



Overview of Medicaid Medically Needy Program

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Implementation of Medically Needy in 1986

- 1984: Florida Legislature passed Public Medical Assistance Trust Fund (PMATF) Act
- PMATF funded by hospital tax
- PMATF originally used to fund Medically Needy – largely to compensate hospitals that provide services to the uninsured*
- Authorized Medically Needy to start in July 1986

*PMATF is now used to fund inpatient and outpatient hospital and physician services.

Brief History 1984-2002

Event	Date Legislation Passed
Florida Health Care Access legislation authorizes Medically Needy Program	May 1984
Medically Needy program implemented; Medically Needy income level (MNIL) set at maximum of 133 1/3% of AFDC payment standard	July 1986
MNIL reduced to 100% of AFDC payment standard	February 1991
Medically Needy Program eliminated	April 1992
Medically Needy Program reinstated	April 1992
HCFA (CMS) publishes regulation allowing states flexibility to exceed 133 1/3% MNIL cap.	May 2001
Medically Needy Program for adults eliminated effective 7/2002 (Chapter 2001-377, Laws of Florida)	December 2001
Restore Medically Needy coverage to adults; continue program with non-recurring funds	May 2002

Brief History 2003-2010

Event	Date Legislation Passed
Repealed provisions of 2002 statute prior to 2003 implementation; funded with non-recurring funds for FY 2003-04	April 2003
Funded Medically Needy for FY 2004-05 with non-recurring funds; effective July 1, 2005, will cover prescribed drugs only	April 2004
Medically Needy changed to remove restrictions to cover prescribed drugs only	May 2005
Medically Needy to cover pregnant women and children only effective 7/1/2009	May 2008
Medically Needy extended for all covered groups through 12/31/2010; 1/1/2011 coverage to be limited to pregnant women and children only	May 2009
Medically Needy extended for all covered groups through 6/30/2011; 7/1/2011 coverage to be limited to pregnant women and children only	May 2010

What is Medically Needy?

- Medically Needy coverage is an “optional” eligibility group
- Provides medical assistance to persons who otherwise qualify for Medicaid, except for too much income or assets
 - Meets categorical requirements
 - Parent/ caretaker
 - Disabled
 - Children
 - Pregnant women
- Family/individual must incur medical expenses equal to amount of Share of Cost (**SOC**)
- Eligibility for Medicaid services is from date share of cost is met through the end of the month
- Department of Children and Families (DCF) has to track bills for each month for a person to receive Medicaid eligibility

Groups Covered- Options for Groups Covered

- Medically Needy groups which may be covered (Florida covers them all):
 - **Pregnant women***
 - **Children up to age 18*** (up to age 21 at option of state; Florida covers children living with parent/caretaker relative up to age 21)
 - Parent/caretaker relatives of dependent children living with them
 - Aged
 - Blind
 - Disabled

*Must be covered under Medically Needy if state has a Medically Needy program. (Other groups listed above are optional)

Medically Needy Enrollment Process

- When DCF is processing an application for Medicaid, and family/individual is otherwise eligible for Medicaid except for income or assets, DCF enrolls family/individual in Medically Needy with a Share of Cost.
- Family/individual remains “enrolled” in Medically Needy;
 - Case reviewed once a year – unless change in circumstances
- “Enrollment” in Medically Needy provides no Medicaid services to family/individual; purpose of enrollment is to let individual know Share of Cost and hold information in DCF system
- Share of Cost must be met each month to be “eligible”
- Medically Needy eligibility begins on the day the Share of Cost is met

How it Works in Florida

- DCF determines monthly Share of Cost amount and “enrolls” person in Medically Needy (see next slide for Share of Cost)
- Individual must provide proof of incurred bills to DCF equal to share of cost to be eligible for any benefits in that month
 - Bill does not have to be paid to be used to meet share of cost
- Once Share of Cost is met, “enrolled” becomes “eligible” for the period of eligibility
- An individual is only eligible for Medicaid services from date share of cost is met through the end of the month
- An individual is not eligible for any Medicaid Services until DCF determines Share of Cost is met.

What is Share of Cost?

- Share of Cost must be met each month to be eligible to have claims covered
- Share of Cost is determined by:
 - Countable monthly income for family/individual
 - Medically Needy Income Level (MNIL)
 - = Share of Cost
- Family/individual must spend down to the MNIL

Medically Needy Income Limit	
Family Size	MNIL
1	\$180
2	\$241
3	\$303

Example of Share of Cost Calculation

- Individual Earning \$60,000 Gross Income
- Countable Earned Income:

<i>Gross Earned Income</i>	\$5000.00
Standard Deduction	-\$90
<i>Earned Income</i>	\$4910.00
Countable Earned Income	\$4910.00

- Determining Family Share of Cost:

Countable earned income	\$4910
Subtract MNIL for family of 4	-\$364
Equals Share of Cost	\$4546

Medically Needy Bill Tracking Process

- Persons enrolled in Medically Needy must provide incurred bills to DCF
- DCF enters bills for bill tracking into its eligibility determination system
- If share of cost is met, eligibility is authorized and sent to FMMIS (Medicaid system for claims payment)
- Provider submits claims to Medicaid; Medicaid adjudicates claims

