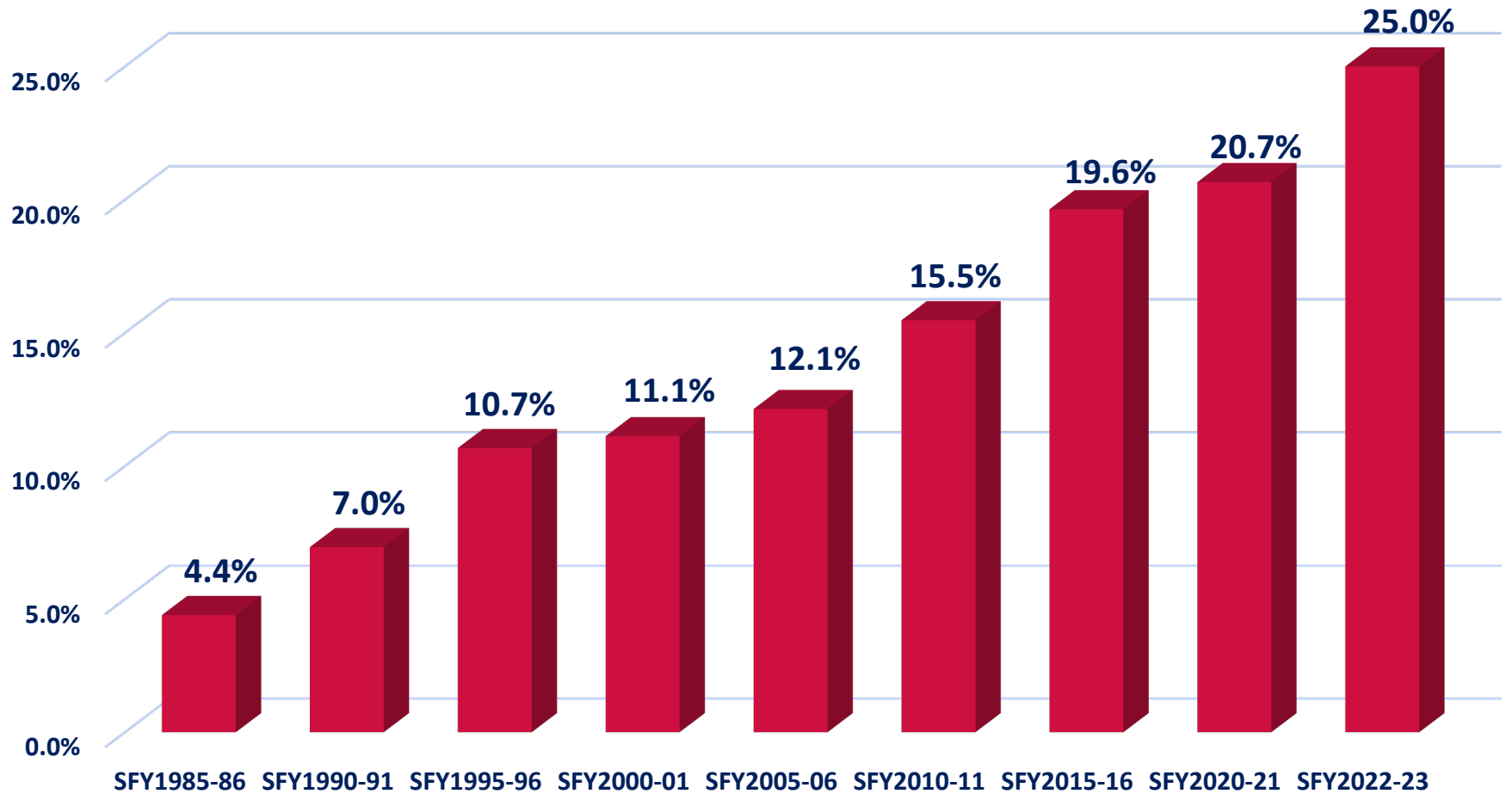
Source:
Medicaid Services Budget Forecasting System Reports.
*FY 2022-23 and 2023-24 Source: August 2022 Social Services Estimating Conference.

