The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, Chair
Senator Rich, Vice Chair

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

MEMBERS: Senator Negron, 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	Update on Social Services Estimating Conference Projections for Medicaid, TANF and KidCare		
2	Public Testimony on Efficiency Measures for Health and Human Services Budget (presentations will be limited to 3 minutes each)		
3	Presentation by OPPAGA on Nursing Home Residents and Potential Cost Savings Measures		
4	Update on Renewal of the Section 1115 Medicaid Reform Waiver		
5	Presentation on Medicaid Funding for Inmates		

Medicaid Estimates:
An Overview with TANF & KidCare

January 12, 2011

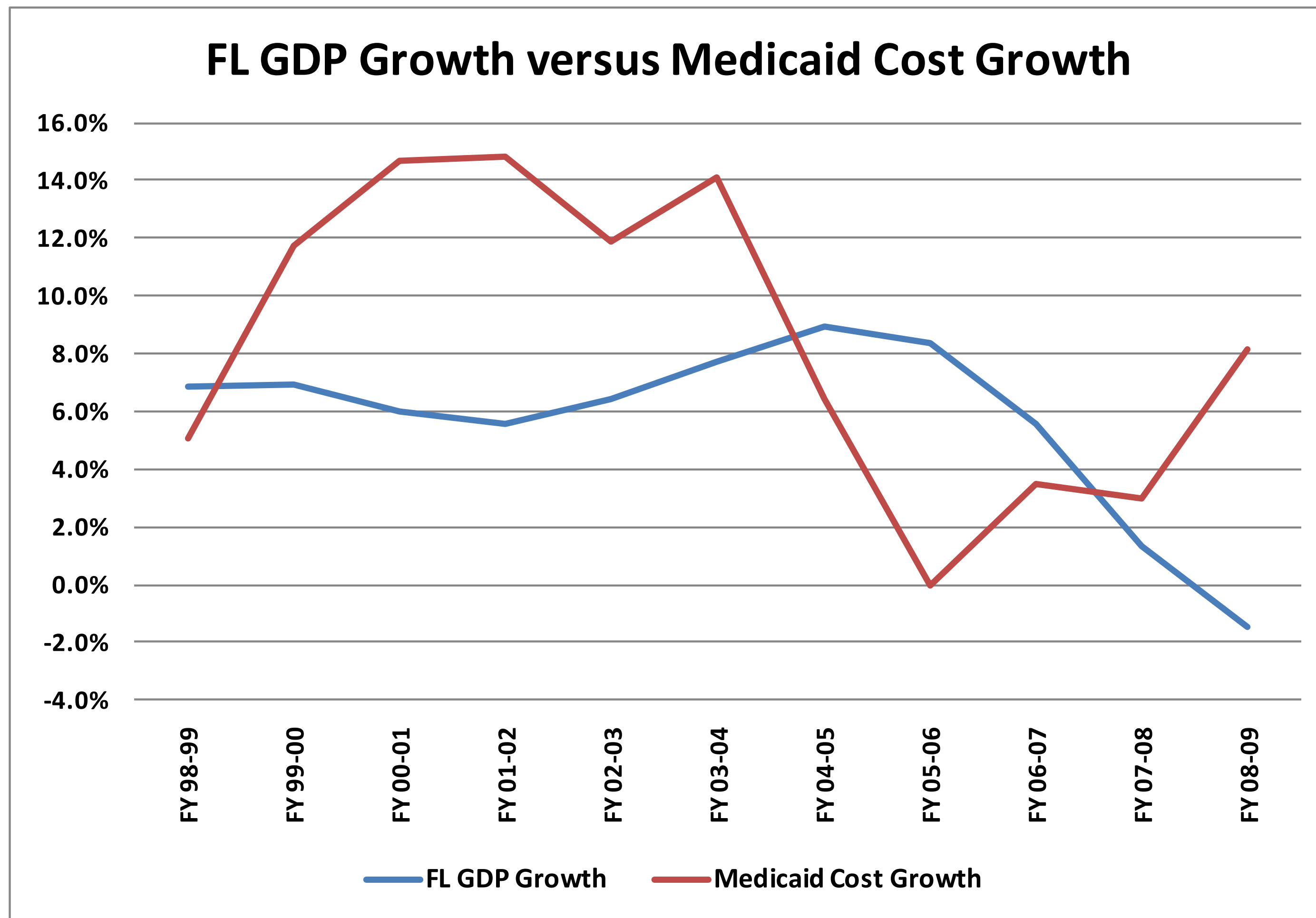
Presented by:

The Florida Legislature
Office of Economic and
Demographic Research
850.487.1402
http://edr.state.fl.us

