

The Florida Senate  
**COMMITTEE MEETING EXPANDED AGENDA**  
**BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN  
 SERVICES APPROPRIATIONS**  
**Senator Negrón, Chair**  
**Senator Rich, Vice Chair**

**MEETING DATE:** Tuesday, November 15, 2011  
**TIME:** 10:45 a.m.—12:45 p.m.  
**PLACE:** *Toni Jennings Committee Room, 110 Senate Office Building*

**MEMBERS:** Senator Negrón, Chair; Senator Rich, Vice Chair; Senators Gaetz, Garcia, Oelrich, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Consideration of Possible Elimination of Medipass		Discussed
2	Reimbursement for Patient Visits at Federally Qualified Health Centers		Discussed
3	Update on the Kidcare Program		Discussed
4	The Forensic Mental Health System, Senate Interim Project 2012-108		Discussed
5	Update on Cancer Drug Shortages in Florida		Discussed
Public Testimony			
Other Related Meeting Documents			

**Overview: Proposed Elimination of MediPass in Counties with Two or More  
Capitated Health Plans**

**Purpose:**

The purpose of this overview is to provide information to the Senate Health & Human Services Appropriations Committee, upon their request, regarding the impact of eliminating the option for MediPass enrollment in all non-reform counties with 2 or more capitated health plans, and requiring all recipients whose participation in managed care is mandatory in those counties to enroll in either a capitated Provider Service Network or a capitated Health Maintenance Organization.

**Current Situation:**

Under the current Florida Medicaid program, recipients receive care through a variety of health care delivery systems. These delivery systems include fee-for-service, primary care case management (offered in Florida through the MediPass program), managed care through a capitated health maintenance organization or managed care through a fee for service or capitated provider service network.

MediPass is the Florida Medicaid primary care case management program and is operational in 62 counties outside of the five Medicaid Reform counties. Under the MediPass program, primary care physicians (PCPs) are responsible for providing primary care and authorizing the specialty care provided to their MediPass enrollees. MediPass providers (physicians, ARNPs, and physician assistants) are paid a \$2.00 monthly case management fee. Medicaid pays for services provided to MediPass members on a fee-for-service basis. As of October 1, 2011, there were 592,089 recipients receiving services through the MediPass program.

**Managed Care in Florida Medicaid:**

The managed care delivery systems, including capitated plans (HMOs or PSNs), fee-for-service PSNs, and the MediPass system, are operated under two waivers: (1) The 1915(b) Managed Care Waiver or the 1115 Medicaid Managed Care Reform Pilot Waiver.

Medicaid managed care in Florida is regulated primarily under state law and federal regulations. Statutory authority includes ss. 409.912, 409.9122, 409.91211, 409.908 and chapter 641, Florida Statutes.

The table below contains data regarding health plan distribution/ penetration as of October 1, 2011.

<i>Florida Counties with Managed Care Health Plan – By Plan Type – October 1, 2011</i>		
<b>Plan Type</b>	<b>Number of Florida Counties</b>	<b>Total Enrollment</b>
Capitated PSN	29 counties	79,855
Capitated Non-Reform HMO	38 counties	953,396
FFS PSN	7 counties	144,362
Capitated Reform HMO	5 counties	150,520

**Overview: Proposed Elimination of MediPass in Counties with Two or More Capitated Health Plans**

<b>Florida Counties with Two or More Managed Care Health Plans – October 1, 2011</b>	
Total Unduplicated Counties with at least 1 Health Plan	51 Counties
Total Unduplicated Counties with Two or More Health Plans	36 Counties
Total Unduplicated Non-Reform Counties with Two or More Health Plans	31 Counties

**Requirements for Mandatory Enrollment in Managed Care Today**

Within the Florida Medicaid program, some beneficiaries are required to enroll with a managed care provider, some have the option of enrolling with a managed care provider and some are prohibited from enrolling with a managed care provider. These beneficiaries can be referred to as “mandatory”, “voluntary”, or “excluded” from managed care enrollment.

Currently, recipients who are considered mandatory for managed care enrollment in non-reform counties have the option of choosing to enroll in either the MediPass program or in a PSN or HMO.

In counties that are participating in the Reform Pilot, recipients mandatory for managed care enrollment must currently select either an HMO or a PSN.

**Statutory, State Plan and Federal Changes Needed for Elimination of MediPass in Counties with Two or More Health Plans**

There are several options available in federal regulation which provide authority to implement this proposal, that are generally described as follows:

- The Agency could submit and obtain a 1915(b) waiver amendment to eliminate MediPass in select counties. Under this approach, the Agency could only require enrollment of mandatory populations.
  - This approach would require federal approval of amendment to 1915(b). The state could amend the 1915(b) managed care Waiver to remove MediPass as long as two or more plans are available to recipients. 1915(b) waivers are waivers of freedom of choice provisions that allow state Medicaid programs to waive the requirement that “any willing qualified provider” can enroll and provide Medicaid reimbursable services. The current approved 1915(b) managed care waiver has language that requires that the state offer MediPass as a choice in all counties (for example, language can be found in the section relating to assignment and in the cost effectiveness methodology.)
  - This approach would require statutory change: 409.912, 409.9122, 409.91211, F.S.
- The Agency could submit and obtain a state plan amendment under § 1932 (a)(1)(A) of the Social Security Act.

## **Overview: *Proposed Elimination of MediPass in Counties with Two or More Capitated Health Plans***

- This approach would limit Medicaid recipients to capitated PSNs and capitated HMOs in non-reform areas.
- This approach would entail an amendment of the 1915(b) waiver (including cost-effectiveness section) and submission of transition plan to federal CMS for review. The state cannot implement 1932 amendment without change to 1915(b) managed care waiver. Once a state has an approved 1915(b) waiver, the state cannot select which portion of the waiver it is going to follow without doing an amendment. Thus, the Agency would need to amend the 1915(b) waiver to implement an expansion of managed care under a 1932 state plan amendment.
- This approach would require statutory change: 409.912, 409.9122, 409.91211, F.S.
- Systems updates are needed in order to implement this change, regardless of the option chosen.

### **Timeline:**

Utilizing either the 1915(b) waiver amendment or the 1932 state plan amendment option will require federal approval. Timelines for approval for both options are the same and are outlined below.

1915(b) and state plan amendments have three 90 day periods:

- Starting on the date of submission, CMS has 90 days to review materials and approve, deny or request clarification
- Upon receiving CMS' response, the Agency has 90 days to respond.
- Once CMS receives the Agency's completed responses, CMS has 90 days to make a final decision.
- CMS must approve state plan amendments that comply with federal Medicaid law.
- CMS is not required to approve requests for an amendment to the 1915(b) waiver.

### **Impact of Proposed Changes:**

Under this proposal, all Medicaid recipients currently mandatory for enrollment in managed care (defined through the 1915(b) Managed Care waiver to include MediPass as an option) would be required to leave MediPass and enroll in either a PSN or a capitated HMO.

The Agency projects that an additional 445,196 recipients would be required to enroll in capitated health plans.

The savings calculations below reflect a 12 month phase-in of the transition population for counties with two or more capitated managed care plans and anticipate that plan capacity will be sufficient to absorb the transition population. These savings reflect a discount rate of approximately 6.0% (with some variation by area), and assume continued receipt of all IGT associated with the Low

**Overview: Proposed Elimination of MediPass in Counties with Two or More Capitated Health Plans**

Income Pool, Disproportionate Share payments, Hospital exempt rates and buy-backs. Administrative costs/ resources for the Agency are not included in this projection.

A fiscal impact of this nature requires detailed analysis of enrollment data, and we were constrained by time to complete this level of analysis with the most recent October 2011 data. Therefore, we utilized January 2011 as a base since that was the latest detail level enrollment data used for a similar fiscal analysis. We applied population ratios from the detailed January enrollment file to October 2011 enrollment to project the number of MediPass recipients, in counties with two or more health plans, who would be eligible for mandatory enrollment in a health plan.

With the above assumptions, the total savings for SFY 2012-13 is estimated to be (\$47,286,314); with (\$19,916,619) General Revenue, (\$27,201,005) Medical Care Trust Fund, and (\$168,690) Refugee Assistance Trust Fund).

<b>Total Projected Savings</b>	<b>(\$47,286,314)</b>
GR per Conference	(\$19,916,619)
MCTF	(\$27,201,005)
RATF	(\$168,690)

Note: This analysis assumes that the 445,196 recipients will be phased in over a 12 month period. While all 445,196 will be transitioned into PSNs and HMOs by the end of the 12 month period, the increase in average monthly caseload for the entire 12 month period is 241,150 for SFY 2012-2013.

Under the Statewide Medicaid Managed care (SMMC) program, as outlined in 2011 House Bill 7107, MediPass is eliminated in all counties as of October 1, 2014. The Agency has requested an amendment to the 1115 Medicaid Reform Waiver to implement this provision.

- Current statute full directs implementation by no later than October 1, 2014.

The SMMC program contains additional cost reduction/cost control elements. These elements include:

- The requirement that all contracted health plans guarantee an aggregate savings during the first contract year of at least 5 percent.
- The requirement that the Agency establish an Achieved Savings Rebate program.
- That additional mandatory populations are required to enroll in managed care plans.

## Overview of Federally Qualified Health Centers

### **Overview: What is a Federally Qualified Health Center (FQHC)?:**

Federally Qualified Health Centers are authorized through the federal Public Health Services act.

A Federally Qualified Health Center (FQHC) is a reimbursement designation referring to several health programs funded under the federal Health Center Consolidation Act (Section 330 of the Public Health Service Act). The Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations.

FQHCs are community-based organizations that provide comprehensive primary care and preventive care, including physical health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

To become an FQHC, the center must receive a grant funded under one of the following sections of the Public Health Services Act, Sections 329 (Migrant Health Centers), 330 (Community Health Centers), or 340 (Homeless Health Centers).

A Federally Qualified Health Center (FQHC) provides primary health care and related diagnostic services. An FQHC may provide dental, optometric, podiatry, chiropractic, and mental health services.

To participate in Medicaid, an FQHC must:

- Receive a 329, 330, or 340 Public Health Services grant;
- Meet the requirements to receive one of the grants listed above; or
- Receive a waiver of the requirements listed above from the Secretary of Health and Human Services.

Florida Medicaid FQHCs must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid FQHC providers.

### **Services Provided/ Utilization:**

Medicaid reimburses FQHCs for the following services:

- Adult health screening services
- Child Health Check-Up screenings
- Chiropractic services
- Dental services
- Immunization services
- Medical primary care services, including obstetrical care
- Family planning and family planning waiver services
- Mental health services
- Optometric services
- Podiatry services

During state fiscal year 2012-13, the Agency projects the 40,027 Medicaid recipients will utilize services through a Federally Qualified Health Centers with projected total expenditures of \$62,739,060.

## Overview of Federally Qualified Health Centers

### **Reimbursement Overview:**

Prior to 2001, Federal law required State Medicaid programs to reimburse Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) based on reasonable costs (cost reporting methods). However, Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA) created a new section 1902(bb) requiring Medicaid programs to make payments for FQHC/RHC services based on a prospective payment system. The base rate was determined using 1999 and 2000 cost reports. Beginning October 1, 2001, and every October thereafter, the FQHC's and RHC's rates will be increased by the percentage increase in the Medicare Economic Index (MEI) for applicable primary and preventative care services for that Fiscal Year.