Average Monthly Caseload Growth



Source: Medicaid Services Eligibility Subsystem Reports.
*FY 2022-23 and 2023-24 from July 2022 Caseload Social Services Estimating Conference

Average Caseload Growth – Percent of Total Florida Population

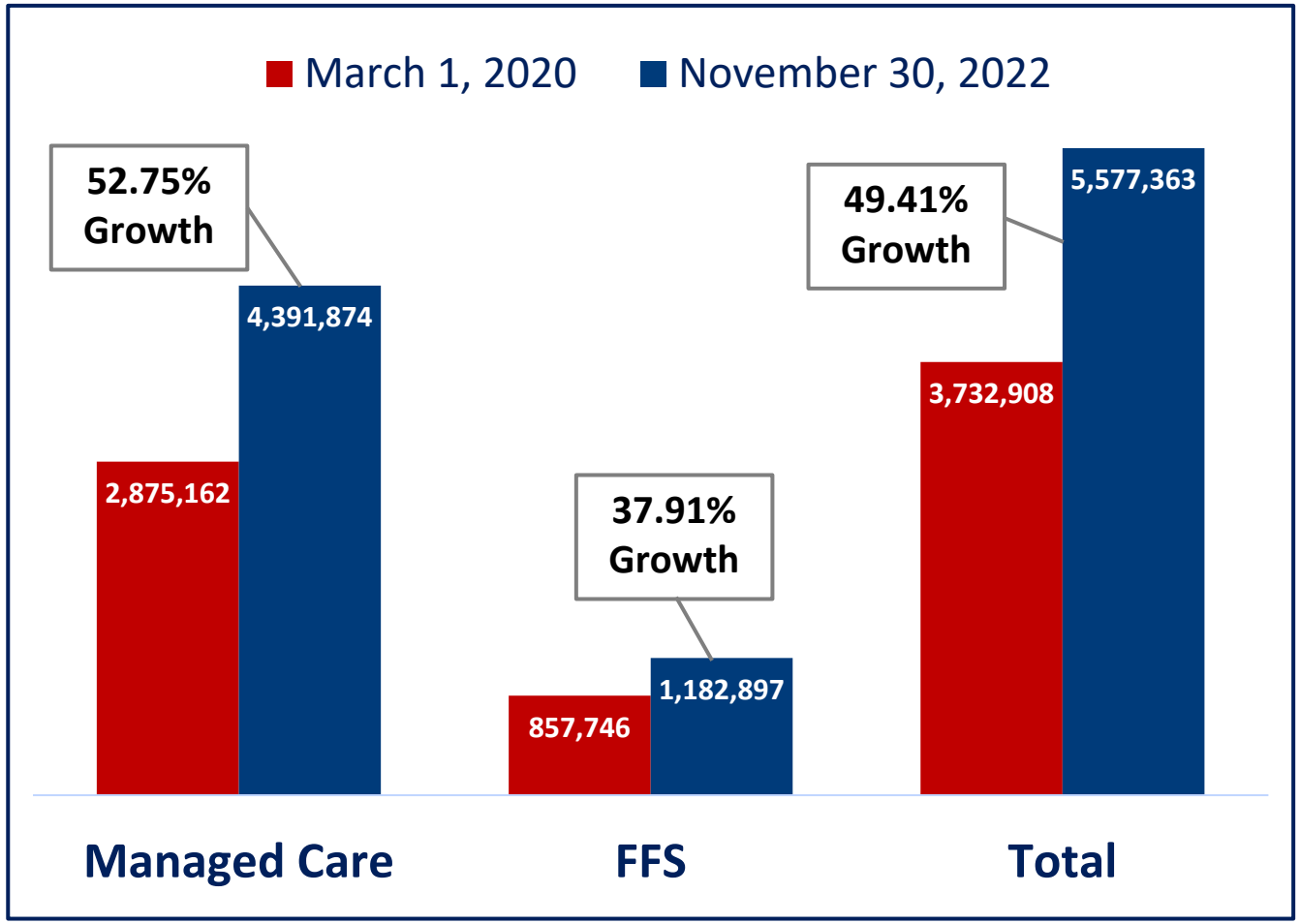


The Public Health Emergency and Enhanced Federal Medical Assistance Percentage (FMAP)

In January, 2020, Federal Department of Health and Human Services declared a Public Health Emergency (PHE); in March, Congress passed the CARES ACT.