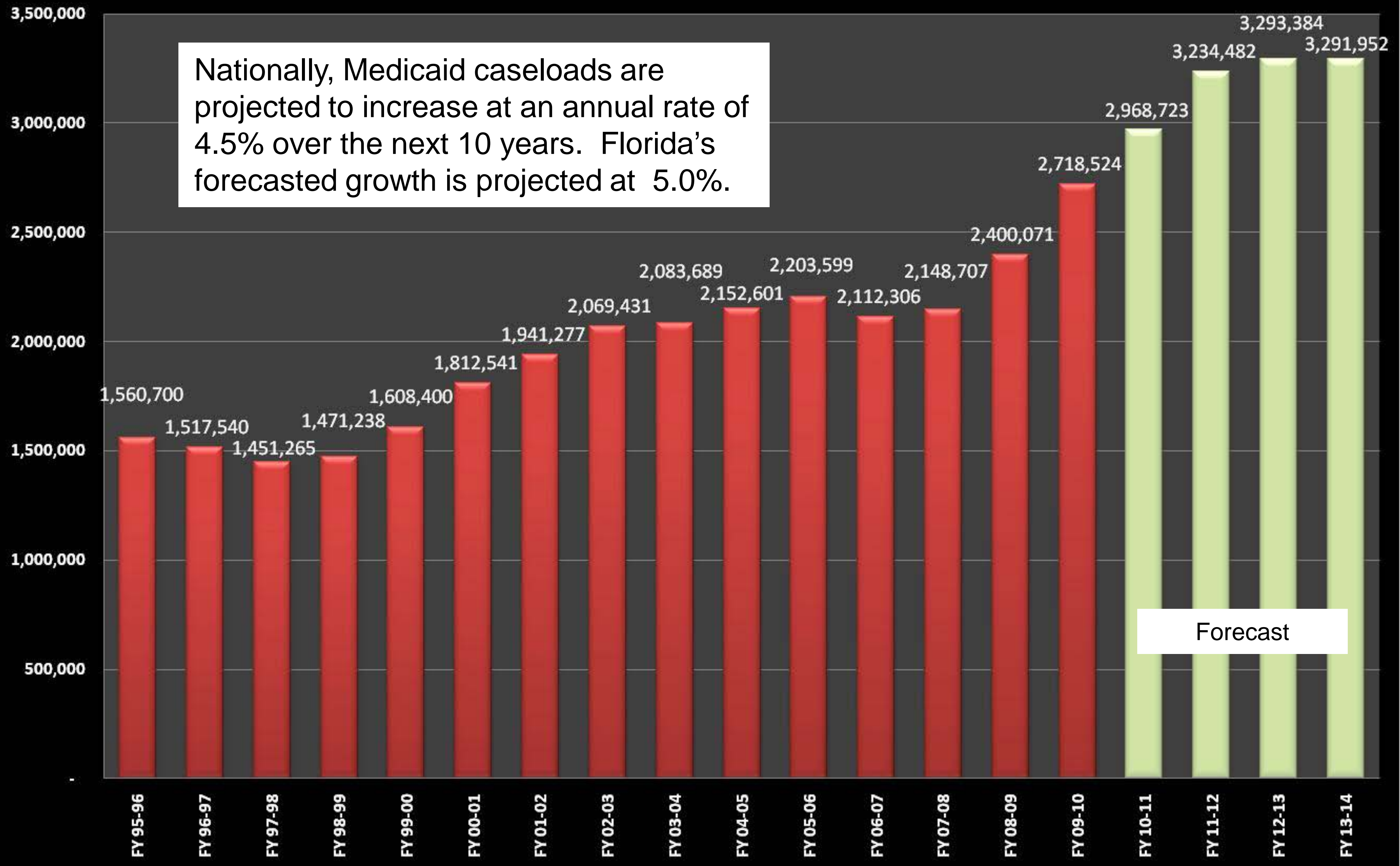
Medicaid Program...

- Medicaid is a means-tested entitlement program that provides health care assistance to certain low-income and disabled persons. It is jointly funded by the federal government and the states.
- The federal government pays a share of each state's Medicaid costs; states must contribute the remaining portion in order to qualify for federal funds.
- Nationally, Medicaid costs (state and federal) represented 2.7% of GDP in 2009. In Florida, this percentage was about 2.4%. Medicaid spending is projected to increase faster than the economy as a whole.
- While much of Medicaid's historical expenditure growth on the national level has been due to expansions of eligibility criteria, the per enrollee costs for Medicaid have also increased significantly faster than per capita GDP.

Countercyclical Pattern...



Medicaid growth accelerates in response to economic downturns and slows in times of economic strength, but generally grows faster than the economy.



