



# *Agency for Health Care Administration*

## *Overview of Follow-Up FY 2012-13 Reduction Proposals*

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# *The Federal Medicaid Program: Parameters for State Programs*

- Medicaid is a joint venture of the federal and state governments.
- If a state chooses to participate in Medicaid, its Medicaid program must comply with certain minimum federal requirements.

## *The Federal Medicaid Program: Parameters for State Programs*

- Historically, states have had leeway to tailor their Medicaid programs, within certain parameters, to meet the health care needs of their citizens.
- This leeway has substantially diminished over the years for a variety of reasons.

## *The Federal Medicaid Program: Parameters for State Programs*

- States have two principal ways to tailor their Medicaid programs to the unique needs of their citizenry:
  1. States can decide eligibility thresholds.
  2. States can decide which health care services to offer Medicaid recipients, and how much of each service they will offer.

## *The Federal Medicaid Program: Parameters for State Programs*

- States can also control Medicaid spending in a couple of other ways:
  - States can set reimbursement rates.
  - States can impose utilization controls on services, either on their own, or through contracts with managed care companies.

# *Eligibility*

- States can no longer, at least temporarily, make changes to their eligibility groups.
- The Affordable Care Act was signed into law on March 23, 2010 by President Obama.
- One key element of the Act that will impact Florida in the coming years is the “maintenance of effort” requirement.
  - Under this requirement, states must maintain the eligibility levels that were in place on March 23, 2010 through December 31, 2013. States are prohibited from reducing eligibility levels for children through September 30, 2019.
  - Violation of this requirement will result in the loss of all federal Medicaid funds for Florida.
  - **Exception:** MEDS-AD

## *Service Package*

- State Medicaid programs can provide up to 29 different health care services listed in federal law.
- In 1989, the federal government made all 29 services mandatory for children.
- Over the years, the federal government has grown the number of mandatory services for adults to eight, leaving 21 optional services.

# *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)

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

## *Amount, Duration and Scope*

- States can choose to limit the amount, duration and scope of mandatory and optional services for non-pregnant adults, and may amend the state plan (upon federal approval) to modify coverage of these services at any time.
  - States must provide services at a level sufficient to achieve their purpose.
  - Limits must be sufficient to provide services to a vast majority of recipients.
    - Percentages used for this exercise all higher than 95%.

## *Amount, Duration and Scope*

- In order to implement reductions to amount, duration and scope for non-pregnant adults, the Agency must process systems changes and submit state plan amendments.
- Timeline for Review of 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, but the approval is retroactive to the first day of the quarter in which the state submitted the state plan amendment.

## *Utilization Controls*

- Florida Medicaid has put prior authorization processes in place for a large number of services, including inpatient hospital services, home health services, diagnostic imaging, therapy services, certain prescription drugs, and others.
- Florida has expanded the use of managed care organizations in the Medicaid program.

## *Summary*

- Generally speaking, to achieve a 10% budget reduction, the Agency must do some combination of the following:
  1. cut the only eligibility group Florida can cut – MEDS AD, or
  2. cut optional Medicaid services to non-pregnant adults, or
  3. pare down the amount, duration, and scope of Medicaid services offered to non-pregnant adults, or
  4. cut reimbursement rates, or
  5. add utilization controls.