- The CARES Act provided a **6.2 percentage point increase** in federal Medicaid matching funds (FMAP) to help states respond to the COVID-19 pandemic.
- The enhanced FMAP was effective January 1, 2020, through the end of the PHE.
- States accepting the enhanced FMAP were required to provide **continuous Medicaid eligibility** through the end of the PHE. This applies to people enrolled as of March 18, 2020, or any time thereafter during the PHE.
- Florida's FMAP with the PHE enhancement, is 66.5%: for every dollar we spend on services, the federal government pays 66.25 cents and the state pays 33.75 cents.

Impact of Public Health Emergency on Enrollment

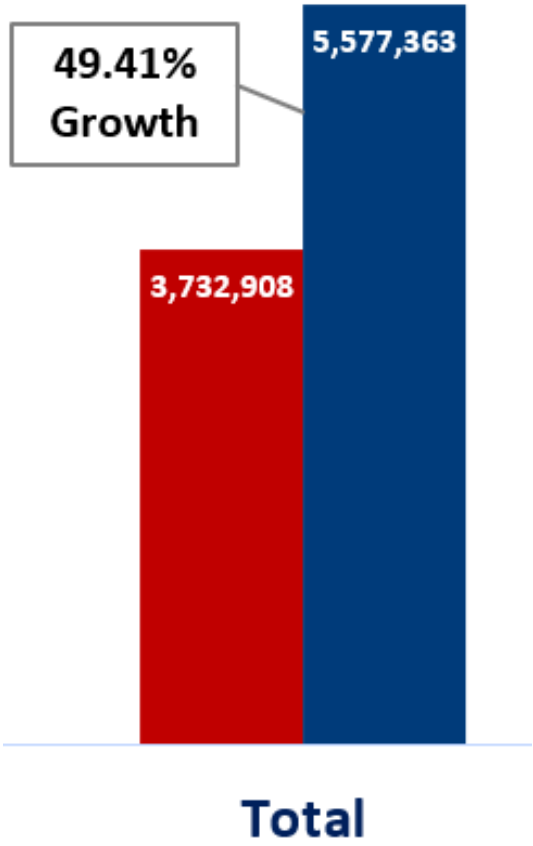


The chart reflects the change in enrollment from March 1, 2020 through November 30, 2022.