Medicaid Caseload
Nationally, Medicaid caseloads are projected to increase at an annual rate of 4.5% over the next 10 years. Florida's forecasted growth is projected at 5.0%.
3,500,000
3,000,000
2,500,000
2,000,000
1,500,000
1,000,000
500,000
-
1,560,700
1,517,540
1,451,265
1,471,238
1,608,400
1,812,541
1,941,277
2,069,431
2,083,689
2,152,601
2,203,599
2,112,306
2,148,707
2,400,071
2,718,524
2,968,723
3,234,482
3,293,384
3,291,952
Forecast
FY 95-96
FY 96-97
FY 97-98
FY 98-99
FY 99-00
FY 00-01
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
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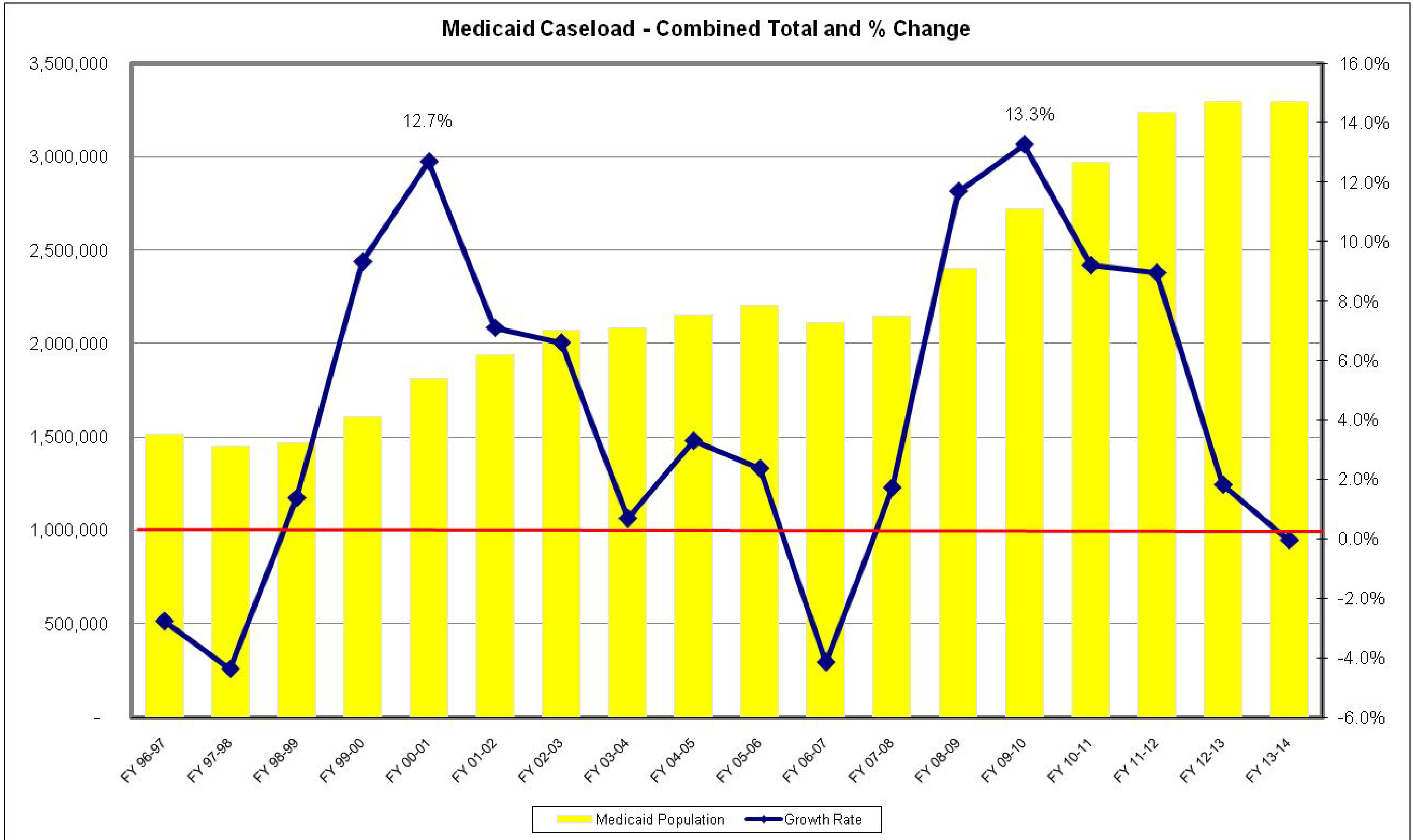
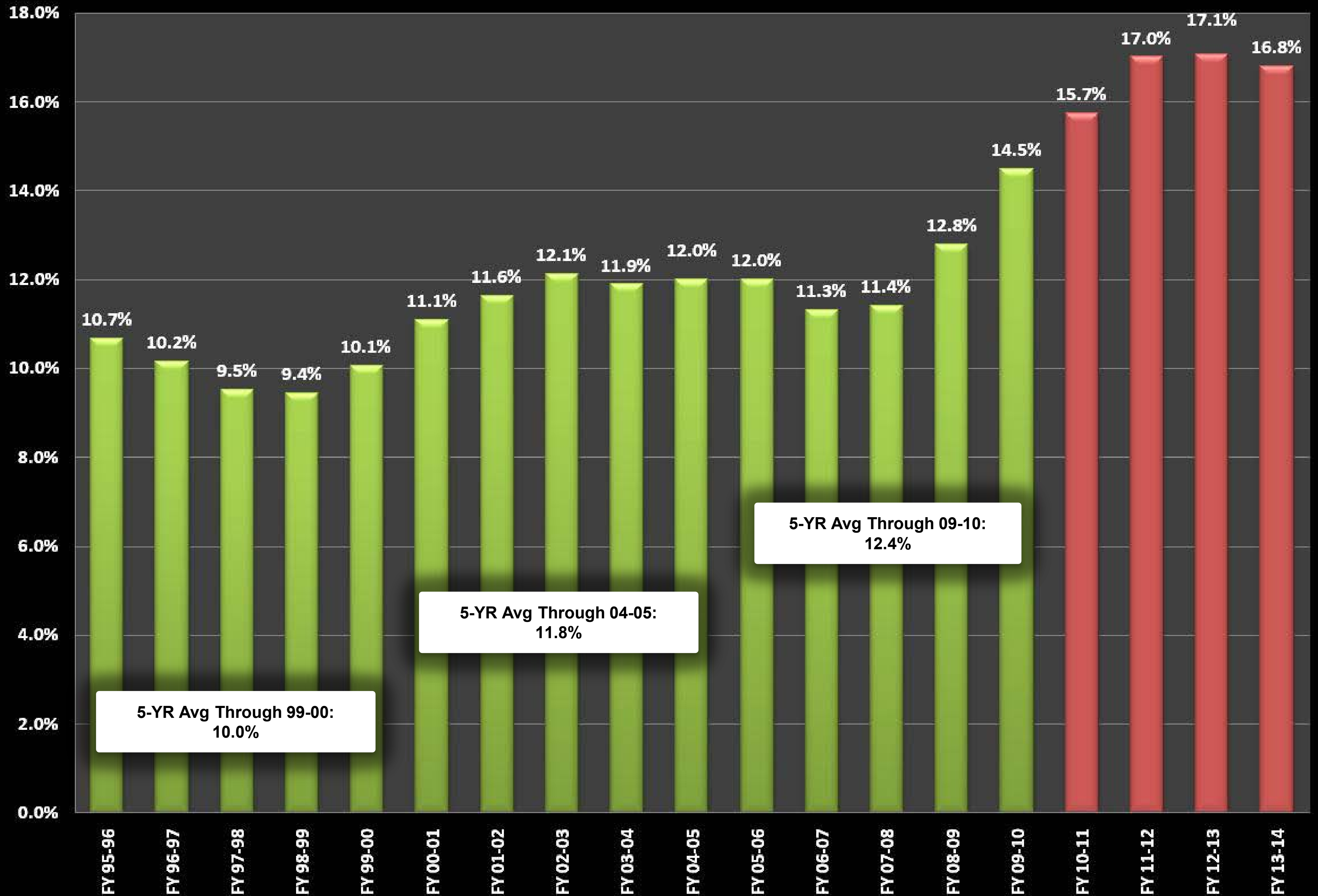
FY 10-11
FY 11-12
FY 12-13
FY 13-14