For new FQHC providers entering the program on or after January 1, 2001, the initial rates are established by taking an average of the rates for centers in the same county or district with similar caseloads. In the absence of centers in the same county or district, with similar caseloads, cost reporting methods are used.

The Federally Qualified Health Center Services Coverage and Limitations Handbook states "Medicaid reimbursement for clinic services is limited to one encounter visit per day, per recipient." Visits are paid based on an "all-inclusive encounter rate." The encounter is a face-to-face medically necessary primary or preventative visit. The encounter includes professional services rendered by one or more licensed health care professionals for a Medicaid recipient. This includes diagnosis, therapy and consultation. Additionally, the encounter includes all services and supplies that are incidental or extra, although integral to the practitioner's services.

The only exception to the current policy is when a recipient has had a visit on a particular day, leaves the clinic, and suffers an additional illness or injury requiring different diagnosis or treatment, and returns to the clinic the same day.

Medicaid reimburses for FQHC services rendered by the following practitioners:

- Advanced registered nurse practitioners (ARNP) licensed in accordance with Chapter 464, F.S.;
- Chiropractors licensed in accordance with Chapter 460, F.S.;
- Dentists licensed in accordance with Chapter 466, F.S.;
- Medical physicians licensed in accordance with Chapter 458, F.S.;
- Osteopathic physicians licensed in accordance with Chapter 459, F.S.;
- Optometrists licensed in accordance with Chapter 463, F.S.;
- Physician assistants licensed in accordance with Chapter 458, F.S.; and
- Podiatrists licensed in accordance with Chapter 461, F.S.

The current encounter rate per visit for Florida FQHCs ranges from \$93.07-\$143.69 per visit, with an average of \$130.62 per visit. A distinct rate is set for each FQHC.

## Overview of Federally Qualified Health Centers

### **State and Federal Regulations:**

The federal authority governing the provisions, requirements, benefits, and service payment of the Federally Qualified Health Center Program is in the Code of Federal Regulations, Title 42, Part 491 (Certification of Certain Health Facilities) and the federal State Medicaid Manual, Section 4231.

Sections 509.905(11) and 408.908 (16), Florida Statutes and Chapter 59G-4.100, Florida Administrative Code, establish Medicaid reimbursement by the Agency for Health Care Administration (Agency) for Federally Qualified Health Center services.

The Agency also maintains the Federally Qualified Health Center Services Coverage and Limitations Handbook which is intended for use by FQHCs that provide services to Medicaid recipients to explain covered services, their limits, and who is eligible to receive them.

### **Proposed change**

Florida Medicaid reimbursement policy for clinic services currently limits reimbursement to one encounter visit per day, per recipient. Two clinic visits cannot be reimbursed on the same day even if the visits are for different types of services. The only exception to the current policy is when a recipient has had a visit on a particular day, leaves the clinic, and suffers an additional illness or injury requiring different diagnosis or treatment, and returns to the clinic the same day.

The proposed change is to increase the FQHC encounter visit per day limitation to two or three clinic visits per day.

For example, increasing to allow two clinic visits on the same day would allow a dental service visit as well as a medical visit in the same day.

A change in policy to allow for more than one encounter visit per day would require amendment to the Chapter 59G-4.100, Florida Administrative Code, and the associated handbook, and minor systems changes in the Florida Medicaid Management Information System (FMMIS) system.

- FMMIS programming should only require file maintenance which is typically completed within 10 business days.
- The rule change can take up to six to nine months, however, since the FQHCs are in support of this proposed change, it should proceed without objection.
- If the Legislature directs the Agency to implement this change, it could be in place within a matter of weeks.

In addition, there will be a potential need for additional funding to implement this change.

## Overview of Federally Qualified Health Centers

### **Fiscal impact**

SFY 2012-13 Projected Expenditures							
FEDERALLY QUALIFIED CENTERS	Base - 10/17/2011	10% Impact		15% Impact		20% Impact	
MEDICAID UTILIZATION RATE	2.91%	3.20%		3.34%		3.49%	
MEDICAID SERVICES PER MONTH	40,027	44,030		46,031		48,032	
MEDICAID UNIT COST	\$130.62	\$130.62		\$130.62		\$130.62	
MEDICAID TOTAL COST	\$62,739,060	\$69,013,436		\$72,149,841		\$75,286,245	
TOTAL COST	\$62,739,060	\$69,013,436	\$6,274,376	\$72,149,841	\$9,410,781	\$75,286,245	\$12,547,185
TOTAL GENERAL REVENUE	\$26,473,283	\$29,120,810	\$2,647,527	\$30,444,242	\$3,970,959	\$31,767,675	\$5,294,392
TOTAL MEDICAL CARE TRUST FUND	\$36,140,915	\$39,755,277	\$3,614,362	\$41,562,008	\$5,421,093	\$43,368,737	\$7,227,822
TOTAL REFUGEE ASSISTANCE TF	\$124,862	\$137,349	\$12,487	\$143,591	\$18,729	\$149,833	\$24,971

### **Other Issues for Consideration:**

Other similar providers, including County Health Department and Rural Health Clinics, are currently restricted to billing for one encounter visit per day, except in specific circumstances. Additionally, individual providers such as physician services providers, have similar limits.

In addition, the state is required by federal law to make "wrap-around" payments, up to the encounter rate, for any FQHC under contract with a managed care plan whose contract with the plan is for a reimbursement amount lower than the encounter payment established by the Florida Medicaid program. Additional encounters at FQHC for recipients enrolled in managed care could result in additional wrap-around payments.

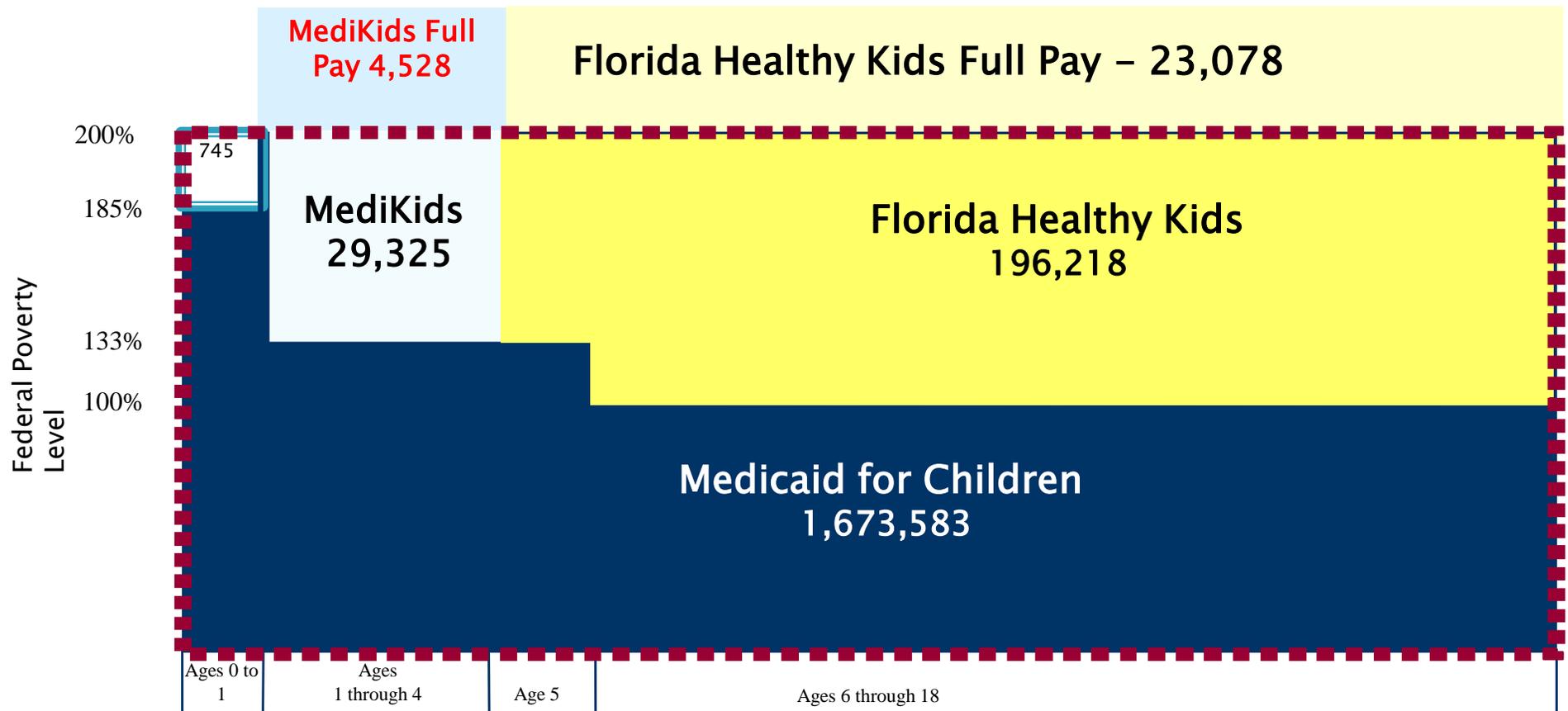
# Florida KidCare

Rich Robleto, Executive Director  
Florida Healthy Kids Corporation

# About Florida KidCare Program

- ▶ The Florida KidCare Program was created by the 1998 Florida Legislature in response to Federal CHIP legislation
- ▶ The Florida KidCare Program includes four parts:
  - Children's Medicaid
  - MediKids
  - Healthy Kids
  - Children's Medical Services Network (CMSN)

# Florida KidCare Eligibility & Enrollment



CMS Network ■ ■ ■ ■  
Title XXI – 22,672

# Service Delivery

- Children's Medicaid is provided through Medicaid providers (HMO, PSN, MediPass and FFS).
- MediKids services are delivered through managed care plans (HMO, PSN and MediPass).
- Healthy Kids services are delivered by managed care plans (HMOs and EPO) and dental plans
- CMSN utilizes a specialized network of physicians and providers

# Non-Medicaid KidCare Financial Projections

	<b>FY 2011-12 Appropriations</b>	<b>Projected Expenditures</b>	<b>Surplus/ (Deficit)</b>
General Revenue	\$61,436,037	\$48,478,490	\$12,957,547
Tobacco Settlement Trust Fund (State)	\$94,996,411	\$94,996,411	\$0
Grants and Donations Trust Fund (State)	\$14,198,369	\$16,728,106	-\$2,529,737
Medical Care Trust Fund (Federal)	\$350,331,505	\$321,281,942	\$29,049,563
<b>Total</b>	<b>\$520,962,322</b>	<b>\$481,484,949</b>	<b>\$39,477,373</b>

\*Per SSEC 9/16/2011

# Healthy Kids Statutory Responsibilities

- ▶ The Healthy Kids Corporation shall:
  - Contract for comprehensive insurance coverage with authorized insurers or any provider of health care services that meet standards established by Corporation.
  - Select health plans through a competitive bid process.
  - Purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care.
  - Maintain the minimum medical loss ratio for a Florida Healthy Kids Corporation contract of 85 percent for health care contracts.
  - Ch 624.91 f.s.

# Healthy Kids Delivery Model

- ▶ The Healthy Kids Delivery Model includes:
  - Competitive bidding for health and dental plans
  - Evaluated on both price and quality
  - Experience refund required if medical loss ratio is greater than 85 percent
  - Annual contract renewals for four years

# Thank You!

If you have questions regarding the Florida KidCare program, please contact me at:

Rich Robleto  
Executive Director  
Florida Healthy Kids Corporation  
(850) 701-6111  
[robletor@healthykids.org](mailto:robletor@healthykids.org)

The logo for Florida KidCare, featuring the word "Florida" in black with a pink heart symbol for the letter "o", and the word "KidCare" in blue below it.

