



Florida Medicaid: Program Overview

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Medicaid

A State and Federal Partnership

- In 1965, the federal Social Security Act was amended to establish two major national health care programs:
 - Title XVIII (Medicare).
 - Title XIX (Medicaid).
- Medicaid is jointly financed by state and federal funds.
- States administer their programs under federally approved state plans.

The Medicaid Program Major Federal Requirements

- ▶ States must submit a Medicaid State Plan to the federal Centers for Medicare and Medicaid Services (CMS).
- ▶ Mandatory eligibility groups and services must be covered.
- ▶ Services must be available statewide in the same amount, duration and scope.

Medicaid Structure

- Federal Medicaid laws mandate certain benefits for certain populations.
- Medicaid programs vary considerably from state to state, and within states over time.
- State Medicaid programs vary because of differences in:
 - optional service coverages.
 - limits on mandatory and optional services.
 - optional eligibility groups.
 - income and asset limits on eligibility.
 - provider reimbursement levels.

Medicaid Structure

(continued)

- Medicaid does not cover all low income individuals.
 - 27% of children.
 - 51.2% of deliveries.
 - 63% of nursing home days.
 - 1,162,020 adults - parents, aged and disabled.

The Federal Medicaid Program

- The Plan outlines current Medicaid eligibility standards, policies and reimbursement methodologies to ensure the State program receives matching federal funds under Title XIX of the Social Security Act.

- Services must be available statewide in the same amount, duration and scope.
 - States cannot choose to provide a service in only one geographic area.
 - States cannot have a higher service limit for a certain group of recipients (with the exception of children).

Medicare vs. Medicaid

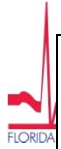
	Medicare	Medicaid
Enacted by Congress	1965	1965
Alternate Program Name	Title XVIII	Title XIX
Financing	Employee/Employer Payroll Tax; Premiums; Federal General Revenue	Federal and State Governments – Matching Rates Based on Per Capita Income
Eligibility	Not Income Based; All Persons Age 65+; Certain Younger Persons on Social Security Disability or Based on Disability and Specific Condition (ESRD); Totally and Permanently Disabled (24 months)	Income Based; All Ages; Mandatory Eligibility Groups; Optional Eligibility Groups
Cost Sharing	<p>Part A Premium For most there is no premium. Buy-in available for those not otherwise qualified (\$450 for 2011)</p> <p>Part A Deductible \$1,132/Benefit Period (2011)</p> <p>Part B Premium \$115.40 (2011)</p> <p>Part B Deductible \$162 (2011)</p> <p>Part B Coinsurance 20%</p> <p>Part D Coinsurance up to 25% / Annual Deductible \$310</p> <p>Co-payments are variable with Income</p> <p>Low Income Subsidies are provided for the above</p>	Nominal; Spend Down for Medically Needy Individuals
Administering Agency	HHS/CMS/Carriers – Financed by Federal Government and Beneficiary Cost Sharing	States – Jointly Financed by State and Federal Governments; Medicaid Programs Vary by State
Benefits	<p>Part A Hospital Insurance for Hospital Care, Skilled Nursing Facilities, Hospice and Some Home Health Care (Qualifying Contributions)</p> <p>Part B Medical Insurance for Physician Services, Outpatient Care and Other Medical Services</p> <p>Part C Medicare+Choice – Health Maintenance Organization Coverage</p> <p>Part D Medicare Prescription drug Insurance</p>	Acute and Long Term Care; Federal Mandated Services and State Optional Services

Florida Medicaid – A Snapshot

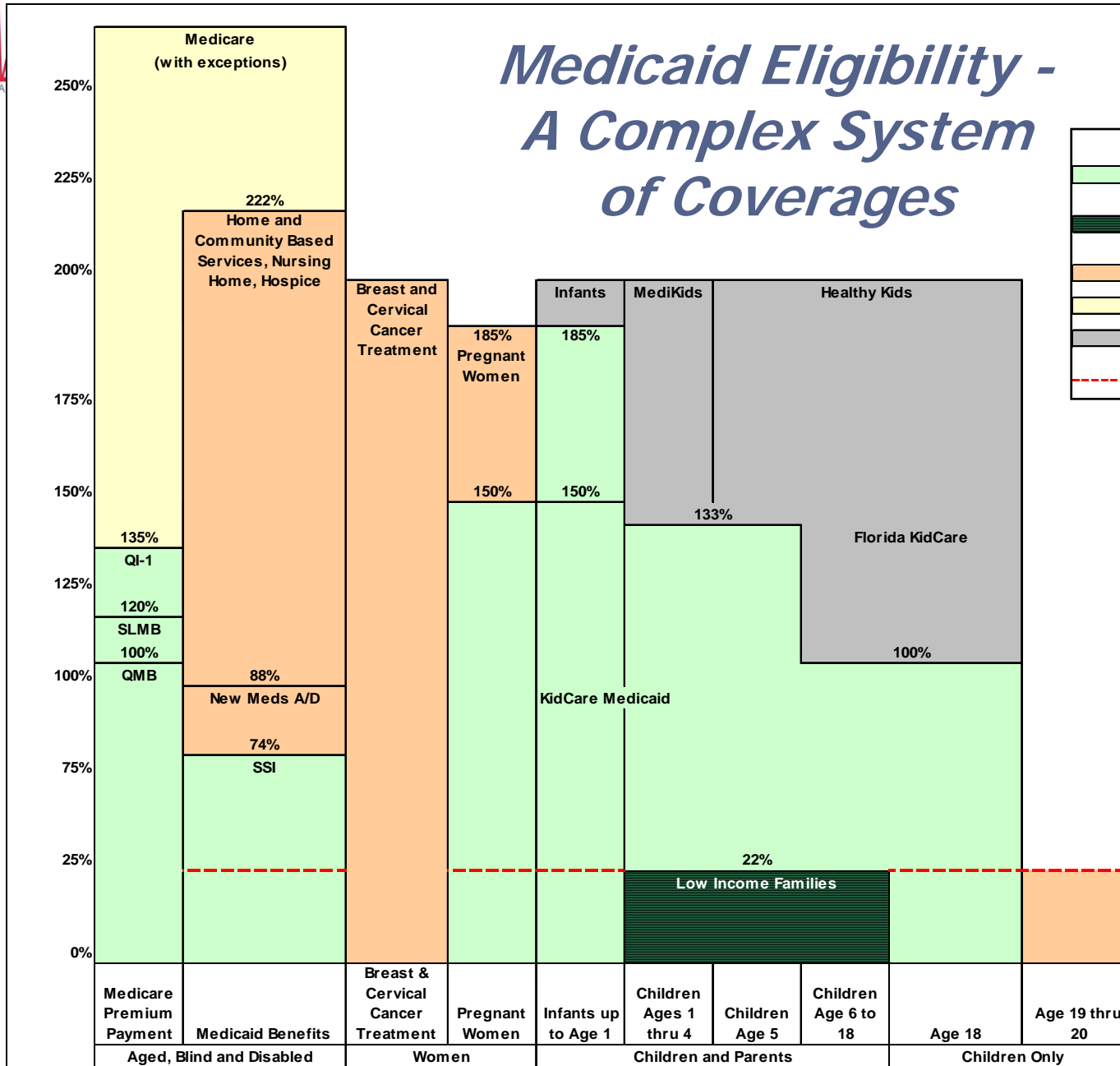
<p><i>Expenditures</i></p>	<ul style="list-style-type: none"> • \$20.3 billion estimated spending in Fiscal Year 2011-12 • Federal-state matching program –55.94% federal, 44.06% state. • Florida will spend approximately \$6,372 per eligible in Fiscal Year 2011-2012. • 45% of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD's); Low Income Pool and Disproportionate Share Payments. • 10% of all Medicaid expenditures cover drugs. • Fifth largest nationwide in Medicaid expenditures.
<p><i>Eligibles</i></p>	<ul style="list-style-type: none"> • 3.19 million eligibles. • Elders, disabled, families, pregnant women, children in families below poverty. • Fourth largest Medicaid population in the nation.
<p><i>Providers/Plans</i></p>	<ul style="list-style-type: none"> • Approximately 110,000 active Fee-For-Service providers; 25 Medicaid Managed Care plans (19 HMOs and 6 PSNs).