## *Potential Reductions*

| Description  | GR                    | MCTF                   | Other Trust           | Total                  |
|--|-----------------------|------------------------|-----------------------|------------------------|
| <b>Issues</b>  | <b>GR</b>             | <b>MCTF</b>            | <b>Other Trust</b>    | <b>Total</b>           |
|  |                       |                        |                       |                        |
| Savings from the Telephony Expansion and Comprehensive Care Management Pilot LBR                     | (\$2,753,390)         | (\$3,580,610)          | \$0                   | (\$6,334,000)          |
| Companion to issues proposed by other Agencies   | \$0                   | (\$76,724,674)         | (\$58,999,144)        | (\$135,723,818)        |
| Elimination of Adult Dental Services   | (\$10,114,611)        | (\$13,153,416)         | (\$219,182)           | (\$23,487,209)         |
| Elimination of the Podiatrist Program  | (\$1,651,993)         | (\$2,153,484)          | (\$17,682)            | (\$3,823,159)          |
| Elimination of Adult Vision & Hearing Services   | (\$6,333,647)         | (\$8,236,507)          | (\$257,312)           | (\$14,827,466)         |
| Elimination of the Chiropractic Program  | (\$551,926)           | (\$717,744)            | (\$4,425)             | (\$1,274,095)          |
| Limit Payment for ER Visits to 12 per year for Adults  | (\$5,154,542)         | (\$7,039,785)          | (\$22,469)            | (\$12,216,796)         |
| Limit Payment IP Days for Each Non-Pregnant Adults to 23 days/ County responsibility begins at day 8 | (\$32,167,143)        | (\$90,510,799)         | (\$33,909,496)        | (\$156,587,438)        |
| Limit Payment for Home Health Visits to 3 per recipient per day                                      | (\$701,066)           | (\$959,969)            | (\$1,825)             | (\$1,662,860)          |
| Limit Payment for General Practice Visits to 2 per month   | (\$1,056,048)         | (\$1,449,820)          | (\$7,806)             | (\$2,513,674)          |
| <b>Total Medicaid Reduction Proposed</b>   | <b>(\$60,484,366)</b> | <b>(\$204,526,808)</b> | <b>(\$93,439,341)</b> | <b>(\$358,450,515)</b> |
|  |                       |                        |                       |                        |
| <b>Grand Total State Funds: General Revenue and Grants &amp; Donations</b>                           |                       |                        |                       | <b>(\$153,239,747)</b> |

## *Reductions to Optional Services*

| Description                                    |                       |                       |                    |                       |
|--|-----------------------|-----------------------|--------------------|-----------------------|
| Issues   | GR                    | MCTF                  | Other Trust        | Total                 |
| Elimination of Adult Dental Services           | (\$10,114,611)        | (\$13,153,416)        | (\$219,182)        | (\$23,487,209)        |
| Elimination of the Podiatrist Program          | (\$1,651,993)         | (\$2,153,484)         | (\$17,682)         | (\$3,823,159)         |
| Elimination of Adult Vision & Hearing Services | (\$6,333,647)         | (\$8,236,507)         | (\$257,312)        | (\$14,827,466)        |
| Elimination of the Chiropractic Program        | (\$551,926)           | (\$717,744)           | (\$4,425)          | (\$1,274,095)         |
| <b>Total Medicaid Reduction Proposed</b>       | <b>(\$18,652,177)</b> | <b>(\$24,261,151)</b> | <b>(\$498,601)</b> | <b>(\$43,411,929)</b> |

## *Elimination of Adult Dental Services*

- This issue eliminates Adult Dental Services as a covered Medicaid Service.
  - Services include partial dentures, comprehensive oral evaluations (on an emergency basis), full dentures and other diagnostic and surgical procedures.
  - Currently Medicaid recipients can receive oral evaluations only for determining the need for dentures or acute emergency services.
  - Estimated 913,918\* individuals could use this service in FY 2012-2013.

➤ **Total reduction: (\$23,487,209)**

|                               |                 |
|-------------------------------|-----------------|
| General Revenue:              | (\$ 10,114,611) |
| Medical Care Trust Fund:      | (\$ 13,153,416) |
| Refugee Assistance Trust Fund | (\$ 219,182)    |

## *Elimination of Adult Vision & Hearing Services*

- This issue eliminates the Adult Vision and Hearing Services program:
  - Adult Vision:
    - Services include eyeglasses, eyeglass repairs as required, prosthetic eyes and medically necessary contact lenses.
    - Currently Medicaid recipients can receive one pair of eyeglasses per recipient every two years, except a second pair may be provided during that period after prior authorization. Eyeglass lenses for adult recipients are limited to one pair of lenses per year.
  - Adult Hearing:
    - Services include diagnostic testing, cochlear implant services, hearing aid evaluation, repair and accessories and hearing aids.
    - Currently Medicaid recipients can receive hearing aids one per ear per recipient every three years and cochlear implants are limited to one in either ear, but not both.
  - Estimated 913,918\* individuals could use these services in FY 2012-2013
- **Total reduction:** **(\$14,827,466)**
  - General Revenue: (\$6,333,647)
  - Medical Care Trust Fund: (\$8,236,507)
  - Other Trust Fund: (\$ 257,312)