Fl♥rIDA  
KidCare



# The Florida Senate

Interim Report 2012-108

September 2011

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Budget Subcommittee on Health and Human Services Appropriations

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## THE FORENSIC MENTAL HEALTH SYSTEM

### Issue Description

Florida's forensic mental health system is a network of state facilities and community services for adults over the age of 18 and juveniles adjudicated as adults who have a mental illness and who are involved with the criminal justice system. These forensic services include evaluations for competency to proceed with a criminal trial, treatment following a finding of not guilty by reason of insanity, and services to individuals on conditional release in the community.<sup>1</sup>

It is in the state's interest to seek the most effective and efficient means to treat individuals requiring competency restoration services. Competency restoration is needed for individuals who are incompetent to stand trial or for individuals who are found not guilty by reason of insanity under ch. 916, Florida Statutes. In 2007, the Florida Supreme Court Task Force on the forensic treatment system recommended the development of safe and cost efficient community-based treatment alternatives to state mental health treatment facilities.<sup>2</sup> More recently, the Department of Children and Families (the "Department") issued a report from the *Mental Health Facilities Review Work Group* in 2010, which recommended:

- Expanding community-based competency restoration services through more effective and less expensive forensic hospital diversion programs, and
- Transferring appropriate hospital residents currently in forensic step-down beds to less expensive community settings.<sup>3</sup>

The Work Group report coincided with the release of a Senate interim report (2011-106) on the forensic hospital diversion pilot program operating in Miami-Dade County.<sup>4</sup> The report recommended expanding the pilot program to two additional areas of the state. During the 2011 Legislative Session, the Senate Committee on Children, Families, and Elder Affairs introduced SB 2064, to provide community treatment rather than hospital treatment for individuals with forensic involvement. The bill would have expanded the Miami-Dade pilot and made other changes in the state's forensic system. While this bill passed the Senate, it died in House Messages.

The 2011 Legislature reduced funding for state-operated forensic treatment facilities by \$14.5 million in general revenue, or seven percent. This reduction resulted in the elimination of 82 surplus forensic beds.

For this interim project, the Budget Subcommittee on Health and Human Services Appropriation reviewed four issues related to the state's forensic mental health system:

- The feasibility and potential cost savings by diverting additional forensic clients from hospital placements to community-based competency restoration programs;
- The feasibility and potential cost savings of transferring clients currently in forensic step-down beds to community placements; and
- The extent to which competency restoration clients cycle between state forensic treatment facilities and county jails and detention centers.

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<sup>1</sup> Chapter 916, F.S.

<sup>2</sup> *Mental Health: Transforming Florida's Mental Health System*, Supreme Court of the State of Florida, Steering Committee on Families and Children in the Court, November 2007.

<sup>3</sup> *Report of the State Mental Health Treatment Facilities Work Group*, Department of Children and Families, October 2010.

<sup>4</sup> Miami-Dade Forensic Alternative Center (MD-FAC).

## Background

Forensic services for persons who are charged with a felony, are mentally ill, and have been found to be incompetent to proceed with their trial due to their mental illness, or who have been acquitted of a felony by reason of insanity are governed by ss. 916.111-916.17, Florida Statutes. These individuals are committed to the Department for treatment and remain under the jurisdiction of the committing court (s. 916.16, F.S.). The statute provides for forensic treatment in three settings:

1. Separate and secure forensic facilities;
2. Civil facilities; and
3. Community residential programs or other community settings.

The Department has two state-operated and two privately-operated, maximum-security forensic treatment facilities: Florida State Hospital (state operated), North Florida Evaluation and Treatment Center (state operated), South Florida Evaluation the Treatment Center (privately operated), and Treasure Coast Treatment Center (privately operated). The Department may transfer individuals who no longer require a secure setting into non-secure forensic step-down beds in one of three civil mental health treatment facilities (Florida State Hospital, Northeast Florida State Hospital, and South Florida State Hospital).<sup>5</sup> The appropriation for state forensic facilities in Fiscal Year 2011-12 is \$139 million from the General Revenue Fund.

The Department's Mental Health Treatment Facilities Unit, located in its central office, assigns committed individuals to forensic treatment facilities. While the Department has the discretion to move individuals from forensic to civil facilities without the approval of the committing court, individuals may not be released into the community without a court order.<sup>6</sup>

Community mental health providers, funded by the Department, provide mental health treatment services to forensic clients who do not require or meet the criteria for placement in the state's forensic facilities. These providers offer the first level of treatment and assessment aimed at stabilizing the client and reducing the need for admission into a state facility. Services may include treatment and competency restoration services in jail or community settings for individuals who are able to proceed with disposition of their criminal charges without requiring facility admission. Community mental health services are provided to individuals while in county jail awaiting state facility admission and to individuals released from state mental health treatment facilities. These services include the monitoring of individuals on conditional release and individuals receiving residential or outpatient services.<sup>7</sup>

## Findings and/or Conclusions

### State Forensic Facility Bed Capacity and Cost

There are 1,098 beds in the state's secure forensic facilities and 420 non-secure forensic step-down beds in the state's civil mental health treatment facilities. As of August 24, 2011, there were 1,012 individuals in secure beds and 417 in non-secure step-down beds. The statewide utilization rate for secure beds on that date was 92 percent, and ranged from 67 percent for the North Florida Evaluation and the Treatment Center to 98 percent for Treasure Coast Forensic Treatment Center.<sup>8</sup>

The average cost for a secure forensic bed is \$333 per day. The lowest cost is for the South Florida Evaluation and Treatment Center (\$298) and the highest cost is for the Florida State Hospital (\$358).<sup>9,10</sup>

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<sup>5</sup> s. 916.105(3), F.S.

<sup>6</sup> s. 916.16(1), F.S.

<sup>7</sup> Interview with Sally Cunningham, Chief, Department of Children and Families, Mental Health Facilities, June 17, 2011.

<sup>8</sup> Data provided by the Department of Children and Families Mental Health Program Office August 2011.

<sup>9</sup> When the cost of payment on the construction bond for South Florida Evaluation and Treatment Center is included, the cost per bed is \$338.

<sup>10</sup> Department of Children and Families, Mental Health Program Office, August 21, 2011.

## Recidivism for Competency Restoration Clients

For Fiscal Year 2010-2011, the Department reported that 7.8 percent of individuals restored to competency in state mental health treatment facilities and returned to jail to await trial were thereafter returned to a treatment facility prior to trial. Individuals return to state facilities because they have deteriorated emotionally and psychologically while incarcerated. Reasons for this include delays in the trial date, differences in the drug formulary between the state treatment facility and the jail, the mental fragility of the individual, and disagreements between the court-ordered competency evaluation and the forensic hospital's evaluation.<sup>11</sup>

## Community-Based Forensic Residential Program Models

To address a shortage of secure forensic beds in state facilities for adults committed to the Department by the court system, the Legislature appropriated \$53.1 million in Fiscal Year 2007-2008. Of these funds, \$41.6 million was to provide 343 additional beds in the state facilities and \$11.5 million was to increase secure and non-secure bed capacity by 70 beds in four community forensic programs. These community forensic programs are still in operation and are located in Tallahassee, Jacksonville, Miami, and Pembroke Pines. The beds are available to individuals statewide and managed by the Department's regional offices.<sup>12</sup>

Community forensic programs provide residential care and mental health services to individuals found incompetent to proceed and to individuals found not guilty by reason of insanity. All individuals served in these programs have a conditional release order issued by the court in lieu of a commitment to a state facility. These programs vary in design from an open campus with minimal supervision to programs that are physically and staff secure. The per diem costs of the programs range from \$85 for an assisted living facility with mental health overlay services, to \$291 for secure beds with an array of mental health and other services. The Department reports that these programs are successful in keeping individuals from entering or re-entering state facilities, as well as reintegrating individuals into the community in less restrictive placements when combined with intensive outpatient services.<sup>13</sup>

The Miami-Dade Forensic Alternative Center (MD-FAC) offers another model for community forensic programs. Started in August 2009, the Miami-Dade program is a collaborative effort between the Department and Eleventh Judicial Circuit. The MD-FAC program is a 10-bed facility serving non-violent second and third degree felons found by the court to be incompetent to proceed. Unlike the other programs, MD-FAC is the only community-based forensic commitment program. In addition to competency restoration services, the program offers a continuum of care during the commitment period and after re-entry into the community. Program staff continue to monitor individuals to ensure that treatment and support services are maintained. An advantage of this model of competency restoration is that, unlike state facilities, the program is able to keep individuals whose competency has been restored in the program rather than in jail while awaiting trial. As a result, individuals are less likely to decompensate, or lose their ability to maintain normal psychological functioning, and be declared incompetent to proceed again. Outcomes for the Miami-Dade program indicate that competency is restored more quickly (103 days) than state facilities (146 days). The Miami-Dade program also cost less per bed day (\$229) than state facilities (\$333).<sup>14</sup>

## Community-Based Forensic Programs

As of June 2011, the Department reported that there were 2,210 individuals receiving treatment and support services in the community through mental health providers. Of these individuals, 69% were in forensic treatment because they were found incompetent to proceed, as opposed to being found not guilty by reason of insanity. Most of the individuals served in community based programs were charged with second or third degree felonies. These individuals are on conditional release status and are either in pre-conviction diversion programs for competency restoration services or post-commitment programs after release from a state facility. While most of

<sup>11</sup> Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Treatment Facilities, June 17, 2011.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> *Miami-Dade Forensic Alternative Center Pilot Program Status Report*, August 2011.

these individuals are served in residential programs, others live in the community and receive intensive outpatient services.<sup>15</sup>

### Considerations for Establishing Community Forensic Programs

Staff interviewed officials with the Department, community mental health providers, local law enforcement, and circuit court judges to identify criteria needed for establishing and maintaining successful community forensic programs.<sup>16,17</sup> The criteria identified include:

- A level of acceptance by the community with treating felons in the community;
- The support of the local judicial system for community services rather than services in state facilities;
- A focus on public safety concerns that ensures that only second and third degree felons who have no history of violent or aggressive behavior, pose no escape risk, and are amenable for treatment, are targeted for community services;
- An array of community services be provided that include residential programs with different levels of security, supported and independent living arrangements for individuals not requiring residential care, intensive outpatient services, and specialized residential and outpatient services for individuals with co-occurring disorders;
- Provider staff knowledgeable about public benefits who can assist individuals establish or re-establish these benefits as they move into community settings; and
- Provider staff to serve as liaisons with the court with knowledge about the judicial system and its requirements.

## Options and/or Recommendations

### Close 30 Civil Beds

The Department estimates that there are approximately 40 individuals residing in non-secure, forensic step-down beds in civil facilities who have been found not guilty by reason of insanity but who no longer pose a public safety risk<sup>18</sup>. Moving these individuals into the appropriate community settings, with the approval of the court, would reduce the civil facility budget by \$3.3 million annually (based upon an average civil bed cost per day of \$303 x 365 days x 30 people). However, \$2 million of these savings would need to be redirected to communities for forensic services (based upon an average cost of the four model programs of \$184 x 365 days x 30 people). These actions would produce cost savings of \$1.3 million.