Recession Pattern to Growth





Medicaid Caseload as Share of State Population
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
10.7%
10.2%
9.5%
9.4%
10.1%
11.1%
11.6%
12.1%
11.9%
12.0%
12.0%
11.3%
11.4%
12.8%
14.5%
15.7%
17.0%
17.1%
16.8%
5-YR Avg Through 99-00:
10.0%
5-YR Avg Through 04-05:
11.8%
5-YR Avg Through 09-10:
12.4%
FY 95-96
FY 96-97
FY 97-98
FY 98-99
FY 99-00
FY 00-01
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
FY 06-07
FY 07-08
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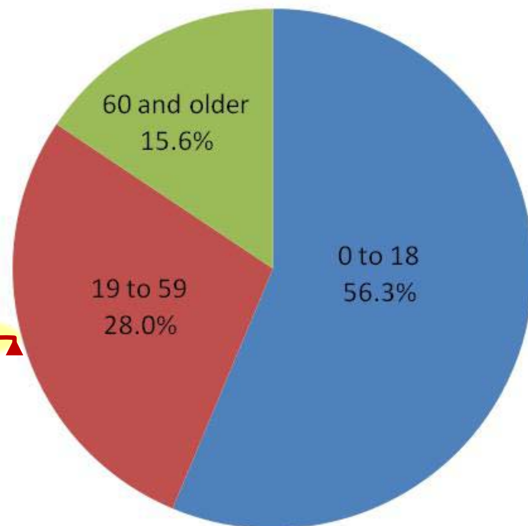
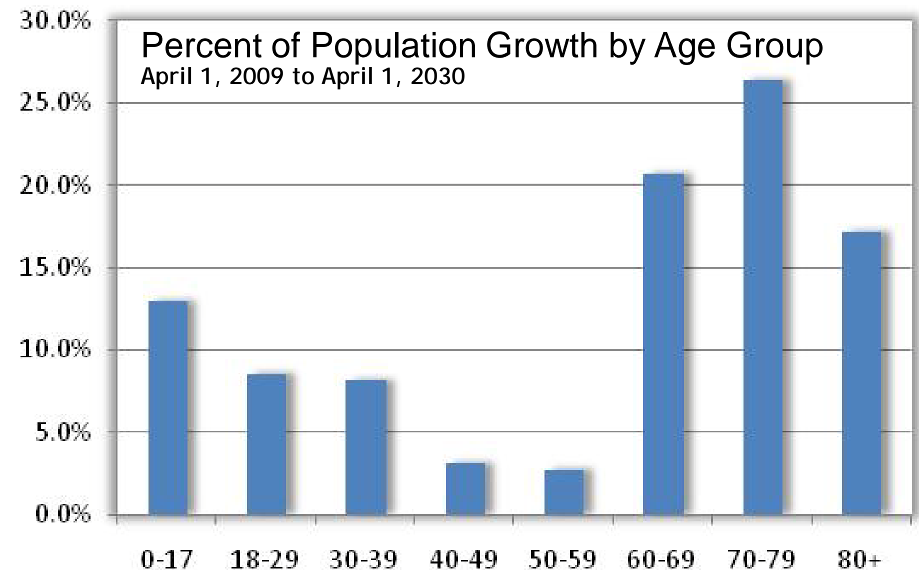
FY 12-13
FY 13-14