Who's Eligible?

- Medicaid eligibility is determined by:
 - Categorical groups, i.e., pregnant women; families and children; and aged, blind, and disabled individuals.
 - Income.
 - Assets.
 - Citizenship.
 - Residency.
 - Cooperation with Child Support Enforcement (when one or both parents are absent from the home).
 - Medical need for home and community-based services, and persons in nursing facilities.
 - Level of medical bills (for Medically Needy).



Medicaid Eligibility - A Complex System of Coverages



- Mandatory Medicaid coverage (entitlement).
- Mandatory Medicaid coverage for low-income families using 1996 AFDC income standard (entitlement).
- Optional Medicaid coverage (entitlement).
- Federal Medicare coverage (entitlement).
- Optional child insurance coverage (non-entitlement).
- Optional Medically Needy income spend down level (entitlement).

Family Size	**Monthly Income
1	\$908
2	\$1,226
3	\$1,545
4	\$1,863
5	\$2,181
6	\$2,500
7	\$2,818
8	\$3,136
Each Additional	\$319

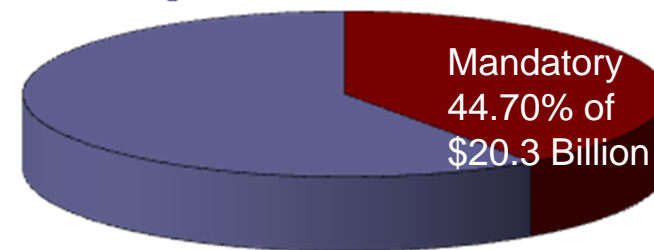
***Coverage for infants up to 185% Federal Poverty Level is required in order for states to receive Title XXI funding.**

****Federal Poverty Level as of January 2011**

Florida Medicaid Mandatory Services

- Advanced Registered Nurse Practitioner Services
- Early & Periodic Screening, Diagnosis and Treatment of Children (EPSDT)/Child Health Check-Up
- Family Planning
- Home Health Care
- Hospital Inpatient
- Hospital Outpatient
- Independent Lab
- Nursing Facility
- Personal Care Services
- Physician Services
- Portable X-ray Services
- Private Duty Nursing
- Respiratory, Speech, Occupational Therapy
- Rural Health
- Therapeutic Services for Children
- Transportation

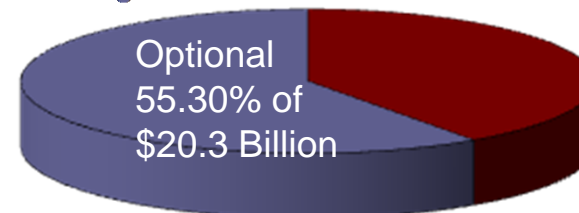
Florida Medicaid Mandatory Services for
All Eligibles FY 2011-12



Florida Medicaid Optional Services*

- Adult Dental Services
- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care Services
- Birth Center Services
- Hearing Services
- Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Healthy Start Services
- Home and Community-Based Services
- Hospice Care
- Intermediate Care Facilities/
Developmentally Disabled
- Intermediate Nursing Home Care
- Optometric Services
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management (MediPass)
- Registered Nurse First Assistant Services
- School-Based Services
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management)

Florida Medicaid Optional Services for All Eligibles FY 2011-12



*States are required to provide any medically necessary care required by child eligibles.

Who Can Provide Medicaid Services?

- Any willing health care practitioner or entity who:
 - provides one of the Medicaid covered services;
 - submits an application to Medicaid;
 - is licensed or certified to practice in the State of Florida;
 - is not terminated from any government health care program; and
 - signs an agreement with Medicaid.
- Managed Care plans with appropriate provider networks.

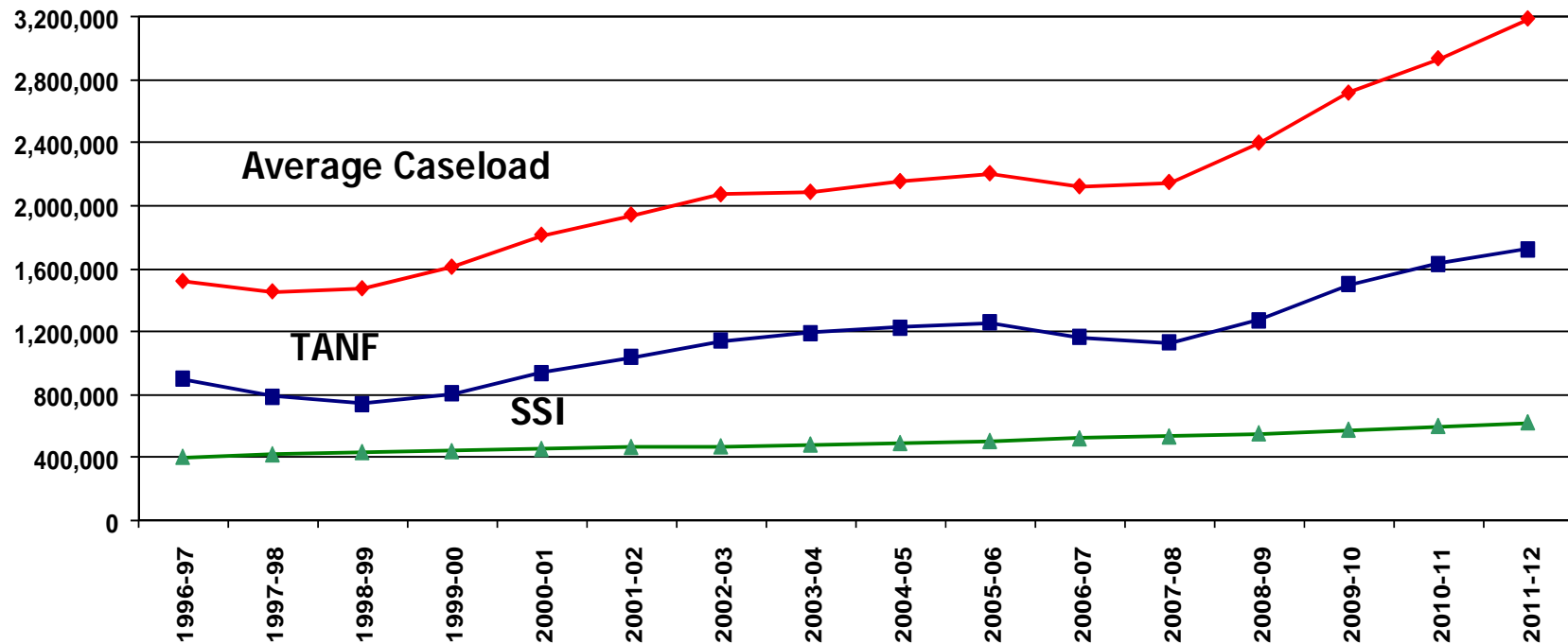
Institutional Providers / Other

- Institutional Providers / Other
 - Examples of provider types:
 - Inpatient Hospitals
 - Outpatient Hospitals
 - Nursing Homes
 - Intermediate Care Facilities for Developmentally Disabled (ICF/DD)
 - Rural Health Clinics (RHCs)
 - County Health Departments
 - Federally Qualified Health Centers
 - Pharmacy