### Close 30 Forensic Beds

As of August 2011, the Department reported 80 vacant forensic beds. Closing 30 of these beds in state operated facilities could reduce the forensic facility costs by as much as \$3.7 million annually (based upon the average cost per day for state facilities of \$336 x 365 days x 30 beds). These funds could be redirected to expand the community competency restoration programs. Such actions were recommended in Senate Interim Report 2011-106 and SB 2064 from the 2011 legislative session. The projected cost to expand the community competency restoration programs is \$1.7 million. This could result in savings of \$2 million to the state.

### Review the Use of North Florida Evaluation and Treatment Facility

The legislature could direct the Department to review the use of the North Florida Evaluation and Treatment Facility to ensure individuals are receiving forensic services in the least costly setting. This facility, located in Gainesville, is the smallest facility in the state system with 193 beds, is 35 years old, and is more costly to operate than other more modern facilities. The Department closed 23 beds in this facility in July 1, 2011. As of August

<sup>15</sup> Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Treatment Facilities (June 17, 2011).

<sup>16</sup> Interviews with Stephanie Colston, Director of Substance Abuse and Mental Health, Department of Children and Families, Bob Sharpe, President, Florida Council for Community Mental Health, Inc., John Petrila, Director of the Florida Mental Health Institute's Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center, Linda McKinnon, CEO of Central Florida Behavioral Health Network, Inc., Joe Rutherford, Mental Health Care Inc., of Tampa, Michael Allen, Polk County Sheriff's Office, Valerie Westhead, Seminole County Sheriff's Office, Marilyn Ford, Volusia County Sheriff's Office, Judges Leifman, 11<sup>th</sup> circuit, Speiser, 17<sup>th</sup> circuit, Sjostram, 2<sup>nd</sup> circuit, Nilon, 8<sup>th</sup> circuit, and Marx, 15<sup>th</sup> Circuit, (June 17-August 12, 2011).

<sup>17</sup> Interview with Judge Steven Leifman, Special Advisor to the Florida Supreme Court on Criminal Justice and Mental Health (August 1, 2011).

<sup>18</sup> Interview with Sally Cunningham, Chief, Department of Children and Families Mental Health Facilities (June 17, 2011).

2011, the facility had a relatively low utilization rate of 67 percent. Once the Department reviews the use of this facility, it may be possible to move these individuals to other less costly facilities and programs, allowing the closure of the North Florida Evaluation and Treatment Facility.

# National Drug Shortages

Gene A. Wetzstein, PharmD, BCOP  
Director of Pharmacy Services





# Objectives

- Provide background on drug shortages
- List reasons for the shortages
- Describe impact of drug shortages
- Discuss executive order, legislation, and potential solutions

# Headlines

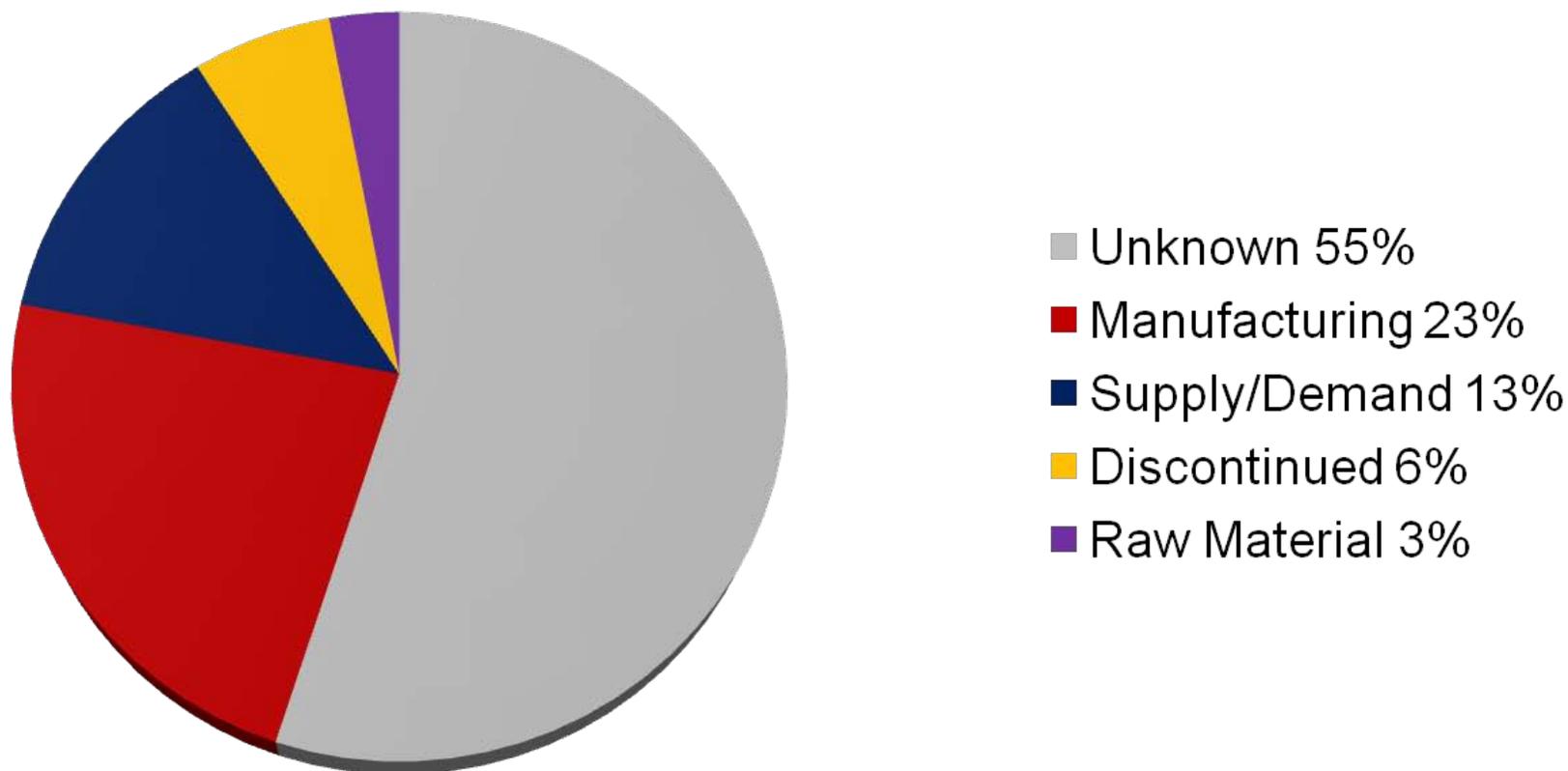
- “Rx Drug Shortages Threaten Treatment and Care”
- “Genzyme Drug Shortage Leaves Users Feeling Betrayed”
- “Teva Propofol Recall Leads to FDA Warning, Drug Shortage”
- “Shortage of Leukemia Drug, Cytarabine, Forcing Hospitals to Turn Some Patients Away”
- “Pharmacies run out of Potassium Iodide”

# Definitions

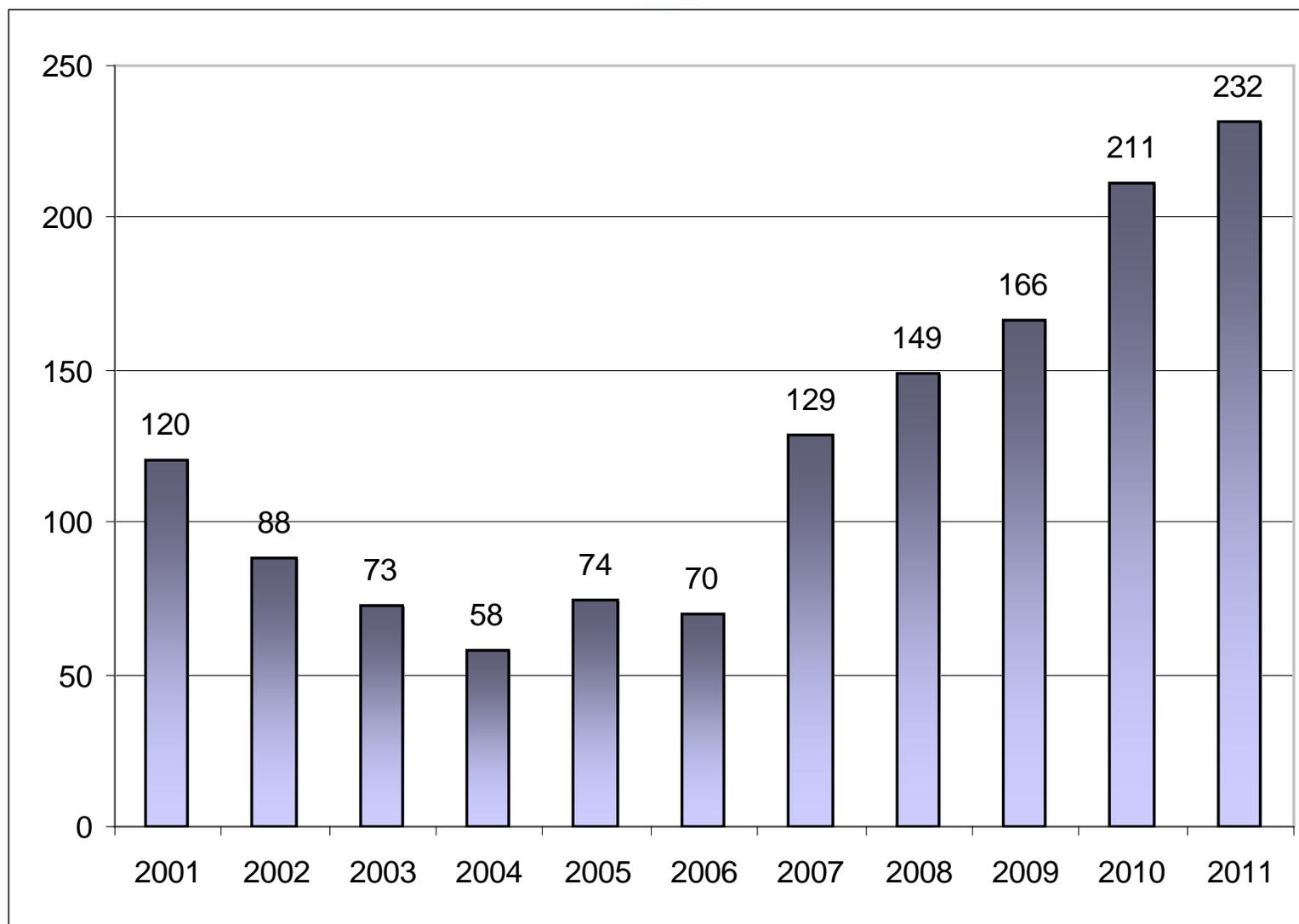
- American Society of Health-System Pharmacists (ASHP)
  - “A supply issue that affects how the pharmacy prepares or dispenses a drug product or influences patient care when prescribers must use an alternative agent”
- FDA
  - “A situation in which the total supply of all clinically interchangeable versions of an FDA-regulated drug is inadequate to meet the current or projected demand at the patient level”