## *Elimination of Podiatric Services*

- This issue eliminates podiatric services as a covered Medicaid service.
  - Services include routine foot care for persons with metabolic disease or circulatory impairment and surgical procedures.
  - Currently Medicaid recipients can receive up to 2 podiatric visits per month.
  - Estimated 31,289\* individuals would use this service in FY 2012-2013. (6,613 children and 24,676 adults)

➤ **Total reduction:** **(\$3,823,159)**

General Revenue: (\$1,651,993)

Medical Care Trust Fund: (\$2,153,484)

Other Trust Fund: (\$ 17,682)

## *Elimination of Chiropractic Services*

- This issue eliminates chiropractic services as a covered Medicaid benefit.
  - Services include new patient visit, manipulation of the spine and spinal x-rays.
  - Currently Medicaid recipients can receive up to 10 Chiropractic visits without prior authorization.
  - Estimated 12,585\* individuals would use this service in FY 2012-2013. (3,912 children and 8,673 adults)

➤ **Total reduction:** **(\$1,274,095)**

|                          |             |
|--------------------------|-------------|
| General Revenue:         | (\$551,926) |
| Medical Care Trust Fund: | (\$717,744) |
| Other Trust Fund:        | (\$ 4,425)  |

## *Reduction of Amount, Duration and Scope*

| Description  | GR                    | MCTF                  | Other Trust           | Total                  |
|--|-----------------------|-----------------------|-----------------------|------------------------|
| <b>Issues</b>  | <b>GR</b>             | <b>MCTF</b>           | <b>Other Trust</b>    | <b>Total</b>           |
|  |                       |                       |                       |                        |
| Limit Payment for ER Visits to 12 per year for Adults  | (\$5,154,542)         | (\$7,039,785)         | (\$22,469)            | (\$12,216,796)         |
| Limit Payment IP Days for Each Non-Pregnant Adults to 23 days/ County responsibility begins at day 8 | (\$32,167,143)        | (\$90,510,799)        | (\$33,909,496)        | (\$156,587,438)        |
| Limit Payment for Home Health Visits to 3 per recipient per day                                      | (\$701,066)           | (\$959,969)           | (\$1,825)             | (\$1,662,860)          |
| Limit Payment for General Practice Visits to 2 per month   | (\$1,056,048)         | (\$1,449,820)         | (\$7,806)             | (\$2,513,674)          |
| <b>Total Medicaid Reduction Proposed</b>   | <b>(\$39,078,799)</b> | <b>(\$99,960,373)</b> | <b>(\$33,941,596)</b> | <b>(\$172,980,768)</b> |

## *Limit Payment for ER visits to 12 per year (Non- Pregnant Adults)*

- This issue limits hospital emergency room visits for non-pregnant adults to no more than 12 visits per year.
- Based on FY 2009-2010 data,
  - 1,676 recipients be impacted
  - 14,086 visits would be eliminated
  - 1.25% reduction to the outpatient services line

➤ **Total Reduction:** **(\$12,216,796)**

|                               |               |
|-------------------------------|---------------|
| General Revenue               | (\$5,154,542) |
| Medical Care Trust Fund:      | (\$7,039,785) |
| Refugee Assistance Trust Fund | (\$ 22,469)   |

## *Limit Payment for Inpatient Days to 23 per year (Non- Pregnant Adults)*

- This issue limits inpatient days for non-pregnant adults to 23 per year.
- Medicaid would be responsible for reimbursing days 1 through 7, with county responsibility beginning at day 8.
- Based on FY 2009-2010 data,
  - 6,918 recipients would be impacted
  - 74,040 days would be eliminated
  - 4.3% reduction in inpatient days
- Statutory change is needed.
- **Total Reduction: (\$156,587,438)**

|                                 |                 |
|---------------------------------|-----------------|
| General Revenue                 | (\$ 32,167,143) |
| Medical Care Trust Fund:        | (\$ 90,510,799) |
| Refugee Assistance Trust Fund   | (\$ 153,259)    |
| Grants and Donations Trust Fund | (\$ 33,756,237) |