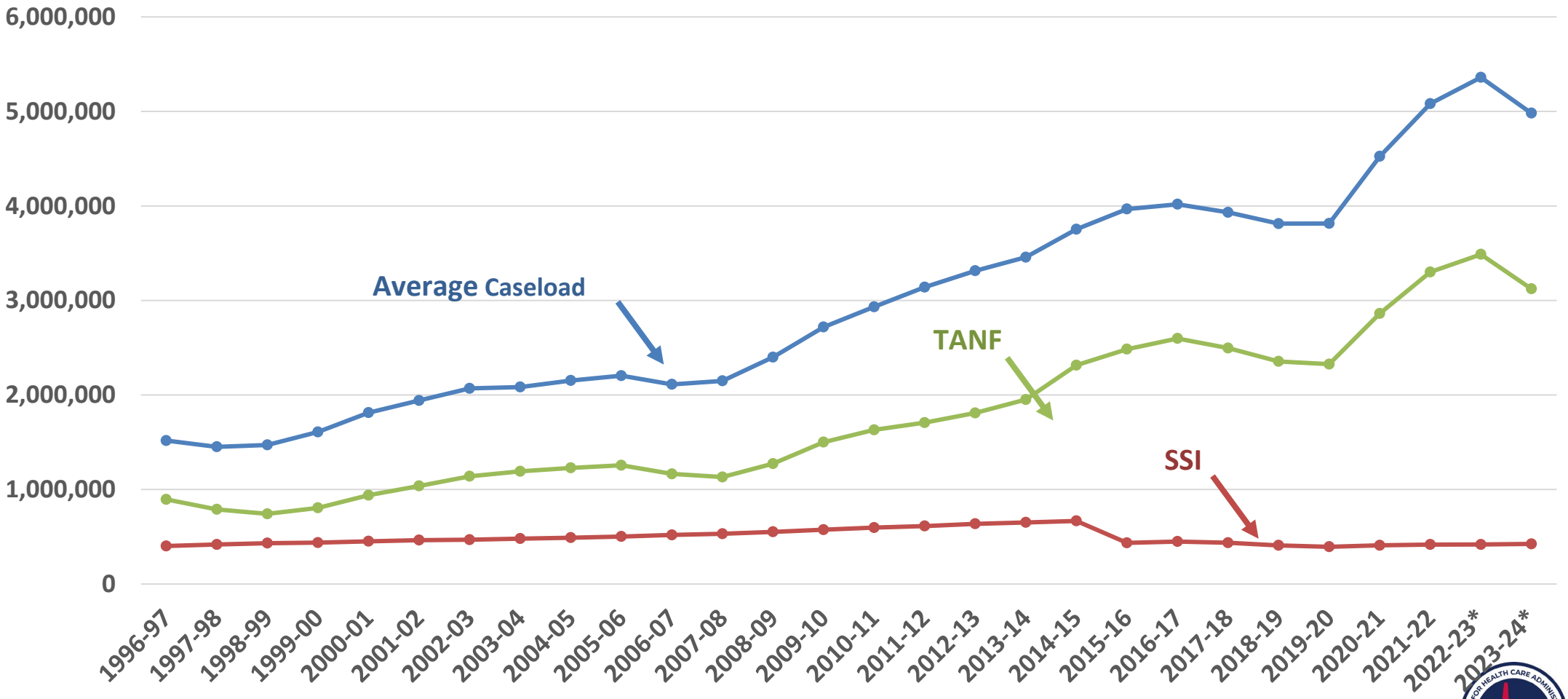
- Since March 2020, Medicaid enrollment has increased by over 1.8 million recipients to nearly 5.58 million (as of November 30, 2022).

Impact of Public Health Emergency by Eligibility Category

- Overall, Medicaid enrollment has increased by 49.41% since March of 2020.
- Some groups have experienced higher growth:
  - For example, Temporary Assistance for Needy Families (TANF) (includes Children, Parents/Caretakers and Pregnant Women) with a 67.6% increase or 1,682,777.
  - Per member per month cost for those in the TANF category: $222.92
- While others experienced lower growth:
  - For example, SSI eligible (the aged, blind and disabled) saw an increase of just 8.5% or 32,189.
  - Per member per month cost for those in the SSI category: $911.19



Growth in Average Monthly Caseload, TANF and SSI



Source: Medicaid Services Eligibility Subsystem Reports.
*FY 2022-23 and 2023-24 from July 2022 Caseload Social Services Estimating Conference

Federal Consolidated Appropriations Act, 2023

- States must provide coverage for children under 19 for 12 months (currently 12 months up to age 5 and 6 months 5-19)
- Makes permanent the state option for Medicaid postpartum coverage for 12 months
- Ends “Continuous Coverage” effective April 1, 2023
- Updates to Enhanced FMAP rate:
  - 5% from April to June of 2023 (currently 6.2%)
  - 2.5% from June to September 2023
  - 1.5% from October to December 2023
- To continue receiving the enhanced Medicaid matching rate, states must:
  - Follow federal Medicaid eligibility requirements
  - Attempt to ensure updated beneficiary contact information
  - Make a good faith effort to contact current enrollees by using more than one modality (e.g., hard copy letter and text message)

Core Tenets for Returning to Normal Medicaid Redetermination Processing

- Prioritize exceptional customer service through strong communication and community collaboration
- Leverage technology and operational efficiencies
- Ensure continuity of coverage for eligible individuals while promoting the availability of alternative health insurance options for those who are no longer eligible