## Reasons for Shortages – 2011 (9/15/11)

### Reason Determined by University of Utah Drug Information During Shortage Investigation

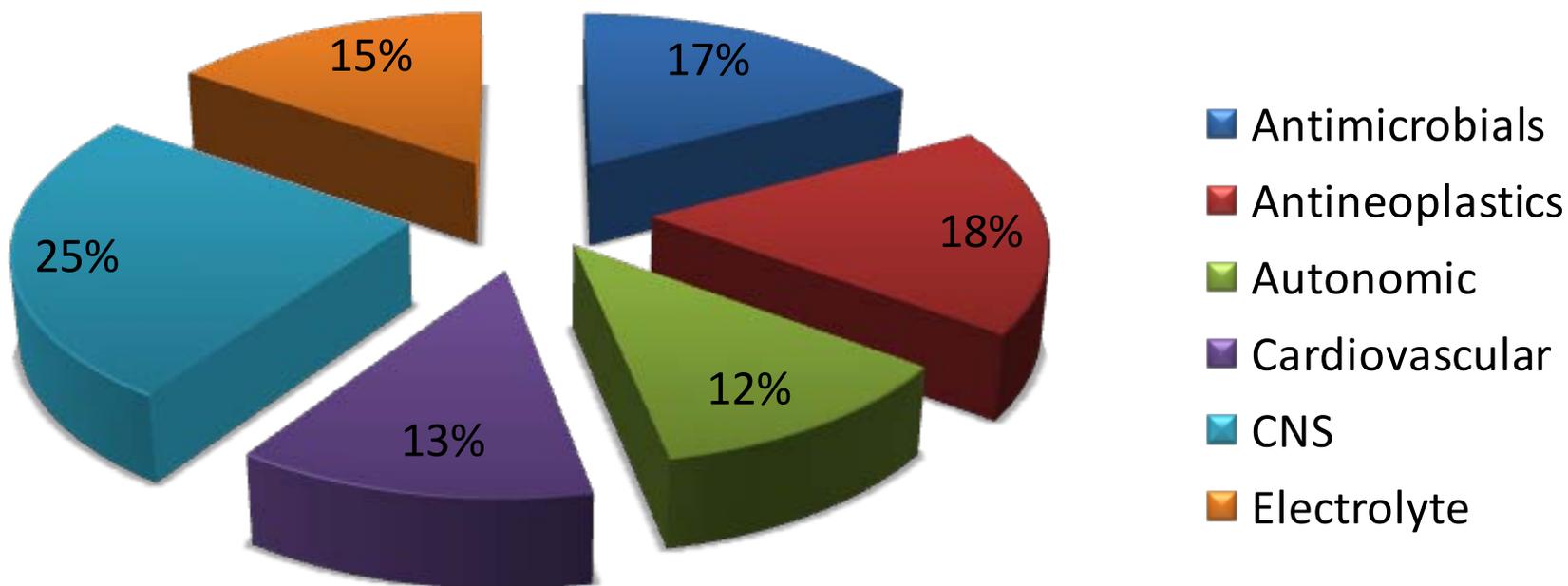


# National Medication Shortages

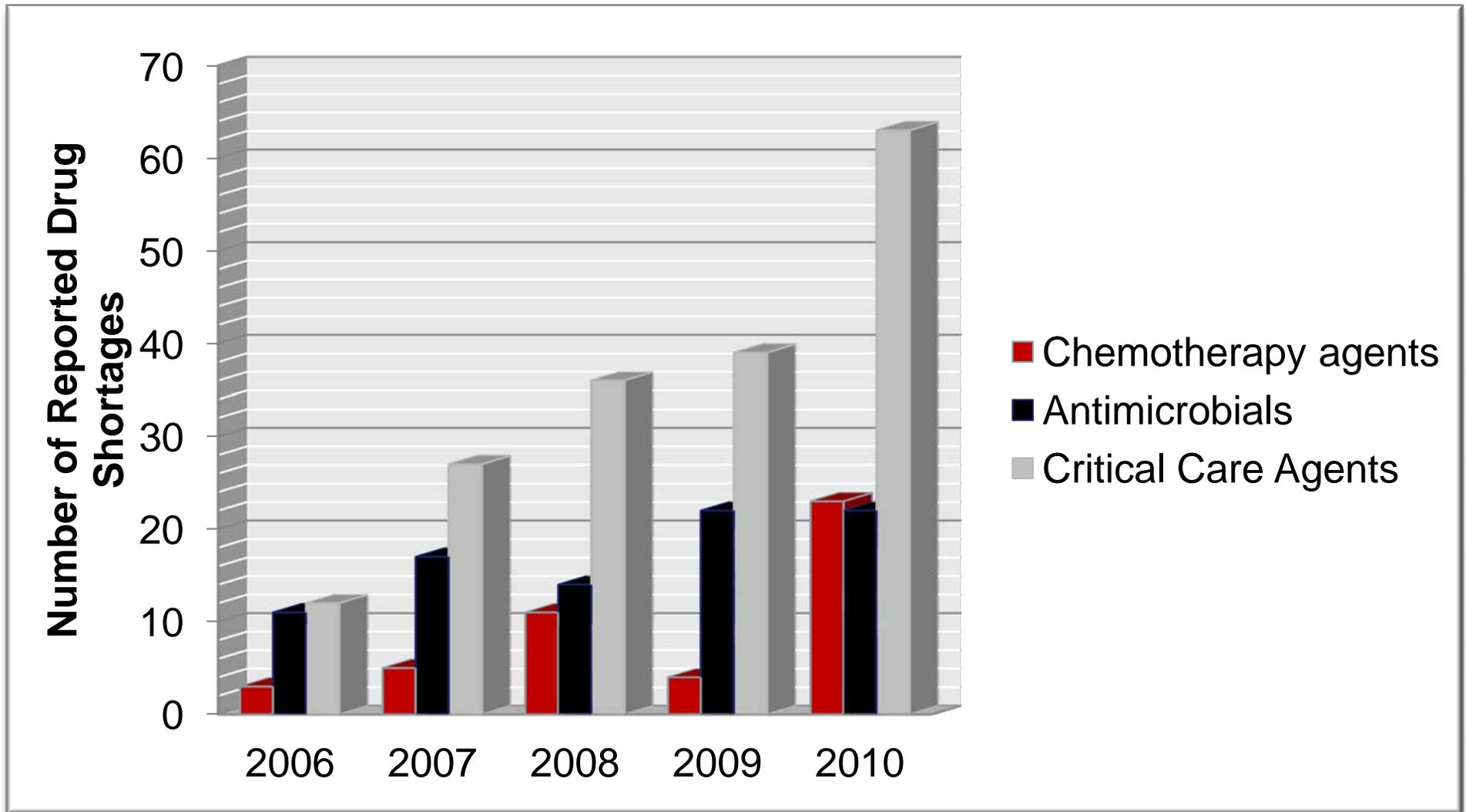


# Medication Shortages

**Listed Drug Shortage in 2010**



# Medication Shortages



# Medication Shortages

## 23 Oncology Drug Shortages in 2010

- Disease States Affected
  - Breast Cancer
  - Lung Cancer
  - Lymphoma
  - Leukemia
  - Sarcoma
  - Testicular Cancer
  - Colorectal Cancer
  - Stem Cell Transplant



# ASHP/ISMP Survey

(% of respondents who frequently or always encountered these problems in past year)

Questionnaire	Percent Response
No information about duration of shortage	85
No advanced warning and suggested alternatives	84
No information about cause of shortage	83
Substantial resources developing plan of action	82
Difficulty obtaining suitable alternative	80
Experience significant financial impact	78
Lack of suitable alternative product	70
Substantial resources preparing alternative	69
Risk of adverse patient outcome	64
Internal hoarding of product	58



# Impact of Medication Shortages

- Inability to treat/ delay in patients therapy or less efficacious regimen
  - Premier Healthcare Alliance survey
    - 80% delay or cancellation of a patient care intervention
- Medication safety concerns
  - ISMP survey
    - 35% reported a near-miss error; 25% medication error
- Increased drug costs
  - Therapeutic alternatives (ex. paclitaxel vs. Abraxane)
  - “Gray Market”- ~ 7 fold price increase
- Increased health care labor costs
  - \$216M since 2010



# Resources for Managing Drug Shortages

- FDA Drug Shortage Website
  - <http://www.fda.gov/drugs/drugsafety/default.htm>
  - Report Drug Shortages – [drugshortages@fda.hhs.gov](mailto:drugshortages@fda.hhs.gov)
- ASHP Drug Product Shortages Management Resource Center
  - <http://www.ashp.org/DrugShortages/Current/>

# How To Manage?

Drug shortage identified by FDA, ASHP, wholesaler and/or networking



Purchase generic equivalent(s) from primary or secondary wholesalers/manufacturers



Obtain P+T approval and purchase therapeutic equivalent (if applicable)



Communicate proposed therapeutic changes to P+T, medical staff, pharmacists and nurses



If allocation becomes necessary, an interdisciplinary task force will convene



Allocation of drug in shortage as determined by the committee and institution-wide communication



## Executive Order- October 31, 2011

- FDA to require drug manufacturers to provide adequate advance notice of manufacturing discontinuances that could lead to shortages of drugs that are life supporting or life sustaining, or that prevent debilitating disease
  - Averted 137 shortages in last 21 months
- FDA to expedite its regulatory reviews to avoid or mitigate existing or potential drug shortages of drugs that are life supporting or life sustaining, or that prevent debilitating disease
- DOJ to enhance enforcement of Federal laws regarding shortages that have led market participants to stockpile the affected drugs or sell them at exorbitant prices
  - “Gray Market” (ex. cytarabine)

# Proposed Legislation

- **Klobuchar-DeGette Bill (S.296/H.R. 2245)**
  - “Preserving Access to Life-Saving Medications Act”
  - Requires manufacturer to notify HHS six months prior to the date of a discontinuance or interruption of a drug.
  - Establishes civil monetary penalties not to exceed \$10,000 for each day on which the violation continues, and not to exceed \$1,800,000 in a single proceeding

# Other Potential Solutions

- Increase Medicare reimbursement of generic medications to motivate manufacturers to boost production and improve quality
  - Average sales price (ASP) + 6% (ex. abraxane vs. paclitaxel)
  - Lead to an increase in pharmaceutical companies in the market
  - Minimize “leakage” to oversea markets
- Clinical pathways that specify preferred chemotherapy combinations and sequences with disease-management fees being paid who are in compliance with pathways

# Other Potential Solutions

- Modifications to the Hatch-Waxman Act (1984)
  - Manufacturers be required to present projections for product demands- “redundant manufacturing capacity”
  - Abbreviated New Drug Application licenses who have met demands would receive prioritization for future generics

NEJM. 2011; Vol. 365, No. 18



# Actions to Consider

- Study the impact of drug shortage and of “gray market” distributors in Florida
- Review legislation from other states that addresses price-gouging on medications during times of emergency
- Consider legislation that prevents price gouging for drugs in short supply, using FDA or AHSP list.



# Questions?



## THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

### COMMITTEES:

Health Regulation, *Chair*  
Agriculture  
Budget - Subcommittee on Health and Human Services  
Appropriations  
Governmental Oversight and Accountability  
Reapportionment  
Transportation

### SENATOR RENE GARCIA

40th District

November 08, 2011

The Honorable Joe Negrón  
306 Senate Office Building  
404 South Monroe Street  
Tallahassee, FL 32399-1100

Dear Chairman Negrón:

Do to unforeseen circumstances; I will not be able to attend the Subcommittee on Health and Human Services meeting scheduled for Tuesday November 15, 2011. Please do not hesitate to contact my office if you have any questions. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "René García".