Fee For Service Providers

- Fee for Service Providers
 - Examples of provider types:
 - Physician Services
 - Home Health Services
 - Dental Services
 - Transportation (Emergency and Non-Emergency)
 - Dialysis
 - Nurse Practitioners
 - Laboratory and X-Ray

*Average Monthly Caseload including
TANF and SSI*



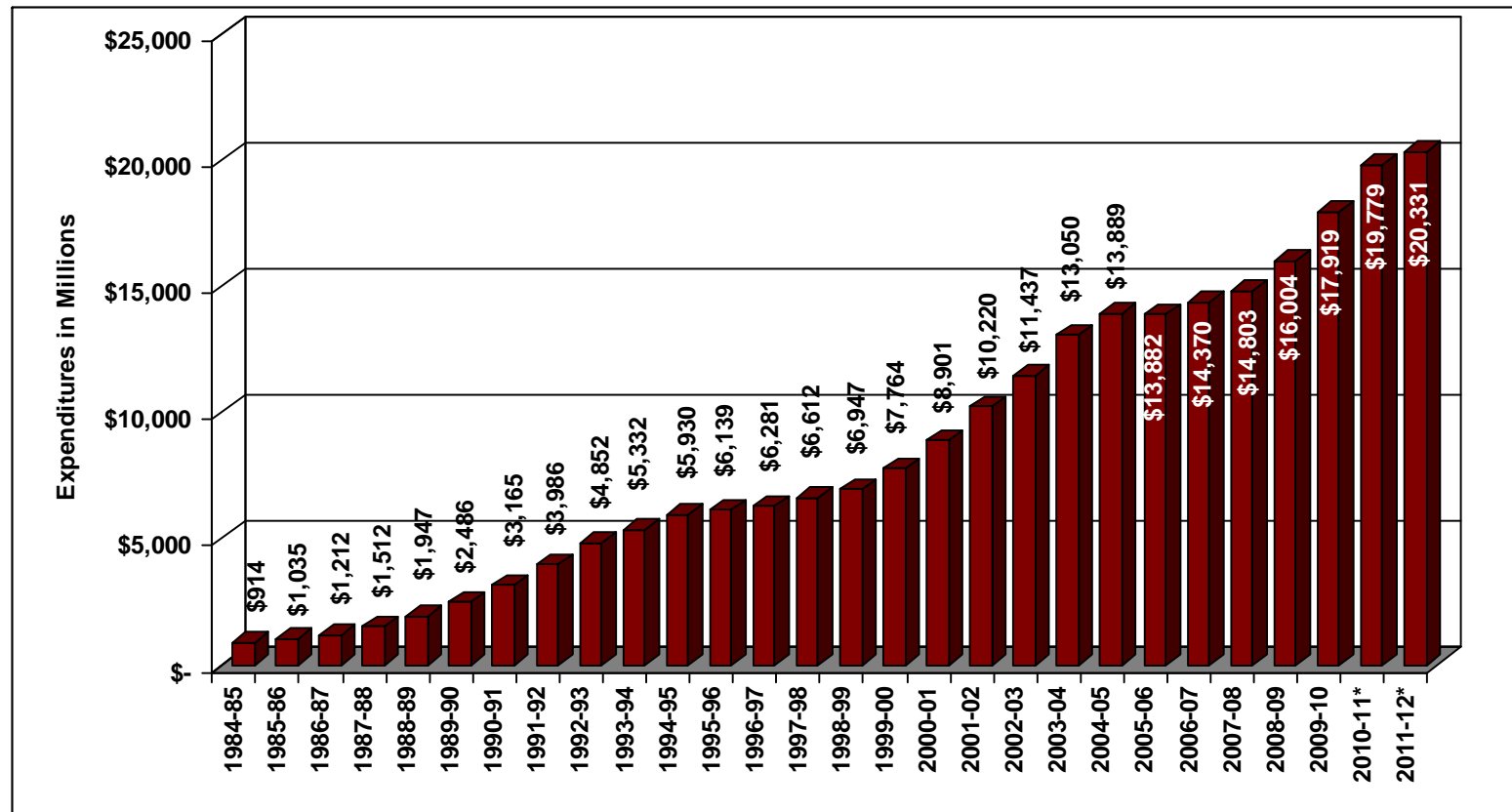
Title XIX Federal Medical Assistance Percentage (FMAP)

Federal Fiscal Year	Federal Share	State Share	Total
2006-07	58.76%	41.24%	100%
2007-08	56.83%	43.17%	100%
2008-09	55.40%	44.60%	100%
2009-10	67.64%	32.36%	100%
2010-11 Q1	67.64%	32.36%	100%
Q2	64.81%	35.19%	
Q3	62.93%	37.07%	
Q4	55.45%	44.55%	
2011-12	55.94%	44.06%	100%

TANF and SSI Related Eligibility Groups for 2011-12

	Total Budget	Avg Monthly Caseload	PMPM
Supplemental Security Income (SSI)	\$10,716,253,178	621,300	\$1,437
Temporary Assistance for Needy Families (TANF)	\$2,921,403,764	971,508	\$251
Medically Needy	\$1,034,570,145	46,096	\$1,870
Children < = 100% of Poverty	\$1,130,542,325	681,925	\$138
Children > 100% of Poverty	\$147,209,115	73,353	\$167
Children – Medicaid Expansion Under Title XXI	\$3,118,619	774	\$336
Pregnant Women < = 100% of Poverty	\$683,867,965	70,527	\$808
Pregnant Women > 100% of Poverty	\$139,086,934	15,837	\$732
Family Planning Waiver	\$23,779,494	60,145	\$33
Categorically Eligible	\$608,706,960	268,842	\$189
Elderly and Disabled (MEDS AD)	\$797,286,206	42,115	\$1,578
Qualified Medicare Beneficiaries (QMB/SLMB/QI)	\$618,564,739	330,346	\$156
Refugee General Assistance	\$33,054,048	8,944	\$308
Other	\$1,473,349,902	N/A	N/A
Total	\$20,330,793,394	3,191,712	\$531