Medically Needy- Claims Payment

- DCF authorizes coverage for Medically Needy and, sends eligibility period to the Florida Medicaid claims and payment system (e.g., fiscal agent)
- Provider submits claims to Medicaid Fiscal Agent
 - Claims paid for Medicaid State Plan covered services only for dates of eligibility authorized by DCF (no difference in claims processing rules for Medically Needy than for “regular” categorical Medicaid)
- Medicaid does not deduct share of cost from medical bills used to meet Share of Cost on the first day of eligibility
- Medicaid Medically Needy “enrollment” coverage does not appear on FMMIS while the individual is “enrolled only”; coverage for only dates of eligibility in the month Share of Cost is met appear on FMMIS only after DCF determines Share of Cost is met

Example #1: Countable Income for Disabled Person

Gross Income from Social Security Income	\$914
General Unearned Income Disregard	-\$20
Countable Income	\$894

Example #1: Bills Incurred on Different Days

➤ **Determining Recipient's Share of Cost:**

Countable earned income	\$894
Subtract MNIL for 1 person	-\$180
Equals Share of Cost	\$714

➤ **Recipient Meeting Share of Cost:**

<i>Share of Cost</i>	\$714
Dental Bill Incurred, 07/01/2011 (SOC not met, person responsible for this bill, not Medicaid)	-\$524
<i>Remaining Share of Cost after deducting 7/1/2011 bill</i>	\$ 190
Hospital Bill Incurred, 07/04/2011 (Share of Cost Met)	-\$1467

➤ **Share of cost is met; eligible 7/4/2011 – 7/31/2011**

Example #2: Countable income for a Family

<i>Gross Earned Income</i>	\$3025.00
Standard Deduction	-\$90
<i>Earned Income</i>	\$2935.00
Countable Earned Income	\$2935.00

Example #2: Meets Share of Cost, 1st Bill

➤ **Determining Recipient's Share of Cost:**

Countable earned income	\$2935
Subtract MNIL for family of 2	-\$334
Equals Share of Cost	\$2601

➤ **Recipient Meeting Share of Cost:**

Share of Cost	\$2601
Bill for GI series (\$2700) date of service 1/14/2011	-\$2700

- Eligibility authorized for 1/14/2011 – 1/31/2011.
- Medicaid full reimbursement for \$2700 bill from provider is \$492 (family pays “zero” for any expenses covered by Medicaid for 1/14/2011-1/31/2011)

Medically Needy: Program Statistics

Average Income by Assistance Group (who have met share of cost)	
SSI Related (individual)	\$1944.81
Family Related (Family of three)	\$3027.05

Based on enrollee data from January 2011

Medically Needy: Program Statistics

- During state fiscal year 2009-2010, there were a total of 177,571 Medicaid recipients who met share of cost and received services reimbursed by the Medicaid program for a least one month.

Total Program Costs			Average Monthly Caseload
SFY 2009-2010	Actual Expenditures:	\$763,151,149	33,447
SFY 2010-2011	Budgeted Expenditures:	\$1,040,352,327	40,621
SFY 2011-2012	Projected Expenditures:	\$1,429,238,766	46,096

Medically Needy: Diagnoses and Related Expenditures

Top Ten Diagnoses and Related Expenditures: SFY 2009-2010		
Disease State	Recipients	Expenditures
Heart Disease	26,299	\$264,434,245.28
Cancer	7,759	\$72,322,935.19
Respiratory Disease, Emphysema, etc.	24,931	\$71,430,013.79
Digestive disease, liver disease, ulcer etc.	17,519	\$54,799,883.72
Metabolic disease, diabetes, etc.	7,881	\$25,897,247.59
Pregnancy	11,735	\$34,655,666.91
Infectious Diseases	4,379	\$13,302,859.23
Nervous system, epilepsy, etc.	9,052	\$13,363,579.32
Mental disorders	5,292	\$12,117,819.53
Chronic Obstructive Pulmonary Disease	3,387	\$5,039,228

Medically Needy: Services and Related Expenditures

Top Ten Services and Related Expenditures: SFY 2009-2010

Service	Expenditures
Hospital Inpatient	\$305,143,246
Hospital Outpatient	\$104,709,029
Prescribed Medicine	\$85,991,655
Physician Services	\$85,990,222
Hospital Insurance Benefit	\$8,589,515
Home Health Services	\$4,188,879
Community Mental Health	\$3,814,278
Transportation	\$3,655,957
Lab and Xray	\$2,123,196
Private Duty Nursing	\$1,823,280

Coverage

- Federal regulations regarding comparability of services differ for the medically needy population.
- According to guidance received from the federal Centers for Medicaid and Medicare Services, we understand that states can reduce the services under Medically Needy programs for non-pregnant adults.
- States are required to provide all medically necessary services to children and pregnant women.
- In order to change services offered under the Medically Needy program, Florida Medicaid must seek and receive approval of a State Plan Amendment.

Anticipated Timeline

- To implement such a change, the State would need to submit a state plan amendment.
 - CMS has 90 days to approve, deny, or send a written request for additional information (RAI) to the State beginning on the day CMS receives the plan amendment.
 - If CMS does send the State an RAI, the State has 90 days to respond in writing to the RAI.
 - Once CMS has received the State's response, CMS has an additional 90 days to review the State's response.
- As a result, it can take 9 months to obtain approval.



Questions?