Enhanced Customer Experience/Engagement

- Implementation of system protections to ensure that Medicaid recipients' coverage will not end until a full redetermination has been completed
- Aligning Medicaid redeterminations with Supplemental Nutrition Assistance Program (SNAP), if applicable, to streamline the customer experience and provide more efficient business operations
- Well-coordinated communications plan that incorporates industry and partner feedback
- Medicaid recipient address validation campaign
- Targeted call center operations, including self-service interactive voice response (IVR) options, and dedicated staff
- Stakeholder meetings:
  - Community organizations
  - Associations
  - Medicaid Health Plans

Communication Strategy

Direct Communication

- Client Call Center
- Postcards
- Yellow Stripe Renewal Notices

Digital Communication

- Email/text messaging
- Social Media
- Call Center Virtual Assistant

Partners

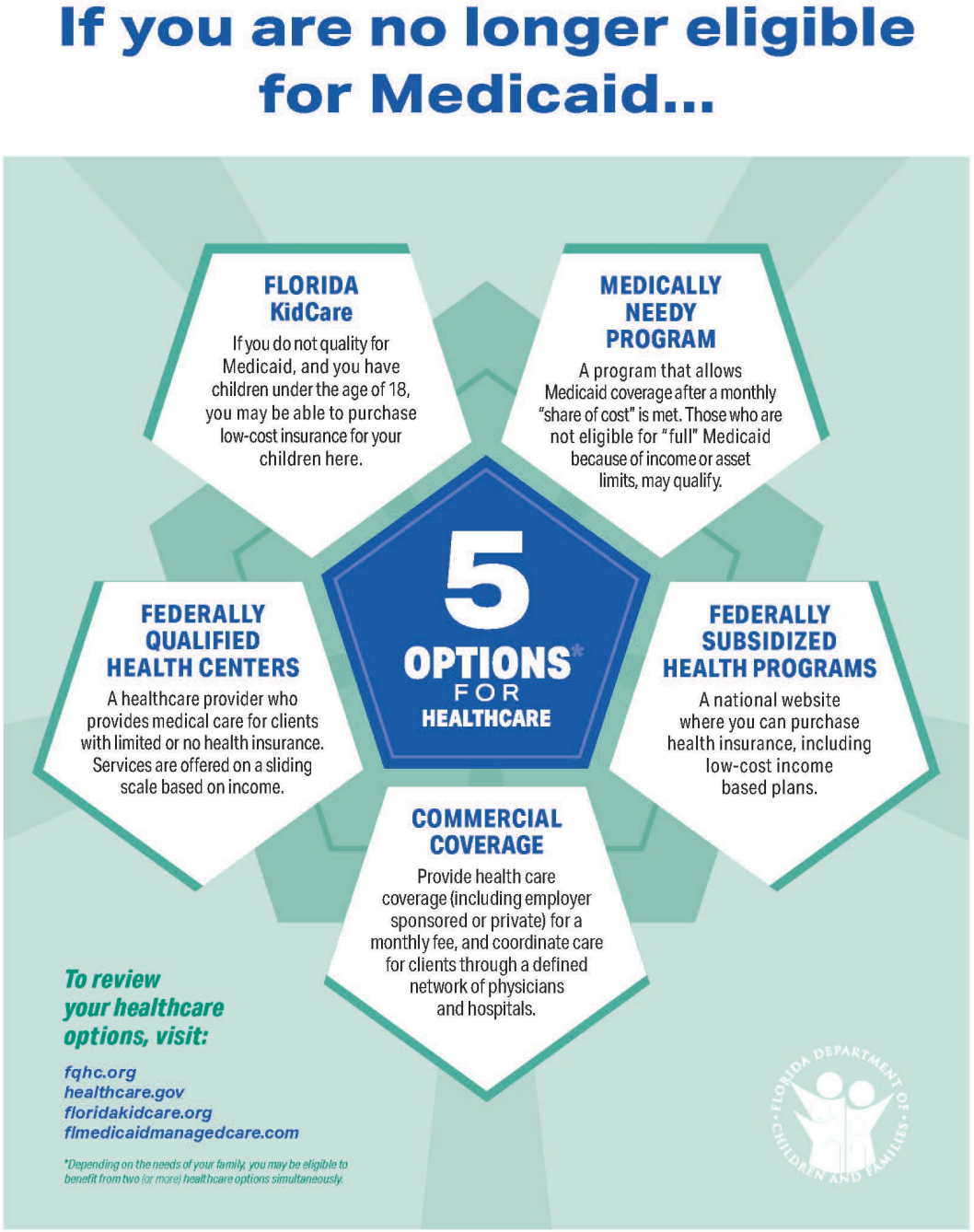
- Validating contact information
- How to assist
- Partner packets