Growth In Medicaid Service Expenditures

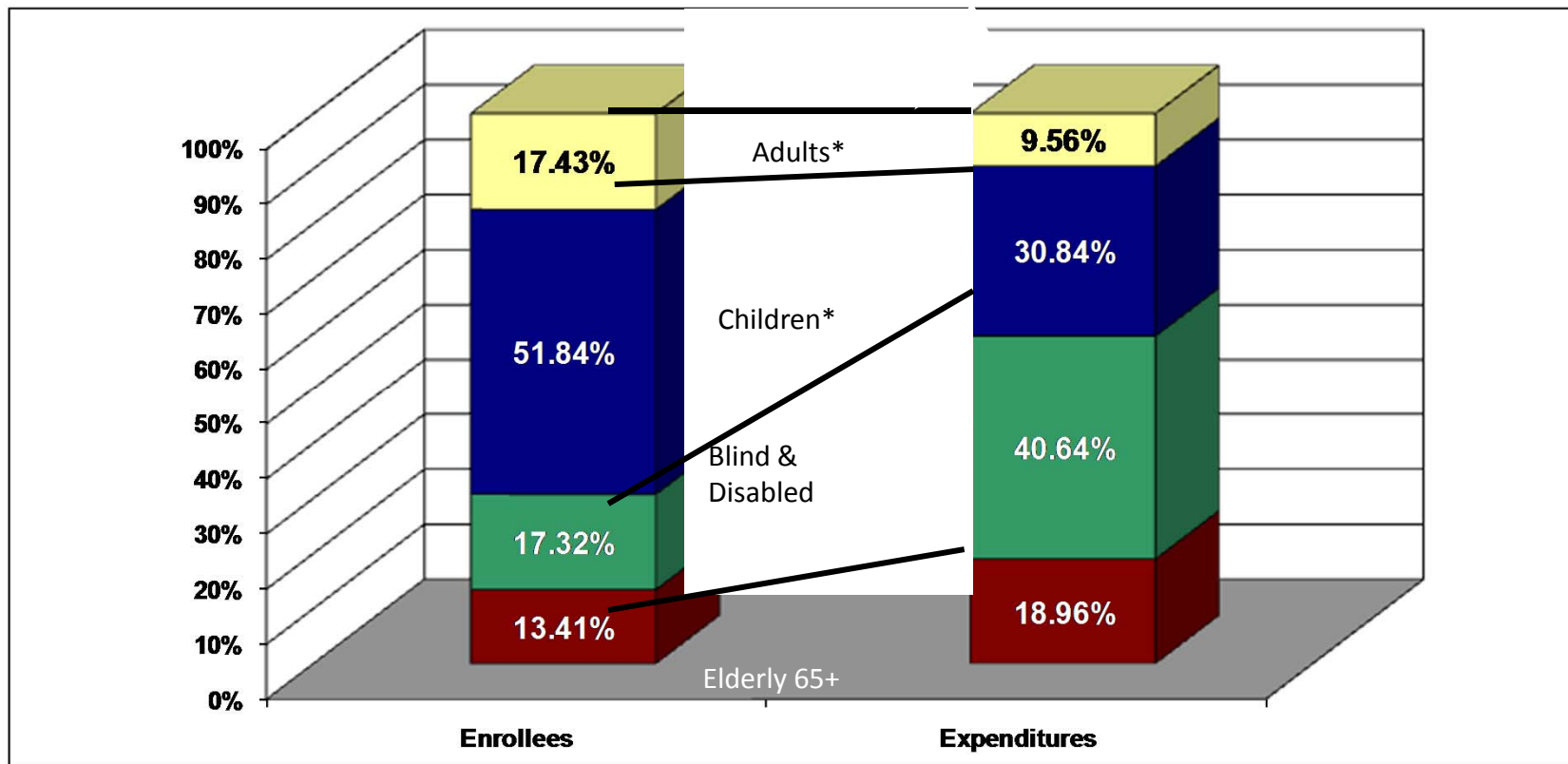


Source: Medicaid Services' Budget Forecasting System Reports.

*FY 2010-11 February 2011 Social Services Estimating Conference.

*FY 2011-12 July 2011 Social Services Estimating Conference.

Medicaid Budget - How it is Spent FY 2009-10

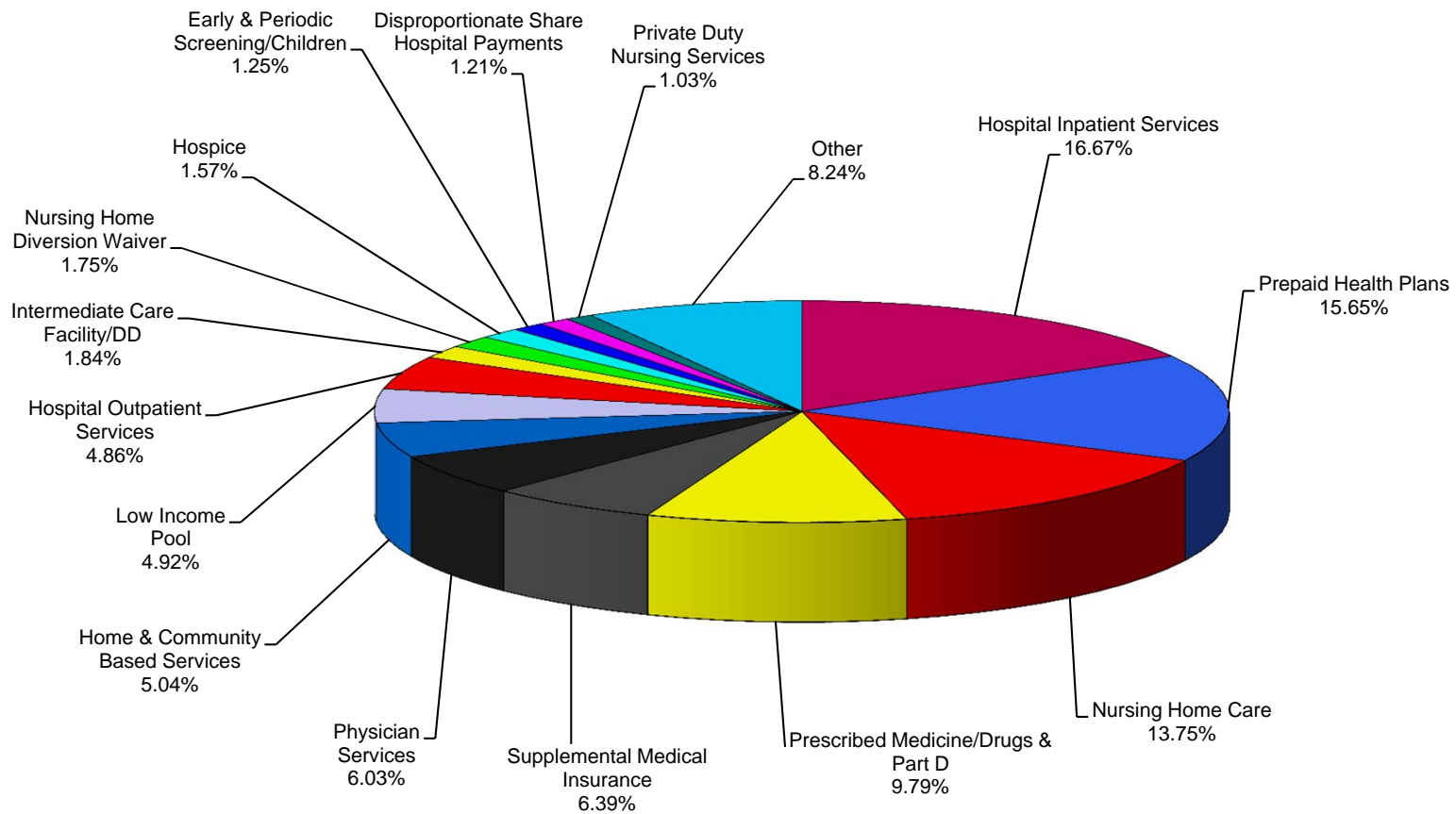


•Adults and children refers to non disabled adults and children.