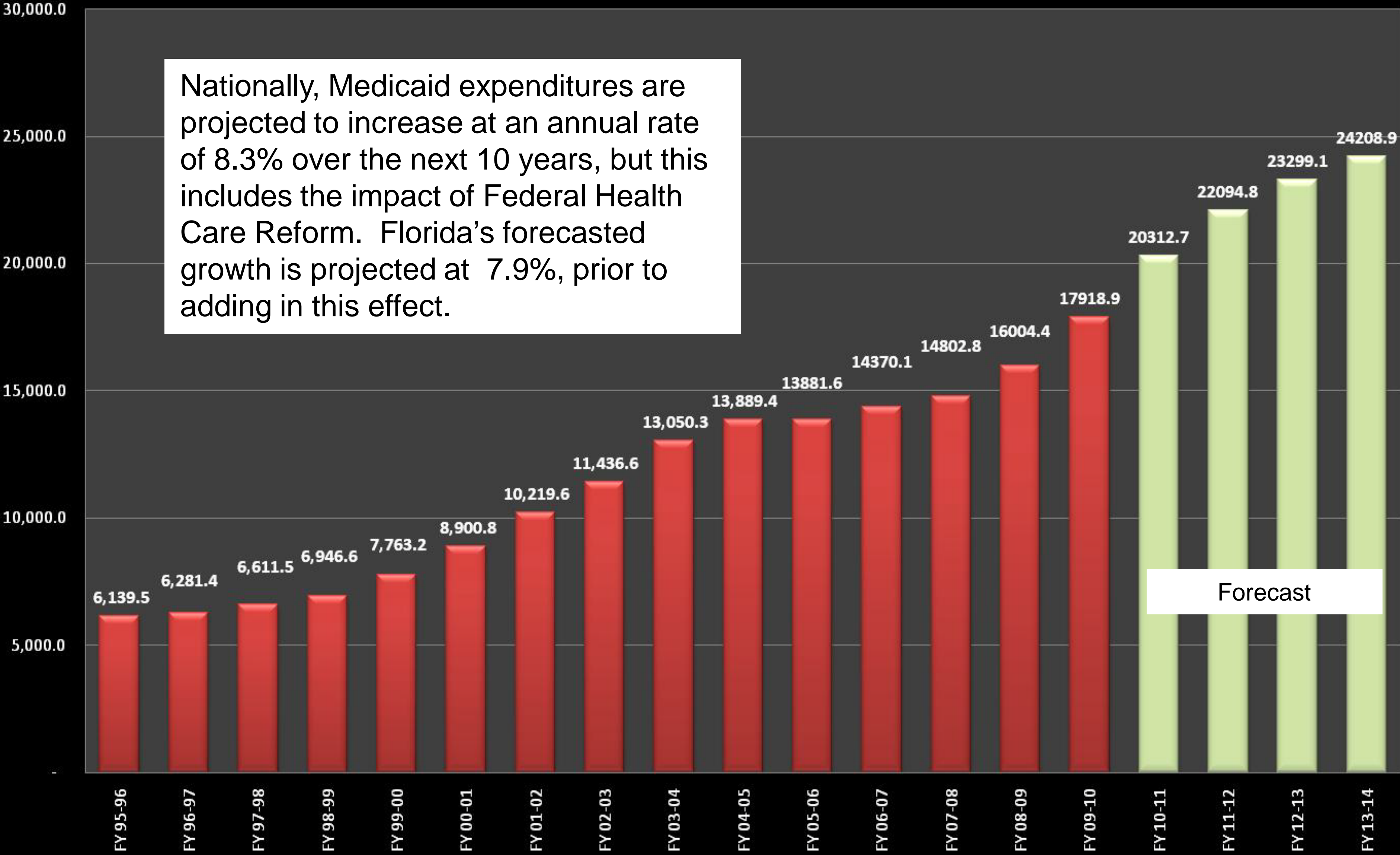
Caseload Composition by Age...