Technology Enhancements

Auto-Review	Returned Mail	Chatbots/Videos	Protections
• Remove filters • Expand sources	• Identify renewals • Text/emails	• “How To” portal • Automated assistance	• Prevent closure before renewal

Alternative Coverage Options

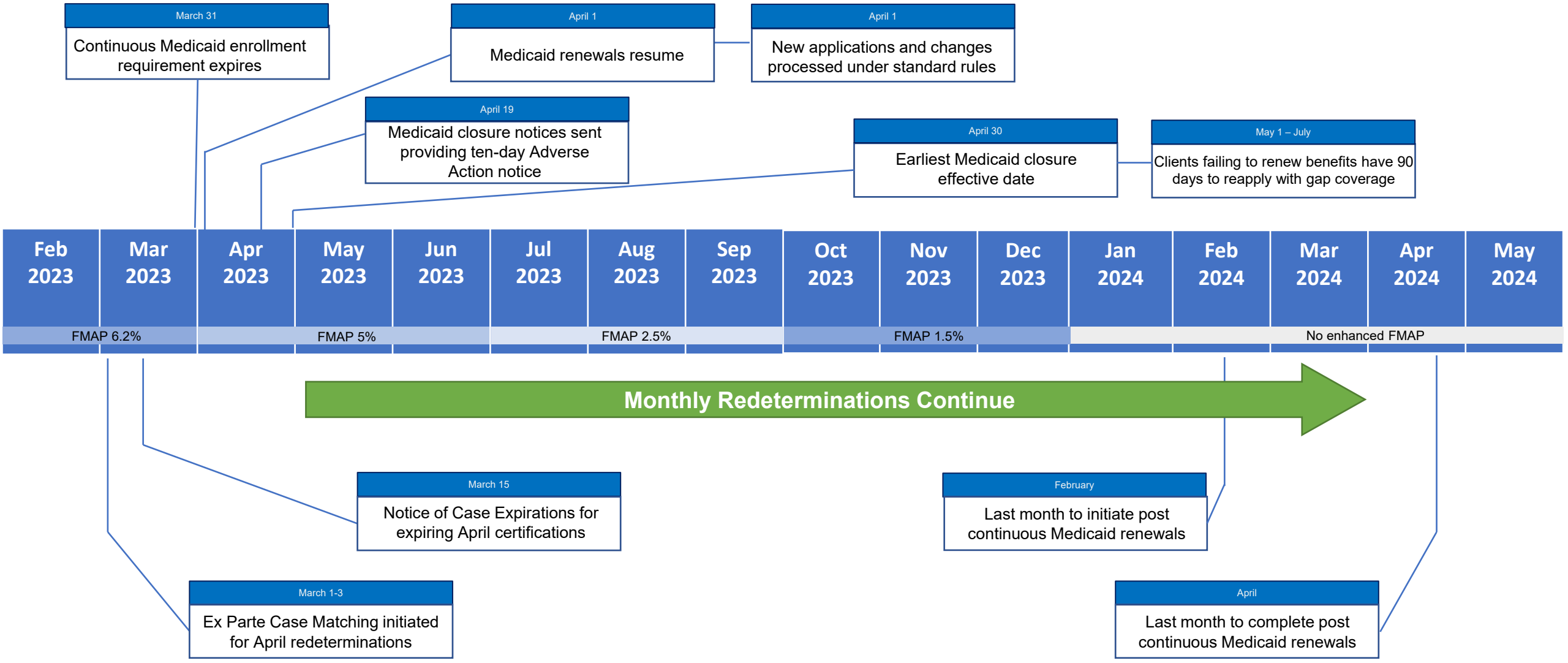
- Current enrollees will receive a notice prior to their renewal date with instructions on how to complete the renewal process
- Automatic partner referrals to organizations like Florida Healthy Kids and other subsidized programs
- Referral information on website for healthcare navigators