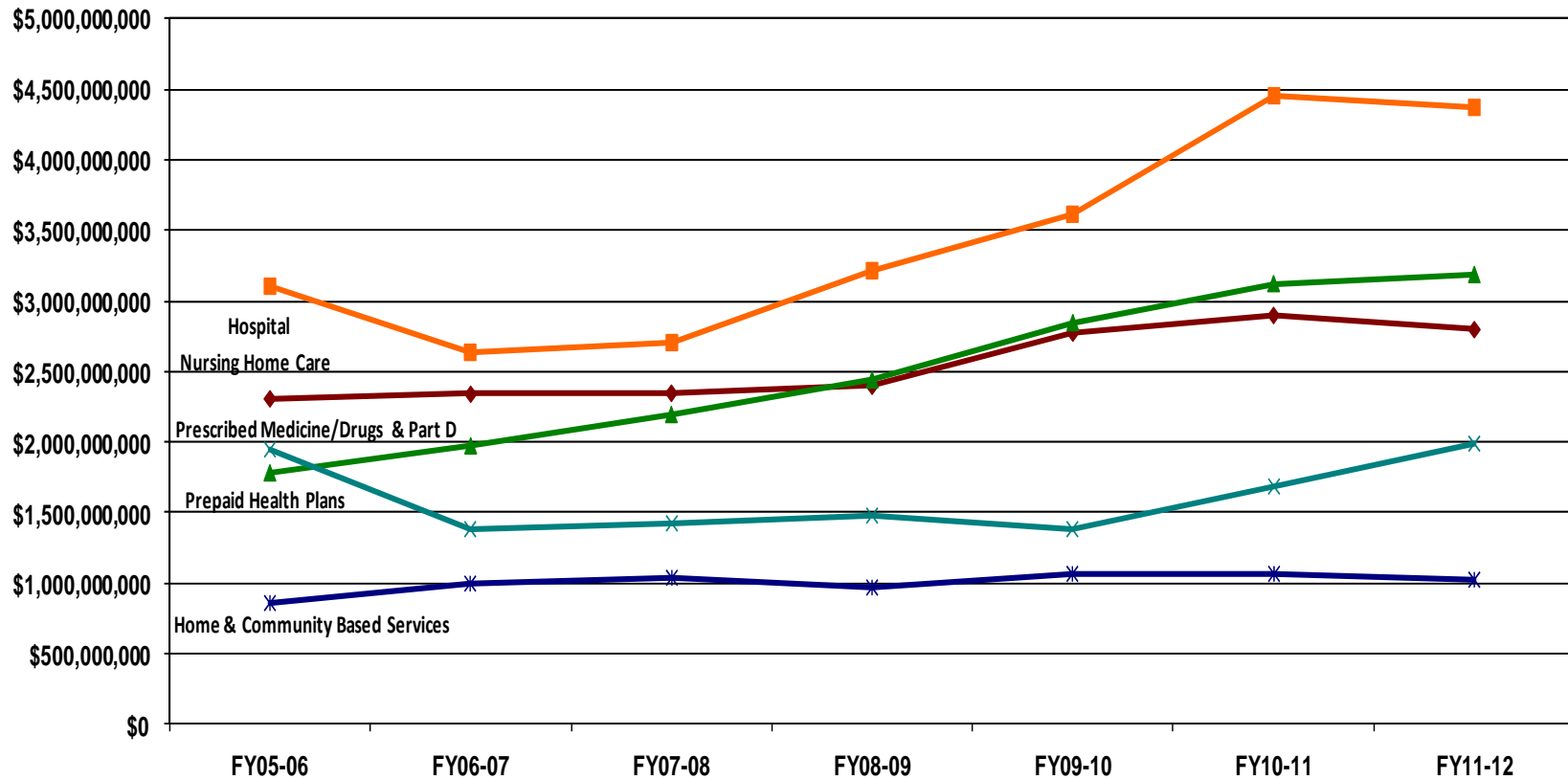
Medicaid Spending for Fiscal Year 2011-12

Service	FY 2011-12 Estimated Spending	Percent of Total
Hospital Inpatient Services	\$3,390,039,763	16.67%
Prepaid Health Plans	\$3,181,001,092	15.65%
Nursing Home Care	\$2,795,230,543	13.75%
Prescribed Medicine/Drugs & Part D	\$1,991,389,946	9.79%
Supplemental Medical Insurance	\$1,299,861,984	6.39%
Physician Services	\$1,226,863,388	6.03%
Home & Community Based Services	\$1,024,717,619	5.04%
Low Income Pool	\$1,000,250,001	4.92%
Hospital Outpatient Services	\$988,179,992	4.86%
Intermediate Care Facility/DD	\$373,081,505	1.84%
Nursing Home Diversion Waiver	\$355,766,695	1.75%
Hospice Services	\$318,982,493	1.57%
Early and Periodic Screening/Children	\$254,420,634	1.25%
Disproportionate Share Hospital Payments	\$246,570,577	1.21%
Private Duty Nursing Services	\$209,254,006	1.03%
Other	\$1,675,183,156	8.24%
Total	\$20,330,793,394	100.00%

Estimated Fiscal Year 2011-12 Medicaid Expenditures By Appropriation Category

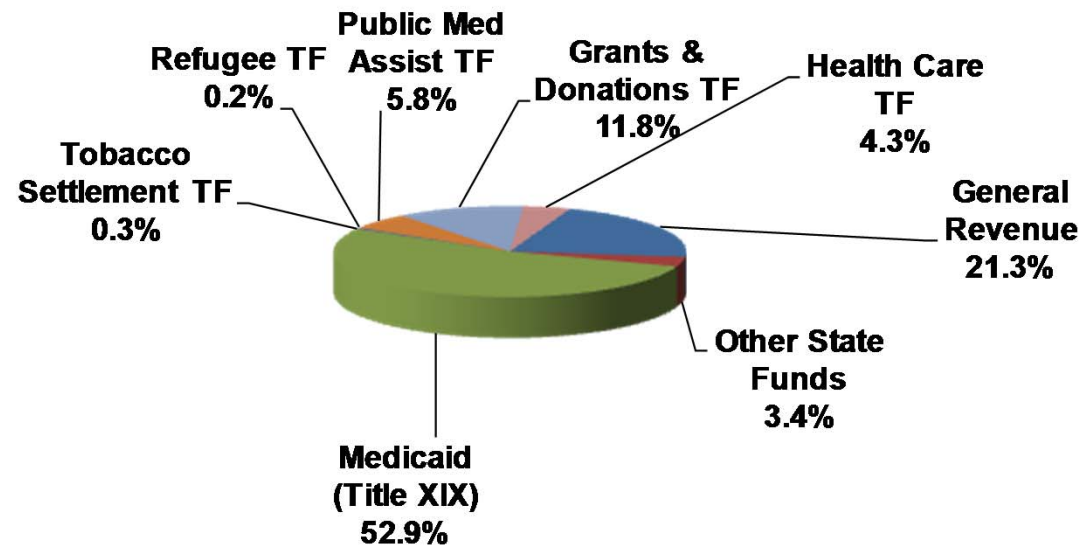


Top 5 Medicaid Services Expenditures on Average



Medicaid Expenditures by Fund Source FY 2011-12 - \$20.3B

<u>In Millions</u>	
Medicaid (XIX)	\$10,758.1
General Revenue	\$4,332.1
Grants & Donations	\$2,384.2
Health Care TF	\$883.5
Other State Funds	\$711.4
PMATF	\$1,169.7
Tobacco Settlement	\$58.7
Refugee	<u>\$33.1</u>
TOTAL	\$20,330.8