Aging Baby Boomers will exert additional pressure on Medicaid over time. Lower standard of living could become the norm for some, especially for those seniors living on fixed incomes for 20 or more years, and the estimated one-third of boomers with limited retirement assets (mainly single women).



Examples:
* Disabled
* Pregnant Women
* TANF Recipients; Families with an Incapacitated Parent
* Mothers Receiving Family Planning Svcs


Medicaid Expenditures ($ millions)
Nationally, Medicaid expenditures are projected to increase at an annual rate of 8.3% over the next 10 years, but this includes the impact of Federal Health Care Reform. Florida's forecasted growth is projected at 7.9%, prior to adding in this effect.
Forecast
30,000.0
25,000.0
20,000.0
15,000.0
10,000.0
5,000.0
-
6,139.5
6,281.4
6,611.5
6,946.6
7,763.2
8,900.8
10,219.6
11,436.6
13,050.3
13,889.4
13881.6
14370.1
14802.8
16004.4
17918.9
20312.7
22094.8
23299.1
24208.9
FY 95-96
FY 96-97
FY 97-98
FY 98-99
FY 99-00
FY 00-01
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
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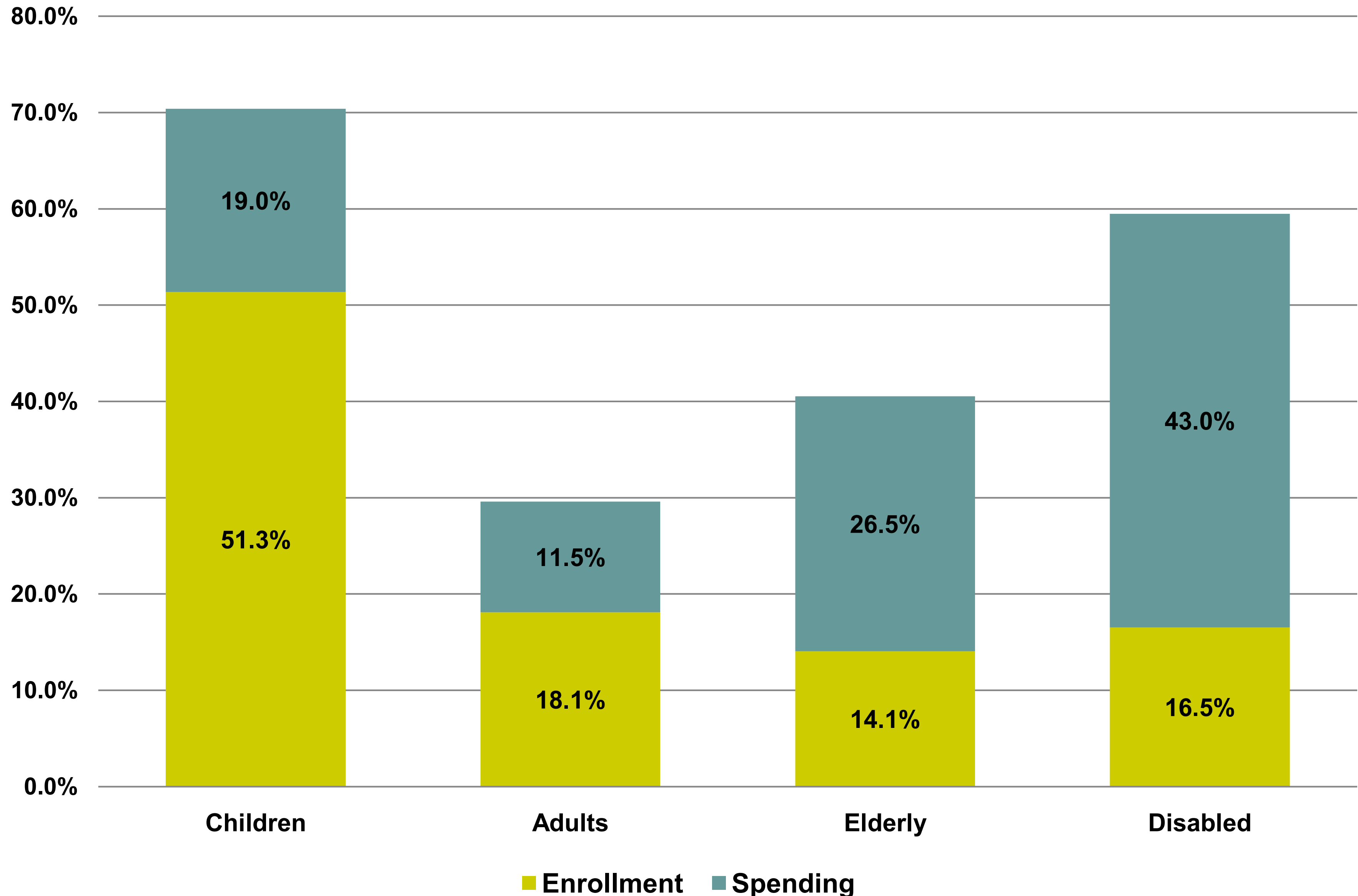
FY 13-14