Redetermination Schedule

- The Department will prioritize redeterminations for the following:
  - Individuals who are no longer eligible based on information on file from their last redetermination review.
  - Recipients who have not used their Medicaid benefit in the last 12 months.
  - Recipients who have not responded to requests for updated eligibility information.
- The remaining recipients will be reviewed on their next regularly scheduled renewal date except when the Department can align the renewal date to coincide with:
  - The date of other members within the household/family unit; or
  - Their renewal date for SNAP or TANF benefits.
- Vulnerable populations (e.g., children with complex medical conditions) will be last in the redetermination schedule

FLORIDA'S MEDICAID REDETERMINATION OPERATIONS



Florida's
MEDICAID ELIGIBILITY
REDETERMINATION PROCESS

PREGNANT OR NEW MOM

DCF CASE REVIEW
DCF automatically reviews client eligibility based on available data.

ELIGIBLE FOR MEDICAID!

Medicaid is available for expecting mothers and is provided up to 12 months for baby and mom

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ELIGIBLE FAMILY WITH CHILDREN UNDER 18

DCF CASE REVIEW
DCF automatically reviews client eligibility based on available data.

NOTICE
If additional information is needed, DCF will send a notice 45 days before Medicaid ends, asking client to complete a renewal application.

U.S. MAIL & EMAIL

Parent provides info

DCF REVIEWS AND MAKES A DETERMINATION

ELIGIBLE FOR MEDICAID!

INELIGIBLE FAMILY WITH CHILDREN UNDER 18

DCF CASE REVIEW AND NOTICE SENT
DCF reviews client eligibility.

INELIGIBLE FOR MEDICAID
AUTOMATIC REFERRAL

SUBSIDIZED FEDERAL HEALTH PROGRAMS

CLIENT SELECTS A PLAN AND PAYS PREMIUM

ELIGIBLE FOR OTHER HEALTH COVERAGE!

INELIGIBLE FOR MEDICAID
AUTOMATIC REFERRAL

Florida Healthy Kids

HEALTHCARE OPTION PROVIDED

Florida Healthy Kids CONTACTS CLIENT
2-3 days:
NOTICE (U.S. Mail)
10 days:
PHONE CALL

CLIENT SELECTS PLAN AND PAYS PREMIUM

ELIGIBLE FOR Florida Healthy Kids!

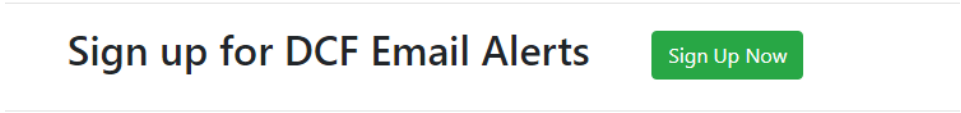
Strategies for Partners

Ensure Customer Contact Information is up-to-date

- Assist with updating address on the DCF customer portal

Stay Informed

- Join DCF's Medicaid email distribution list
- Check our web page for up-to-date information – www.myflfamilies.com/Medicaid
- Participate in informational calls, meetings and feedback sessions
- Flyers, social media posts, and content creation to be shared with customers seeking assistance



Stay Connected

- Constant feedback loop with our state and federal partners to ensure Floridians are informed

What's Next

- Federal Guidance
  - Awaiting final federal guidance from CMS on implementation of Federal Consolidated Appropriations Act, 2023
- Medicaid Recipients
  - Update address and contact information with DCF via MyACCESS Account
  - Be on the lookout for the yellow stripe envelope
- Partners
  - Sign up for updates through DCF's distribution list
  - Partner Packet and Communications