Source: July 2011 Social Services Estimating Conference

Medicaid Program Grants & Donations Trust Fund FY 2011-12

Sources of Funds (millions)

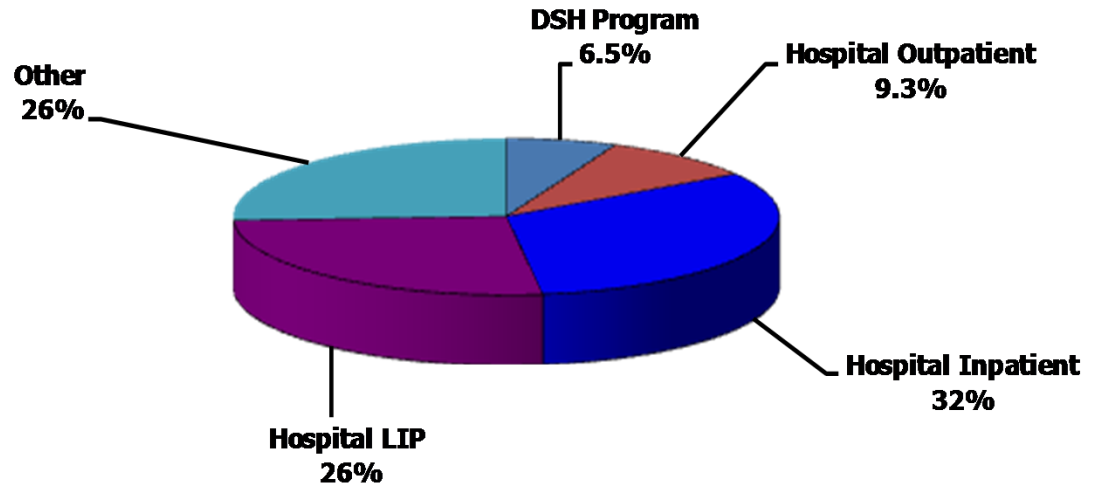
Local IGT's	\$1,641.1
Rebates (F)	\$405.1
Rebates (S)	\$319.0
Fraud/Abuse	<u>\$19.0</u>
TOTAL	\$2,384.2



Source: July 2011 Social Services Estimating Conference

Medicaid Program Intergovernmental Transfers (IGT's) FY 2011-12

<u>Sources of Funds</u> <u>(millions)</u>	
Hospital LIP	\$431.52
Hospital IP	\$525.01
DSH Program	\$107.64
Hospital OP	\$152.91
Other	<u>\$424.02</u>
TOTAL	\$1,641.1



Source: July 2011 Social Services Estimating Conference

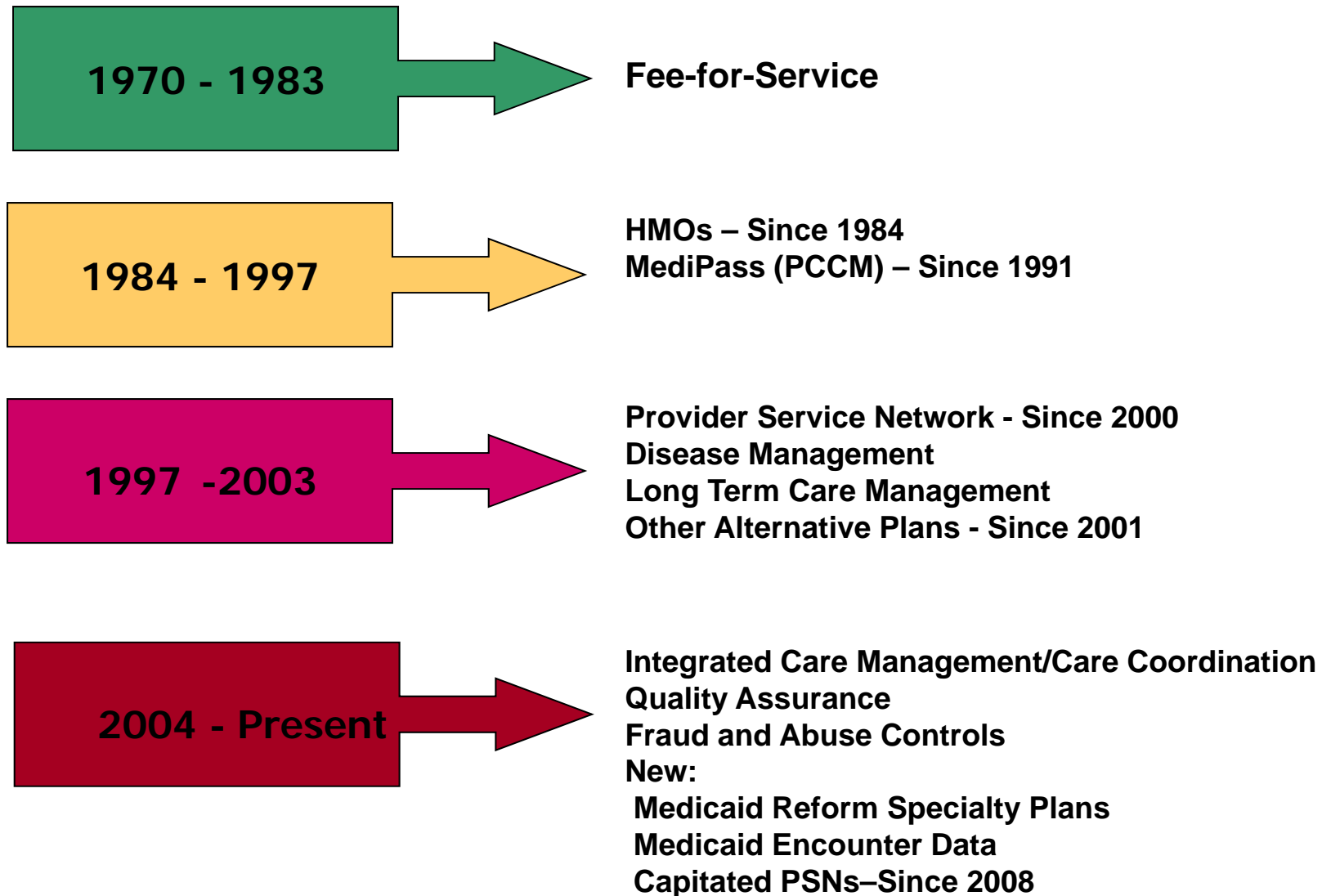
Florida Medicaid Enrollment Today

(August 1, 2011)

Delivery System	Statewide Enrollment	Number of Plans	Number of Counties
Health Maintenance Organization (Non-Reform)	976,204	17	36
Health Maintenance Organization (Reform)	152,762	9	5
Capitated Provider Service Network	81,079	4	6
FFS Provider Service Network	144,138	2	29
Nursing Home Diversion	16,674	16	43
Total Managed Care Enrollment	1,370,857	–	–

Delivery System	Statewide Enrollment	Number of Plans	Number of Counties
Fee-For-Service	994,314	N/A	67
MediPass	601,123	N/A	67
Total Fee-For-Service Enrollment	1,595,437	–	–

The Evolution of Florida Medicaid Delivery Systems



Medicaid Program Overview of 2011 Legislation

- During the 2011 Florida Legislative Session, the House and Senate passed HB 7107 and HB 7109, which require the state Medicaid program to implement a Statewide Medicaid Managed Care program that expands and improves Florida's Medicaid managed care programs.
- The Statewide Medicaid Managed Care program will have two key program components:
 - the Long-term Care Managed Care program
 - the Managed Medical Assistance program
- All Medicaid recipients are required to enroll in a managed care plan unless specifically exempted in the legislation.
- Certain recipients are eligible for and required to enroll in the Long-term Care Managed Care component of the Statewide Medicaid Managed Care program.