## *Limit Payment for Home Health Visits to 3 per day (Non- Pregnant Adults)*

- This issue would limit home health visits for non-pregnant adults to 3 visits per day
- Based on FY 2009-2010 data,
  - 580 recipients would have been impacted
  - 88,014 visits would be eliminated
  - 1.27% reduction in the home health line item

➤ **Total Reduction:** **(\$1,662,860)**

|                               |              |
|-------------------------------|--------------|
| General Revenue               | (\$ 701,066) |
| Medical Care Trust Fund:      | (\$ 959,969) |
| Refugee Assistance Trust Fund | (\$ 1,825)   |

## *Limit Payment for General Physician Visits to 2 per month (Non- Pregnant Adults)*

- This issue would limit general practice physician visits to 2 per month for non-pregnant adults.
- . Based on FY 2009-2010 data,
  - 35,815 recipients would be impacted
  - 54,969 visits would be eliminated
  - 0.2% reduction

➤ **Total Reduction:** **(\$2,513,674)**

|                               |               |
|-------------------------------|---------------|
| General Revenue               | (\$1,056,048) |
| Medical Care Trust Fund:      | (\$1,449,820) |
| Refugee Assistance Trust Fund | (\$ 7,806)    |

## *Potential Reductions*

| Description  | GR                   | MCTF                  | Other Trust           | Total                  |
|--|----------------------|-----------------------|-----------------------|------------------------|
| <b>Issues</b>  | <b>GR</b>            | <b>MCTF</b>           | <b>Other Trust</b>    | <b>Total</b>           |
|  |                      |                       |                       |                        |
| Savings from the Telephony Expansion and Comprehensive Care Management Pilot LBR | (\$2,753,390)        | (\$3,580,610)         | \$0                   | (\$6,334,000)          |
| Companion to issues proposed by other Agencies                                   | \$0                  | (\$76,724,674)        | (\$58,999,144)        | (\$135,723,818)        |
| <b>Total Medicaid Reduction Proposed</b>   | <b>(\$2,753,390)</b> | <b>(\$80,305,284)</b> | <b>(\$58,999,144)</b> | <b>(\$142,057,818)</b> |

## *Expand the Telephony and Comprehensive Care Management Pilots*

- Section 31 and 32 of Chapter 2009-223, Laws of Florida directed the Agency to implement two home health pilot programs in Miami-Dade County.
  - Telephony: Verify utilization and delivery of home health services; electronic billing interface for home health services.
  - Comprehensive Care Management: For home health visits which include: face-to-face assessments by a nurse, substantiation of medical necessity, and on-site and desk review of recipient medical records.
- Combined impact of two pilots after one year of operation:
  - 2009-2010: 253 providers in Miami-Dade were reimbursed \$43,285,931.
  - 2010-2011: 203 providers in Miami-Dade were reimbursed \$21,628,538.

## *Expand the Telephony and Comprehensive Care Management Pilots (cont.)*

- This proposal would expand operation of the Telephony pilot to Broward, Escambia, Martin and Palm Beach counties.
- This proposal would expand operation of the comprehensive care management pilot:
  - From only home health visit monitoring in Miami-Dade
  - To monitoring of home health visits, private duty nursing, and personal care services in Miami-Dade, Broward, Orange, and Palm Beach counties.

➤ **Total Reduction:** **(\$6,334,000)**

General Revenue: (\$2,753,390)

Medical Care Trust Fund: (\$3,580,610)

## *Elimination of Medicaid Related Waiver Services*

- This is a companion issue to issues by the Agency for Persons with Disabilities and the Department of Elder Affairs.
- These agencies have General Revenue reduction issues to Medicaid waiver programs they administer.
  - APD \$36 M in GR to their waiver
  - DOEA \$23 M in GR to their waivers
- These funds are transferred to AHCA for the payment of waiver services on a monthly basis.
- AHCA would need to reduce state trust fund budget associated with these reduction items in order remain in balance.
- **Total Reduction:** **(\$135,723,818)**

Medical Care Trust Fund – CASH from other agencies (\$58,999,144)

Medical Care Trust Fund: (\$76,724,674)

*Questions?*