State Senator René García  
District 40

CC: Claude Hendon, Staff Director

#### REPLY TO:

- 3814 West 12th Avenue, Hialeah, Florida 33012 (305) 824-5058
- 310 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5106

Senate's Website: [www.flsenate.gov](http://www.flsenate.gov)

**MIKE HARIDOPOLOS**  
President of the Senate

**MICHAEL S. "MIKE" BENNETT**  
President Pro Tempore

Tab 1

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/15/11  
Meeting Date

Topic Possible Elimination of Medicaid

Bill Number \_\_\_\_\_  
*(if applicable)*

Name Justin Senior

Amendment Barcode \_\_\_\_\_  
*(if applicable)*

Job Title Acting Medicaid Director

Address 2727 Mahan Drive

Phone 850-412-4007

Tallahassee FL 32308  
City State Zip

E-mail \_\_\_\_\_

Speaking:  For  Against  Information

Representing AHCA

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

**This form is part of the public record for this meeting.**

S-001 (10/20/11)

Tab 2

THE FLORIDA SENATE  
**APPEARANCE RECORD**

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/15/11  
Meeting Date

Topic Patient visits at FQHC

Bill Number \_\_\_\_\_  
*(if applicable)*

Name Phil Williams

Amendment Barcode \_\_\_\_\_  
*(if applicable)*

Job Title Asst. Deputy Sec. for Medicaid Finance

Address 2727 Mahan Drive

Phone 850-412-4008

Tallahassee FL 32308  
City State Zip

E-mail \_\_\_\_\_

Speaking:  For  Against  Information

Representing AHCA

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

**This form is part of the public record for this meeting.**

S-001 (10/20/11)

Tab 3

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/15/11  
Meeting Date

Topic KidCare

Bill Number N/A  
(if applicable)

Name Rich Robieto

Amendment Barcode \_\_\_\_\_  
(if applicable)

Job Title Exec Dir - Healthy Kids

Address 661 E Jefferson St

Phone \_\_\_\_\_

Tallah AL 32309  
City State Zip

E-mail \_\_\_\_\_

Speaking:  For  Against  Information

Representing Healthy Kids

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

Tab 5

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/15/11  
Meeting Date

Topic National Drug Shortages

Bill Number N/A  
(if applicable)

Name Gene A. Wetzstein

Amendment Barcode \_\_\_\_\_  
(if applicable)

Job Title Director of Pharmacy Services

Address 12902 Magnolia Dr

Phone gene.wetzstein@moffitt.org

TAMPA, FL 33612  
City State Zip

E-mail (813) 745-4644

Speaking:  For  Against  Information

Representing Moffitt Cancer Center

Appearing at request of Chair:  Yes  No

Lobbyist registered with Legislature:  Yes  No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

# CourtSmart Tag Report

**Room:** EL 110

**Case:**

**Type:**

**Caption:** Senate Budget Subcommittee on Health and Human Services Appropriations

**Judge:**

**Started:** 11/15/2011 10:48:04 AM

**Ends:** 11/15/2011 12:05:21 PM      **Length:** 01:17:18

**10:48:09 AM** Meeting called to order  
**10:48:12 AM** Roll call  
**10:48:47 AM** Tab 1 - Consideration of Possible Elimination of Medipass  
**10:49:07 AM** Justin Senior, General Counsel and Acting Medicaid Director, AHCA  
**11:05:58 AM** Tab 2 - Reimbursement for Patient Visits at Federally Qualified Health Centers  
**11:06:46 AM** Phil Williams, Medicaid Chief Financial Officer, AHCA  
**11:27:13 AM** Tab 3 - Update on the Kidcare Program  
**11:27:45 AM** Rch Robleto, Executive Director, Florida Healthy Kids Corporation  
**11:41:37 AM** Tab 5 - Update on Cancer Drug Shortages in Florida  
**11:41:55 AM** Gene A. Wetzstein, PharmD, BCOP, Director of Pharmacy Services, Moffitt Cancer Center  
**11:59:02 AM** Tab 4 - The Forensic Mental Health System, Senate Interim Project 2012-108  
**Remarks from Chairman Negron**  
**12:04:13 PM** Closing remarks/Adjourned

Budget Subcommittee on  
Health and Human Services  
Appropriations  
(November 15, 2011)

APD

Follow-up Materials from  
October 6, 2011 Meeting

**Summary Developed by the Agency for Health Care Administration  
Feasibility of Florida Medicaid Requiring Families of Individuals Enrolled on the  
Developmental Disabilities Waivers to Help Pay for the Cost of Care**

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*The purpose of this paper is to provide information about the options available to the state for premiums and cost-sharing for Individuals enrolled in the Development Disabilities Waivers to help pay for the cost of care and the feasibility of implementing the options.*

*In the initial paper prepared in April 2010, the focus was on premium payments. However, since premium payments for children cannot be implemented in Florida until October 2019 due to the Affordable Care Act Maintenance of Effort provision, the focus of this paper is on cost-sharing for waiver services.*

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<i>III.</i>	<i>Determining Family Income for Premiums and Cost Sharing</i>	<i>5</i>
<i>IV.</i>	<i>Five Percent Limit on Aggregate Liability: Requirement for State Tracking and Notification to the Provider and Beneficiary</i>	<i>5</i>
<i>V.</i>	<i>Cost Sharing</i>	<i>5</i>
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<i>VII.</i>	<i>Monthly Federal Poverty Level Table</i>	<i>10</i>
<i>VIII.</i>	<i>Aggregate Cost Sharing Limits</i>	<i>10</i>

*Legal Basis for Cost Sharing and Premium Collection: section 1916A of the Social Security Act which was added by sections 6041, 6042, and 6043 of the Deficit Reduction Act of 2005 (DRA), amended by section 405(a)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA) and further amended by section 5006(a) of the American Recovery and Reinvestment Act of 2009 (the Recovery Act); and Final Federal rules: Federal Register: May 28, 2010 (Volume 75, Number 103), pages 30243-30265 <http://edocket.access.gpo.gov/2010/2010-12954.htm>*

**I. Overview**

Premiums and Cost Sharing

Section 1916A of the Social Security Act (added by the Deficit Reduction Act, or DRA) provides states with flexibility to increase consumer involvement in health care decisions and save Medicaid funds by requiring patients to contribute to the cost of their care. The premise behind this concept is that recipients will be better health care consumers when they must contribute financially. There are two ways to do this: cost sharing and premiums. Cost sharing is any

deduction, co-payment or similar charge required to use Medicaid services. A premium is an enrollment fee or similar charge, such as a monthly fee.

Section 2001 of the Patient Responsibility and Affordable Care Act enacted on March 23, 2010, imposes a "Maintenance of Effort" which requires states to maintain the same eligibility standards, methodologies, or procedures that were in effect on March 23, 2010 under the State's Medicaid plan or waiver. The requirement is in effect through 2013 for adults and through 2019 for children. Implementing a requirement for premium payment as a condition of eligibility would violate this provision (since non-payment if premium would result in loss of eligibility); therefore, Florida is prohibited from implementing a requirement for premiums for children in Home and Community Based Services (HCBS) until October 1, 2019. The discussion of premium payments is provided in Section VI of this memo.

Based on our current understanding of the Maintenance of Effort provision in the Patient Responsibility and Affordable Care Act, Florida Medicaid is not similarly prohibited from implementing Medicaid cost-sharing. A discussion of the provisions for Medicaid cost-sharing is provided in Section VI.

#### Home and Community Based Services Optional Medicaid Eligibility Coverage Group

States may elect to participate in Home and Community Based Services (HCBS) waivers to allow Medicaid to cover services traditionally viewed as "long-term care" which may not be available to all Medicaid eligibles and provide them in a community setting to individuals that would otherwise require nursing home or ICF/DD care.

States have the option of providing Medicaid coverage to individuals enrolled in a waiver to receive Medicaid Home and Community Based Services (HCBS) who would not otherwise qualify for Medicaid. This means that children over the age of 6 whose gross family income exceeds 100% of the Federal Poverty Level or whose countable income, which includes consideration of parental income, exceeds the SSI cash assistance limit, can qualify for full Medicaid coverage through enrollment in an HCBS waiver. The income limit for the HCBS waiver coverage group is currently \$2022, three times the SSI benefit rate of \$674 (224% of the Federal Poverty Level of \$903 for an individual). In determining eligibility for a child under the HCBS waiver coverage group, neither parental income nor assets can be taken into consideration. (The purpose of the original HCBS waiver was to remove the barrier for access to Medicaid for children who qualified for Medicaid while in a medical institution because they were not living with their parents, but who would lose Medicaid eligibility when they lived at home because their parents' income and assets were counted.)

For adults whose Medicaid eligibility is derived from enrollment in an HCBS waiver, spousal income is not used in determining eligibility. The rules for counting income to determine eligibility used for persons in nursing facilities are the rules the state must use to determine eligibility for HCBS.

In determining the amount of income available for either cost sharing or premium collection, Florida has the ability to consider parental income for children and spousal income for adults to determine the amount of family income used to determine monthly liability limit for cost sharing and premium payment.

This memo will focus primarily on cost sharing for individuals enrolled in the Developmental Disabilities waivers. Although premium collection is addressed, premium collection for children is not an option available to Florida until October 2019 or for adults until January 2014.

## II. Federal Requirements for Premium Collection and Cost-Sharing

Section 1916A of the Social Security Act provides state Medicaid agencies with the option to impose increased premiums and cost sharing for certain Medicaid recipients. The limits for children and adults are specified in the charts below in this section.

Section 1916A of the Act allows states to make payment of premiums a condition of Medicaid eligibility and payment of cost sharing a condition of receiving services. In addition, it allows states to vary the premiums and cost sharing charged based on income, eligibility category, and type of service. It restricts the total amount of cost sharing and premiums to not more than 5 percent of the family's income.

Federal regulations (42 CFR 447.70) identify the services which are exempt from cost-sharing (e.g.; preventive services for persons under age 18 regardless of income, emergency services, and family planning services and supplies).

Rules for Children: Children who are eligible under any of the mandatory coverage groups for children, are in Foster Care, or are eligible for Medicaid based on eligibility for adoption subsidy are exempt from cost-sharing and premium collection provisions. These exempt groups include children under the age of six in families with income below 133 percent of the poverty line and children from age 6 to 18 in families with income below 100 percent of the poverty line.

Section 1916A allows cost-sharing and premiums for some children in families with income above the poverty line:

- Children who are not exempt and whose families have income between 100 and 150 percent of the poverty line cannot be charged premiums, but can be charged up to 10 percent of the cost of the service for services other than prescription drugs and non-emergency use of the emergency room. They can be charged nominal co-payments for non-preferred prescription drugs and up to twice the nominal amount for use of the emergency room for non-emergency services.
- Children whose families have income above 150 percent of the poverty line can be charged premiums (starting 2019 due to ACA) and cost-sharing up to 20 percent of the cost of the service for non-preferred prescription drugs, and other services. There is no limit on cost-sharing for use of the emergency room for non-emergency services.