Why Change the Program?

- The goals of Statewide Medicaid Managed Care program are:
 - patient centered care, personal responsibility and active patient participation
 - provide for fully integrated care through alternative delivery models with access to providers and services through a uniform statewide program
 - implement innovations in reimbursement, quality and increased plan accountability.

*The Statewide Medicaid Managed Care program
does not/is not:*

- The Statewide Medicaid Managed Care program **does not** limit medically necessary services.
- The Statewide Medicaid Managed Care program **is not** linked to changes in the Medicare program and does not change Medicare benefits or choices.
- The Statewide Medicaid Managed Care program **is not** linked to National Health Care Reform, or the Affordable Care Act passed by the U.S. Congress.
 - It does not contain mandates for individuals to purchase insurance.
 - It does not contain mandates for employers to purchase insurance.
 - It does not expand Medicaid coverage or cost the state or federal government any additional money.

Other Key Legislative Provisions

- Some other key provisions of the legislation include:
 - changes to the Medically Needy Program relating to plan enrollment and premium requirements
 - changes to the Developmental Disabilities program relating to premium requirements for families of certain enrollees
 - opt-out and premium assistance program for eligibles with access to other insurance
 - increased copayments for nonemergency use of the emergency room.
- Federal authority has been requested to implement key provisions.

When will changes occur?

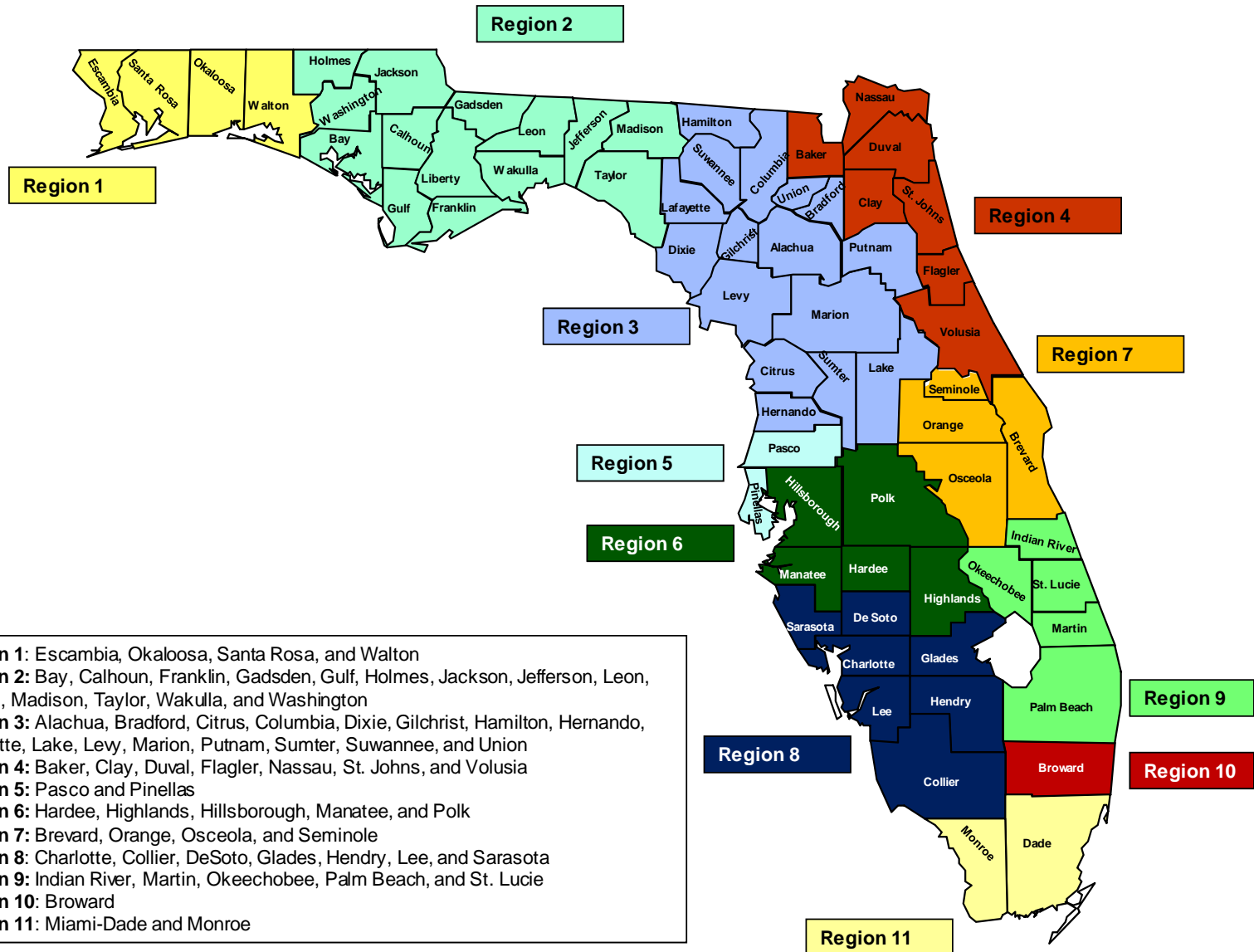
HB 7107 provides timelines for implementation of both the Long-term Care Managed Care component and the Managed Medical Assistance component.

- The required federal authority was requested August 1, 2011.
- Full program implementation of the Statewide Medicaid Managed Care program must be completed by October 1, 2014.
 - The Agency must begin implementation of the Long-term Care Managed Care component by July 1, 2012 and have the component fully implemented by October 1, 2013.
 - The Agency must begin implementation of the Managed Medical Assistance component by January 1, 2013 and have the component fully implemented by October 1, 2014.

Where will the program be implemented statewide?

- The State will be divided into 11 regions that will coincide with the existing Medicaid areas.
- The Agency is required to separately procure for Long-term Care Managed Care plans and Managed Medical Assistance plans in each of the 11 regions.
- The Agency is required to select a limited number of eligible plans to participate in the Statewide Medicaid Managed Care program using invitations to negotiate.
- Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

Statewide Medicaid Managed Care Regions Map



What to expect

- Ongoing discussion and approval of program design with the federal Center for Medicaid and Medicare Services (CMS).
- Release of solicitation documents for health plan selection no later than July 1, 2012 for Long-term Care and no later than January 1, 2013 for Managed Medical Assistance.
- Ongoing opportunity for public comment.
- Notification to recipients of available plans once readiness review of selected plans is completed.
- Notification to recipients of timeline for plan choice.

What to expect

Federal Submissions

- 1915(b)/(c) and state plan amendment have three 90 day periods:
 - CMS has 90 days to review, from 8/1; CMS may approve, deny or request clarification
 - Upon receiving the response, the Agency has 90 days to respond
 - Once CMS receives documents back from the Agency, they have 90 days to make a final decision
- The 1115 waiver has no time periods to which either CMS or the Agency must comply.

What to expect Long-term Care Managed Care

- The Long-term Care Managed Care component of the Statewide Medicaid Managed Care program will be implemented first.
- HB 7107 sets specific timelines for implementation of the Long-term Care Managed Care Program.
 - The Agency must begin implementation by July 1, 2012.
 - The Agency must complete implementation in all regions by October 1, 2013.

Long-term Care Managed Care: Procurement Process

- The Agency must competitively procure plans to serve the Long-term Care Managed Care population.
- The Agency is required to conduct simultaneous procurements for Long-term Care plans in each of the 11 regions.

Long-term Care Managed Care: Plans per region

- The Agency is required to select a limited number of eligible plans to participate in the Long-term Care Managed Care component using invitations to negotiate: a minimum of 30, a maximum of 53 and at least one PSN in each region.

	Min # of Plans	Max # of Plans	# of PSNs
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1
Total	30	53	11

Long-term Care Managed Care: ITN Procurement

- The Agency anticipates release of the procurement no later than July 1, 2012.

- The Agency will develop a schedule for enrollment into plans based on, but not limited to, the following:
 - plan readiness
 - utilization patterns
 - number of eligible recipients.

Long-term Care Managed Care: Participating Plans

- Eligible plans include:
 - Health Maintenance Organizations
 - Provider Services Networks
 - Exclusive provider organizations
 - Accountable care organizations
 - Medicare Advantage Preferred Provider Organizations
 - Medicare Advantage Provider-sponsored Organizations
 - Medicare Advantage Special Needs Plans
 - Program of All-Inclusive Care for the Elderly.

Long-term Care Managed Care: Covered Services

Minimum Required Covered Services: Long-term Care Managed Care Plans

Behavior management	Medication management
Caregiver Training	Nursing Facility Care
Case management	Nutritional Assessment and risk reduction
Home accessibility adaptation	Personal Care
Home delivered meals	Personal emergency response system
Hospice	Respite Care
Intermittent and skilled nursing	Services provided in assisted living facilities
Medical requirement and supplies, including incontinence supplies	Therapies (Occupational, Speech, Respiratory, Physical)
Medication administration	Transportation

Who will participate in Long-term Care Managed Care program?

- Medicaid recipients who meet all of the following criteria are must receive long-term care services by participating in the Long-term Care Managed Care program.
- The recipient must be:
 - (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
 - (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

Who will participate in Long-term Care Managed Care program?

- Medicaid recipients who, on the date Long-term Care Managed Care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the Long-term Care Managed Care program.

Program	Enrollment April 2011
Assisted Living for the Elderly	3,402
Aged/Disabled Adult	10,482
Adult Day Health Care	22
Aged/Disabled Adult /Consumer-Directed Care Plus Program	346
PACE	562
Nursing Home Diversion	17,252
Channeling	1,340

Who will not Participate in Long-term Care Managed Care program?

- HB 7107 does not expand enrollment to include those currently on home and community based services wait lists.
 - HB 7107 provides that the Department of Elder Affairs will make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to availability of funds.
 - The Department of Elder Affairs is required to determine that sufficient funds exist before making offers of enrollment.

What to expect Managed Medical Assistance program

- The Managed Medical Assistance component of the Statewide Medicaid Managed Care program will be implemented second.
- HB 7107 sets specific timelines for implementation of the Managed Medical Assistance Program.
 - The Agency must begin implementation by January 1, 2013.
 - The Agency must complete implementation in all regions by October 1, 2014.

Managed Medical Assistance program: Procurement Process

- The Agency must competitively procure plans to serve the Managed Medical Assistance program population.
- The Agency is required to conduct simultaneous procurements for Long-term Care plans in each of the 11 regions.
- Long-term Care Managed Care plans can elect to submit bids to become Comprehensive Long-term Care plans, which provide both Managed Medical Assistance and Long-term Care Services.

Managed Medical Assistance program: Plans per Region

- The Agency is required to select a limited number of eligible plans to participate in the Managed Medical Assistance program using invitations to negotiate: a minimum of 30, maximum of 53 and at least one PSN in each region.

	Min # of Plans	Max # of Plans	# of PSNs
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1
Total	30	53	11

Managed Medical Assistance program: Timelines

- The Agency anticipates release of the procurement no later than January 1, 2013.

- The Agency will develop a schedule for enrollment into plans based on, but not limited to, the following:
 - plan readiness
 - utilization patterns
 - number of eligible recipients.

Managed Medical Assistance program: Eligible Plans

- Eligible plans include:
 - Health Maintenance Organizations
 - Provider Services Networks
 - Exclusive provider organizations
 - Accountable care organizations
 - Children's Medical Services Network
 - Specialty Plans (serving a specific target population based on age, chronic disease state, or medical condition of the enrollee).

Managed Medical Assistance program: Covered Services

Minimum Required Covered Services: Managed Medical Assistance Plans

Advanced registered nurse practitioner services	Medical supply, equipment, prostheses and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Dental services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy
Emergency services	Physician services, including physician assistant services
Family planning services and supplies (some exception)	Podiatric services
Healthy Start Services (some exception)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

Managed Medical Assistance program: Covered Services

- Managed Medical Assistance plans are authorized to customize their benefits packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services.
 - The Agency is required to evaluate the proposed benefit package to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.
- Certain services are excluded from the plan benefit packages and are “carved out” to remain under the fee-for-service system.
 - Services provided in a prescribed pediatric extended care facility.
 - Provision of anti-hemophilic factor replacement products to recipients diagnosed with hemophilia through the Agency’s hemophilia disease management program.

Who will participate in the Managed Medical Assistance program?

- All Medicaid recipients will be enrolled in a managed care plan unless specifically exempted.
- Recipients required to enroll in either a Managed Medical Assistance plan or a Long-term Care plan will include, but are not limited to:
 - Temporary Assistance for Needy Families (TANF) and TANF related
 - Children with chronic conditions, including foster care children
 - Pregnant women
 - Medically Needy recipients
 - Individuals with Medicare coverage (Medicaid acts as a secondary payer)
 - Persons eligible for Medicaid by reason of a disability, excluding the Developmentally Disabled population
 - Persons determined by the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3), F.S., for whom sufficient funding is available.


Who may participate in the Manage Medical Assistance Program?

- Recipients who may choose to enroll in a Managed Medical Assistance program, but we are not required to enroll include:
 - Medicaid recipients who have other creditable health care coverage, excluding Medicare
 - Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by section 394.455(32), F.S.
 - Persons eligible for refugee assistance
 - Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville
 - Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.

Who will not participate in Managed Medical Assistance Program?

- Recipients who are excluded from the Managed Medical Assistance Program and who will not participate include:
 - women who are eligible only for family planning services
 - women who are eligible only for breast and cervical cancer services
 - persons who are eligible for emergency Medicaid for aliens
 - children receiving services in a prescribed pediatric extended care center.

Where to find information about program changes

- Today's presentation is posted on the Agency website.
- The Agency website will include information about:
 - the status of waiver negotiations
 - copies of documents and correspondence with CMS
 - the implementation timeline
 - the progress of the negotiation and contracting with plans
 - information for providers and recipients about implementation and plan enrollment as it becomes available.
- Go to www.ahca.myflorida.com and click  .
 - Sign up to receive e-mail updates via the website.

Ways to submit comments

- Fill out and submit the comment form provided at the sign-in table.

- Email your comments and suggestions to:
FLMedicaidManagedCare@AHCA.myflorida.com.

- Submit comments by mail to:

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



Questions?