Cost-sharing and Premiums for Non-Exempt Children (Note: Premiums for Children are prohibited under the MOE provisions of ACA through 2019)		
	Other children – Income to 150 percent of the poverty line	Income > 150 percent of the poverty line
Most Services	Up to 10 percent of the cost of the service	Up to 20 percent of the cost of the service
Prescription drugs	Nominal for non-preferred	Up to 20 percent of the cost for non-preferred
Non-emergency use of the ER	Two times nominal	Any amount
Enforceability of co-payments	Yes	Yes
Premiums	Not allowed	Allowed

Rules for Adults: The following rules apply to cost-sharing for adults:

- Beneficiaries who are in a hospital, nursing home or other any other medical institution that requires them to contribute all but a nominal amount of their income for their care are exempt from cost-sharing as are patients who are receiving hospice care. Women who are eligible under the Breast and Cervical Cancer Screening and Treatment program are also exempt from cost-sharing.
- Pregnant women are exempt from cost-sharing for services relating to their pregnancy or for any other medical condition which may complicate their pregnancy.
- States can impose nominal cost-sharing charges for non-preferred drugs and non-emergency use of the emergency room on beneficiaries who are otherwise exempt from cost-sharing.
- States cannot impose cost-sharing on emergency services or on family planning services and supplies.
- Health care providers cannot refuse services to beneficiaries with income below the 100% of the Federal Poverty Level who cannot afford to pay a cost-sharing charge (but can refuse services to persons with income at or above 100% of the Federal Poverty Level).

<b>Cost-sharing and Premiums for Non-Exempt Adults</b>			
<b>(Note: Premiums for most adults are prohibited under the MOE provisions of ACA through 2013)</b>			
	Income <100 percent of the poverty line	Income 100 to 150 percent of the poverty line	Income > 150 percent of the poverty line
Most Services	Nominal cost-sharing	Up to 10 percent of the cost of the service	Up to 20 percent of the cost of the service
Prescription drugs	Nominal cost-sharing	Nominal cost-sharing	Up to 20 percent of the cost of the drug for non-preferred
Non-emergency use of the emergency room	Nominal cost-sharing	Two times nominal	No limit
Enforceability of co-payments	No	Yes	Yes
Premiums	Not allowed	Not allowed	Allowed

### **III. Determining Family Income for Premium Payment or Cost-Sharing**

States may use a family's gross income or other alternative way of counting income for purposes of determining the amount of premiums and cost-sharing. The State Plan Amendment must identify the methodology used to determine family income, including what disregards (if any) are applied. (A disregard is income deducted from gross income; e.g., the SSI program has a general income disregard of \$20.) In addition, the State Plan Amendment must specify the process by which an individual may request a reassessment of the family's income.

Premium amounts may be determined on a sliding scale and cost sharing charges can range from nominal to up to 10% or 20% of the cost of the service, depending on the family income. The aggregate amount of premiums and cost-sharing liability for all individuals in the family enrolled in Medicaid cannot exceed 5 percent of the family's income.

Under the provisions for premium collection and cost-sharing, the state has the option of using parental income to determine the amount of premium and cost-sharing even though the parental income was not used in determining eligibility for the Home and Community Based Services Waiver. The state must establish how family income is determined for the purpose of calculating the amount of cost sharing and premium payment.

### **IV. Five Percent Limit on Aggregate Liability: Requirement for State Tracking and Notification to the Provider and Beneficiary**

The aggregate amount of premiums and cost-sharing for all individuals in the family enrolled in Medicaid cannot exceed 5 percent of the family's income.

If a state adopts cost-sharing rules that could place families at risk of reaching the total aggregate limit for premium and cost sharing under Medicaid, the state must develop a mechanism to track the beneficiary's incurred premium and cost sharing. The state cannot rely on the beneficiary to do the tracking. In addition, the state must have the ability to notify providers and the beneficiary when the limit has been reached and services are no longer subject to the cost-sharing expenses for the remainder of the month.

In addition, the State Plan Amendment submitted by the state must describe how the state identifies whether cost-sharing for a specific item or service may be imposed and whether the provider may require the beneficiary to pay the cost-sharing charge as a condition of receiving the service.

### **V. Cost-Sharing**

States have the option of imposing deductibles, copayments or coinsurance for services.

- A *deductible* is a specified dollar amount paid for all services rendered during a specific time period (e.g., per month or year) before health insurance (e.g., Medicaid) begins to pay for care.
- *Coinsurance* is a specified percentage of the cost or charge for a specific service rendered.
- A *copayment* is a specified dollar amount for each item or service delivered.

States have the ability to determine the level of income at which a family becomes liable for cost sharing and the amount of the cost sharing. The Federal regulations and law, however, prescribe limits.

The amount of the cost sharing for a specific service cannot exceed 20% of the Medicaid rate for the service for individuals with family income above 150% of the Federal Poverty Level; for individuals with income above 100% of the Federal Poverty Level up to 150% of the Federal Poverty Level, the cost sharing cannot exceed 10% of the Medicaid rate for the service.

The Medicaid Eligibility income limit for Home and Community Based Services is currently \$2022 per month, or 224% of the Federal Poverty Level for a family of 1. If the family income level for HCBS participants responsible for cost sharing is set lower than 224% of the Federal Poverty Level, both adults and children have cost sharing liability. If the family income level is set higher than 224% of the Federal Poverty Level, only children enrolled in the waiver with parental income above 224% of the Federal Poverty Level would have cost sharing.

According to a Congressional Research Service report to Congress dated January 2007, among the four states with approval for alternative benefit packages via the provisions of Section 1916A of the Social Security Act, only Kentucky includes cost-sharing for participants. This report may be found at: <http://ccf.georgetown.edu/index/cms-filesystem-action?file=research%2Fcost+sharing%2Fdra+cost+sharing+-+1-25-07.pdf>

Significant practical challenges arise in imposing cost sharing under Section 1916A. Medicaid is required to reduce the reimbursement to a provider by the amount of cost sharing when the provider bills for services subject to cost sharing which are provided to an individual who is subject to Medicaid cost sharing. This would require the Florida Medicaid Management Information System (FMMIS) to provide the cost sharing amount to the provider at the point of service and the provider to access the information for the provider to know how much to collect from the recipient. The provider has the right to refuse service if the individual does not pay the required cost sharing charge. Additionally, since the total amount of cost sharing cannot exceed 5% of the family's income, a tracking mechanism would need to be developed in FMMIS to be able to track when the family's monthly liability for cost-sharing had been met. When the family reaches the 5% cap, cost sharing would not apply for the remainder of the month.

Florida currently has no data on the number of children in the DD waiver whose family income exceeds 100% of the Federal Poverty Level (see chart in section VII for the 2010 Federal Poverty Levels). The August 2010 report of Medicaid eligibles produced by Medicaid indicates there are a total of 2239 children enrolled in the optional Medicaid Home and Community Based Services coverage group; not all of the children enrolled in HCBS waivers are enrolled in the DD waiver. Because data on parental income and information for other members of the family is not needed by the Department of Children and Families (DCF) to determine eligibility for children in HCBS waivers, no data are available on the amount of family income for children enrolled in the HCBS/DD waiver in the optional HCBS waiver Medicaid eligibility coverage group.

The average expenditure for waiver services for a child under age 18 in the optional Home and Community Based Services Waiver group who is enrolled in one of the DD waivers is \$2030 per month (based on data for FY09/10 provided by Medicaid). Since the maximum cost sharing which can be imposed for persons with family income above 150% of the Federal Poverty Level is 20% of the Medicaid reimbursement rate, the average amount of cost sharing would be \$406 per month. The amount of the \$406 Medicaid would be able to impose is subject to the aggregate liability cap based on the family income. Refer to the tables in Section VII for the poverty levels based on family size and Section VIII for a table of the amounts of the aggregate 5% liability cap (limit) based on family size and income level. (Parental income can be taken

into account in determining cost sharing liability even though it cannot be taken into account in determining eligibility.)

Example:

This is an actual record of DD waiver expenditures for services for April 2010 for a child enrolled in the waiver. The total Medicaid reimbursement equals \$787.48. The 20% maximum cost sharing would be \$157.50 for the services, subject to the aggregate monthly limit of 5% of the family income. If the child was a member of a family of 4 with family income of \$4594 (250% of the Federal Poverty Level), the full \$157.50 cost sharing would be imposed as it is below the aggregate cap of \$230 (5% of \$4594).

Provider ID	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Paid	
692284898	MCD	04/10/2010	04/14/2010	PROFESSIONAL	PAID	04/21/2010	\$96.64
686790198	MCD	04/30/2010	04/30/2010	PROFESSIONAL	PAID	05/12/2010	\$65.48
692284896	MCD	04/29/2010	05/04/2010	PROFESSIONAL	PAID	05/12/2010	\$120.00
692284898	MCD	04/17/2010	04/28/2010	PROFESSIONAL	PAID	05/12/2010	\$108.72
692284896	MCD	04/15/2010	04/20/2010	PROFESSIONAL	PAID	04/28/2010	\$120.00
692284896	MCD	04/12/2010	04/13/2010	PROFESSIONAL	PAID	04/21/2010	\$60.00
692284898	MCD	04/01/2010	04/07/2010	PROFESSIONAL	PAID	04/14/2010	\$96.64
692284896	MCD	04/22/2010	04/27/2010	PROFESSIONAL	PAID	05/05/2010	\$120.00

It is not clear if the reduction in Medicaid expenditures from cost sharing would sufficiently reduce the Medicaid expenditures to cover the operational costs of determining family income, sending recipient notices for cost sharing, programming the DCF eligibility determination system (FLORIDA) to collect the monthly family income to calculate the cost sharing limit, for DCF to transmit the information to the Florida Medicaid Management Information System (FMMIS), and for Medicaid to make the necessary FMMIS changes to provide information to each provider to identify the amount of cost sharing due for each service for a specified recipient and to notify the recipient and the provider when the cost sharing liability has been met for the month.

Federal approval of a Medicaid State Plan Amendment is required to implement cost sharing for DD waivers. The State would need to return the federal Medicaid matching funds to the federal government for any cost sharing savings.

Legislation would be required to impose cost sharing to:

- Provide authority
- Allow providers to refuse service if recipient does not make the required copayment
- Set the rules for calculating family income
- Set the income limit for imposing cost sharing (e.g., for individuals in the DD waiver with family income equal to or exceeding 250% of the FPL)
- Set the cost sharing rates

Implementation of Cost Sharing:

Department of Children and Families/ ACCESS

- Promulgate rules for determination of family income for cost sharing
- Make needed changes to the eligibility determination system to collect income information and compute family income for cost sharing
- Collect parental income information (it is not currently collected as it is not used in determining eligibility for the child under the Home and Community Based Waivers)

- Provide income information to FMMIS, along with information that indicates which other members of the family are subject to Medicaid cost sharing
- Provide appropriate client notices to advise of cost sharing liability amount at time of approval and when there is a change in income

Agency for Health Care Administration (AHCA)

- Develop and submit Medicaid State Plan Amendment and DD waiver amendments in conjunction with DCF
- Promulgate amended DD Waiver administrative rule
- Arrange for or conduct provider training for cost sharing
- Make necessary changes to FMMIS carry family income information from DCF, track cost sharing liability for the family and allow providers access to the amount of cost sharing liability due for a particular service, as well as notify the recipient when the cost sharing liability is met for the month.
- Educate recipients and providers about the new requirements (in conjunction with DCF and Agency for Persons with Disabilities)

Providers: Establish capability to access cost sharing data in FMMIS at time of service to know amount of cost sharing to collect from the recipient.

**VI. Premium Payment (cannot be implemented prior to 10/1/2019 for children or prior to 1/1/2014 for adults - per Maintenance of Effort requirement in Patient Protection and Affordable Care Act)**

The State may charge families with income above 150% of the Federal Poverty Level (FPL) a premium that equals up to 5% of the family's monthly income (provided it is not implemented in conjunction with other cost-sharing). Payment of the premium becomes a condition for waiver eligibility. The State has two options for enforcing a premium payment for waiver eligibility:

- 1) Prepayment of the premium for coverage for a month; or
- 2) Termination of Medicaid coverage because of failure to pay the premium for at least 60 days.

Federal approval of a Medicaid State Plan Amendment and DD Waiver amendments are required to implement premiums for the DD waiver. The State would need to return the federal Medicaid matching funds to the federal government for any premiums collected.

Legislation would be required to impose premiums to:

- Provide authority to collect premiums
- Make payments for premiums a condition of eligibility
- Specify where the collections would be deposited
- Specify which agency is responsible for collecting the premiums

Impacts of imposing premiums:

- Department of Children and Families (DCF) would need to collect income information from parents of children in DD waivers who would otherwise not qualify for Medicaid unless they were enrolled in the waiver, and calculate a premium amount based on the income and assets of the parents. (If a child qualifies for Medicaid based only on waiver enrollment, the parents' income and assets cannot be considered in determining eligibility for Medicaid, but the parents' income may be considered in determining the amount of premium due.)

- A vendor would need to be procured to handle collections and transmission of premium collection information to DCF or resources would need to be allocated to a state agency to handle this function.
- The DCF automated eligibility determination system (FLORIDA) would need to be programmed to receive premium payment information to indicate whether or not the premium amount had been paid in order to stop or start coverage. When a premium payment is not received, DCF would be required to send adequate, advance notice to terminate benefits. Currently the individual must be provided a 60-day grace period before terminating benefits.

Implementation of Premiums:

Two to three entities would be responsible for implementing a premium collection program.

Department of Children and Families/ ACCESS

- Promulgate rules for determination of amount of premium payment due
- Make needed changes to the eligibility determination system to collect income information and compute amount of premium payment due
- Collect parental income information (it is not currently collected as it is not used in determining eligibility for the child under the Home and Community Based Waivers)
- Provide income information to a collection agent
- Collect premium payments or receive premium payment information from a contracted collection agent
- Provide appropriate client notices
- Transmit the eligibility coverage to FMMIS based upon premium payment collection
- Obtain and manage collection payment contract

Collection Agent (if this function is outsourced)

- Receive income information from DCF
- Send invoices and transmit premium payment information to DCF

AHCA

- Develop and submit Medicaid State Plan Amendment and DD waiver amendments in conjunction with DCF
- Promulgate amended DD Waiver administrative rule
- Educate recipients and providers about the new requirements (in conjunction with DCF and Agency for Persons with Disabilities)

Other State's Experiences with Premium Collection: Kansas, Minnesota and Wisconsin have implemented programs called "parental fee programs" that require certain parents of children in waiver programs to pay a monthly fee. The amount of the fee varies depending on the size of the family and the percent of the parents' adjusted gross income that is above the Federal Poverty Level.

These programs share several features:

- The parental fee programs were implemented through mandates from the State legislatures;
- Neither parental income nor assets are counted in determining eligibility for the affected waiver programs;
- In Minnesota and Kansas, the fee is a monthly payment based on the parent's adjusted gross income.

Considerations in Implementing a Premium Collection Program

Advantages:

- Under the Affordable Care Act Maintenance of Effort Provisions, premiums are prohibited for children through 2019, and for most adults through 2013.
- A successful premium collection program may create cost savings for the State of Florida.

Disadvantages:

- There will be administrative costs to state agencies to implement premium collection. Revenue generated may offset any increased administrative costs, but this would reduce net savings.

Implementation Timeframe and Requirements for Premium Collection: At least twelve to eighteen months would be needed to procure a collection contractor or develop a system and staff in-house, program the Medicaid Fiscal Agent and DCF systems, seek approval of amendments to the Medicaid State Plan and the DD waiver, and update administrative rules.

The State Plan Amendment must include specific information about which participants will be charged a premium, how family income is determined, the amount of the premium, and the mechanisms for premium collections.

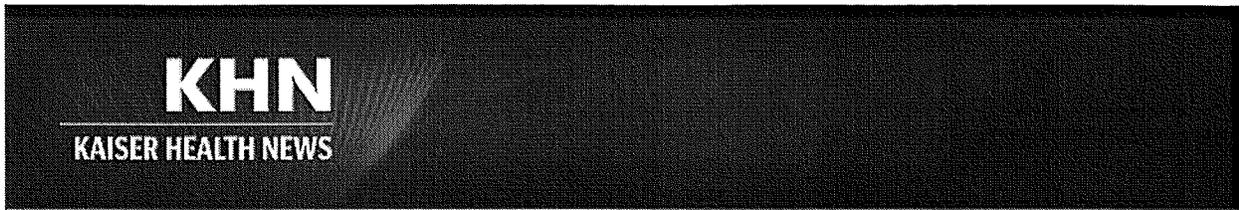
**VII. Monthly Poverty Level Table**

(Source of data: Centers for Medicare and Medicaid Services, <https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf> )

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE					
	100%	150%	200%	250%	300%	350%
1	903	1,354	1,805	2,256	\$2709	\$3160
2	1,214	1,821	2,428	3,035	\$3642	\$4249
3	1,526	2,289	3,052	3,815	\$4578	\$5341
4	1,838	2,756	3,675	4,594	\$5514	\$6433
5	2,149	3,224	4,298	5,373	\$6447	\$7521
6	2,461	3,691	4,922	6,152	\$7383	\$8613

**VIII. Aggregate Limit for Total Monthly Medicaid Premium and Cost Sharing Liability For Family Table**

FAMILY SIZE	5% of 150%	5% OF 200%	5% of 250%	5% of 300%	5% of 350%
2	1,821 X 5%=91	2,428 X 5%=121	3,035 X 5%=152	\$3642 X 5%=\$182	\$4249 X 5%=\$212
3	2,289 X 5%=114	3,052 X 5%=153	3,815 X 5%=191	\$4578 X 5%=\$229	\$5341 X 5%=\$267
4	2,756 X 5%=138	3,675 X 5%=184	4,594 X 5%=230	\$5514 X 5%=\$276	\$6433 X 5%=\$322
5	3,224 X 5%=161	4,298 X 5%=214	5,373 X 5%=269	\$6447 X 5%=\$322	\$7521 X 5%=\$376
6	3,691 X 5%=185	4,922 X 5%=246	6,152 X 5%=308	\$7383 X 5%=\$369	\$8613 X 5%=\$430



## Children's Health Program Opened To Low-Income State Employees

TOPICS: STATES, MEDICAID

By SARAH BARR

KHN Staff Writer

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At least six states have opened their Children's Health Insurance Programs to the kids of low-income state employees, an option that was prohibited until the passage of the 2010 health law.



This relatively small step has as its backdrop years of debate related to CHIP, and to concerns that it encourages states -- and consumers -- to replace private insurance with taxpayer-subsidized coverage.

Now, as a result of the policy change, families of lower-income state employees who have struggled to pay for family coverage can qualify for the program. CHIP, which is jointly financed by the states and the federal government, provides coverage to uninsured children of families that make too much to qualify for Medicaid but cannot afford private insurance.

The federal government had closed that option to most states when CHIP was originally established in 1997 because of concerns that it might be an easy way to shift the costs of some public employee health benefits from financially strapped states to the federal government. Federal employees were allowed to enroll their children.

"State employees shouldn't be the only people in the country who cannot access the program," said Steven Kreisberg, the director of collective bargaining and health care policy at the American Federation of State, County and Municipal Employees. And, in an era of frozen wages, pay cuts and furloughs for state employees, the ability to participate in CHIP is critical for families, he added.

But critics have long worried that CHIP does not do enough to guard against the market phenomenon known as crowd-out, when public insurance replaces private. This concern was part of the motivation for including the state prohibition when the program was created. Without it, some said, states could push their lower-income employees' dependents into the CHIP program, thereby saving on health benefit costs because the federal government would be picking up part of the tab.

The health law requires states to show that they have not cut their share of employee health

insurance costs in an effort to push their workers' children to CHIP or that the cost of the coverage available to employees is a financial hardship for families.

Despite this dictate, Nina Owcharenko, the director of the Heritage Foundation's center for health policy studies, said there still is a real risk of this scenario playing out particularly among higher-income CHIP participants. Ultimately, Owcharenko expects states to weigh how they can get the best deal—a consideration that she says could mean finding ways to draw down more federal dollars.

But Tricia Brooks, senior fellow at the Georgetown University Center for Children and Families, said that the federal matching funds that will flow to the states are a plus but are not the primary reason states are pursuing the policy change.

"I think the intent was much more motivated by the fact that there were children who were being discriminated against," she said.

Georgia, which is waiting for final federal approval, is the latest state to offer its lower-income employees the CHIP option-known as PeachCare for Kids. The Centers for Medicare and Medicaid Services has already given the nod to plans by Alabama, Kentucky, Montana, Pennsylvania and Texas.

Georgia's open enrollment period began in October, and officials expect 42,000 children to switch to PeachCare for state savings of \$32 million in fiscal year 2012. If those expectations are met, Georgia -- out of the six states -- would have the highest number of state employees' children enrolled in CHIP.

Leigha Basini, a program manager at the National Academy for State Health Policy who works with state CHIP directors, said more states are enthusiastic about the option because of the potential savings and the chance to expand coverage to more kids. "It potentially is a win-win for the states and the employees," she said.

In each state, the number of employees who will be able to get this coverage will be affected by what ceiling that state sets for CHIP eligibility -- in Georgia, it's \$52,500 for a family of four -- and how much workers are paid. In addition, state employees' opinions about the quality of their state-based coverage and CHIP will factor into their decision about whether to switch programs.

A spokeswoman for Georgia's Department of Community Health said the state expects the new option will benefit state employees through lower out-of-pocket costs, although the exact savings will depend on factors such as the private plan in which the child was enrolled, family income and the child's age.

Meanwhile, for some states, new cost-sharing requirements for the qualifying state employees sometimes go along with the CHIP change.

Diane Joiner, a single mother who works for Alabama's health department, enrolled her teenage daughter in All Kids, Alabama's version of CHIP, when a state-subsidized CHIP look-alike program was canceled because the state prohibition was lifted. (A number of states had such plans in place to aid low-income state employees when their participation in CHIP wasn't allowed.)

She says she is pleased with the coverage, but points out that she now pays a \$100 annual premium. Although this amount is more than she paid in the state-subsidized program, it is much less than if she would have to pay regular coverage premiums.

Otherwise, her benefits and copays are the same. "My daughter's got to be covered, and I can't afford [the state plan]," she said.

And some state officials say the change is making a real difference for children and families.

Katherine Buckley-Patton, who directs the Healthy Montana Kids program, said some low-income state employees have been struggling to keep their family insured or may not be able to afford coverage for their children. Allowing them to move to CHIP has relieved this pressure and helped to keep some at-risk kids covered.

Here's how the policy change is playing out in the other states:

-- Montana has enrolled 513 children of state employees since October 2010 in its CHIP program. State officials expect this number to increase as the state does aggressive outreach efforts. Buckley-Patton noted that some employees had questioned why they were excluded when federal workers were not. "The door has been closed on them a number of times in the past," she said.

-- Texas expects to save \$16 million over two years, according to a spokeswoman. The state's CHIP spending is \$340 million this year.

-- In Kentucky, which had used state dollars to cover state employees' CHIP-eligible children, the change has saved the state \$2 million.

-- Pennsylvania officials expect part-time or seasonal workers to be among the beneficiaries of their state's policy change. They estimate less than 1 percent of state employees qualify for the program.



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