Spending Needs Vary Across Groups

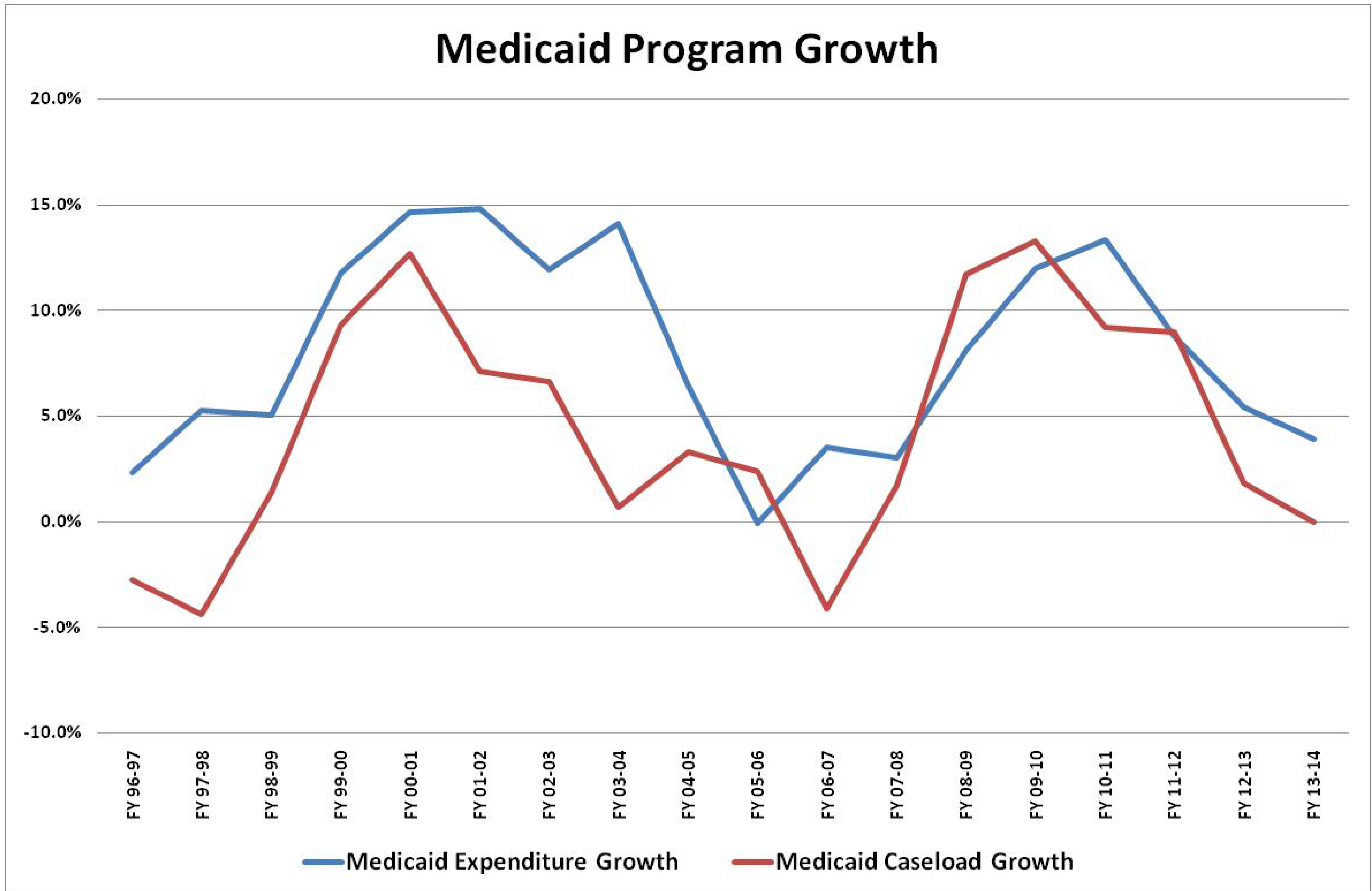


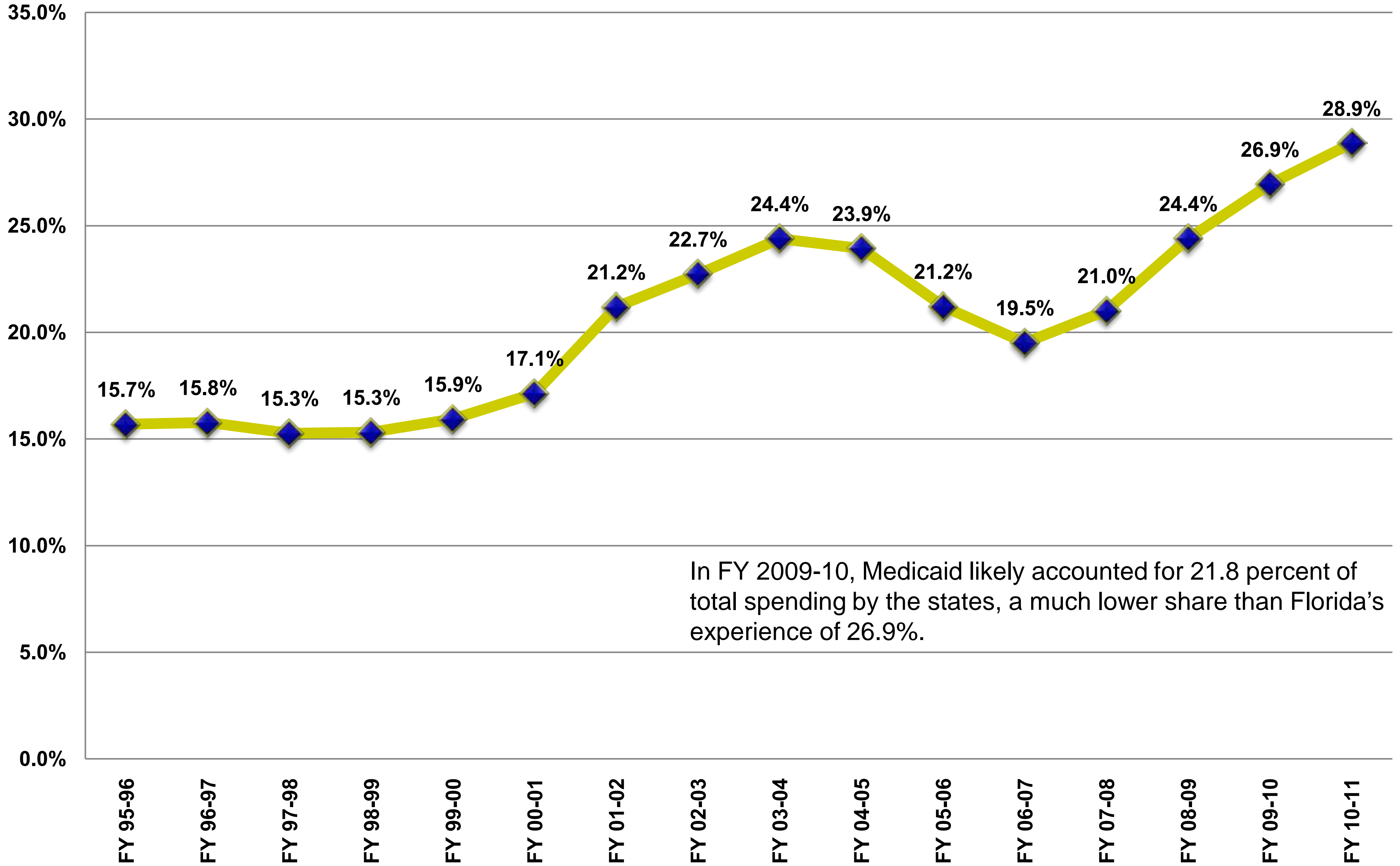
State Cost Comparison...

Federal Fiscal Year 2007 Medicaid Spending Per Enrollee

State	Children	Adults	Elderly	Disabled	Total
National Average	$ 2,135	$ 2,541	$ 12,499	$ 14,481	$ 5,163
California	$ 1,445	$ 969	$ 9,467	$ 14,437	$ 3,168
Florida	$ 1,665	$ 2,854	$ 8,449	$ 11,677	$ 4,487
Georgia	$ 2,000	$ 3,773	$ 7,254	$ 9,065	$ 3,892
Illinois	$ 2,602	$ 3,242	$ 9,567	$ 18,386	$ 5,386
Michigan	$ 1,622	$ 3,036	$ 16,762	$ 11,521	$ 4,660
New York	$ 2,344	$ 3,897	$ 22,159	$ 28,223	$ 8,450
North Carolina	$ 2,525	$ 3,466	$ 9,758	$ 14,935	$ 5,668
Ohio	$ 1,672	$ 2,844	$ 18,087	$ 15,674	$ 5,781
Pennsylvania	$ 2,656	$ 3,414	$ 20,702	$ 12,266	$ 7,159
Texas	$ 2,400	$ 3,185	$ 8,437	$ 13,572	$ 4,555
Out of All 50 States...					
Florida Rank	45	32	45	39	42
Percent of National Average...					
Florida %	78.0%	112.3%	67.6%	80.6%	86.9%

Expenditures Grow Faster Than Caseloads




Historical Medicaid Expenditures as Share of Total State Budget
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
15.7%
15.8%
15.3%
15.3%
15.9%
17.1%
21.2%
22.7%
24.4%
23.9%
21.2%
19.5%
21.0%
24.4%
26.9%
28.9%
FY 95-96
FY 96-97
FY 97-98
FY 98-99
FY 99-00
FY 00-01
FY 01-02
FY 02-03
FY 03-04
FY 04-05
FY 05-06
FY 06-07
FY 07-08
FY 08-09
FY 09-10
FY 10-11
In FY 2009-10, Medicaid likely accounted for 21.8 percent of total spending by the states, a much lower share than Florida's experience of 26.9%.

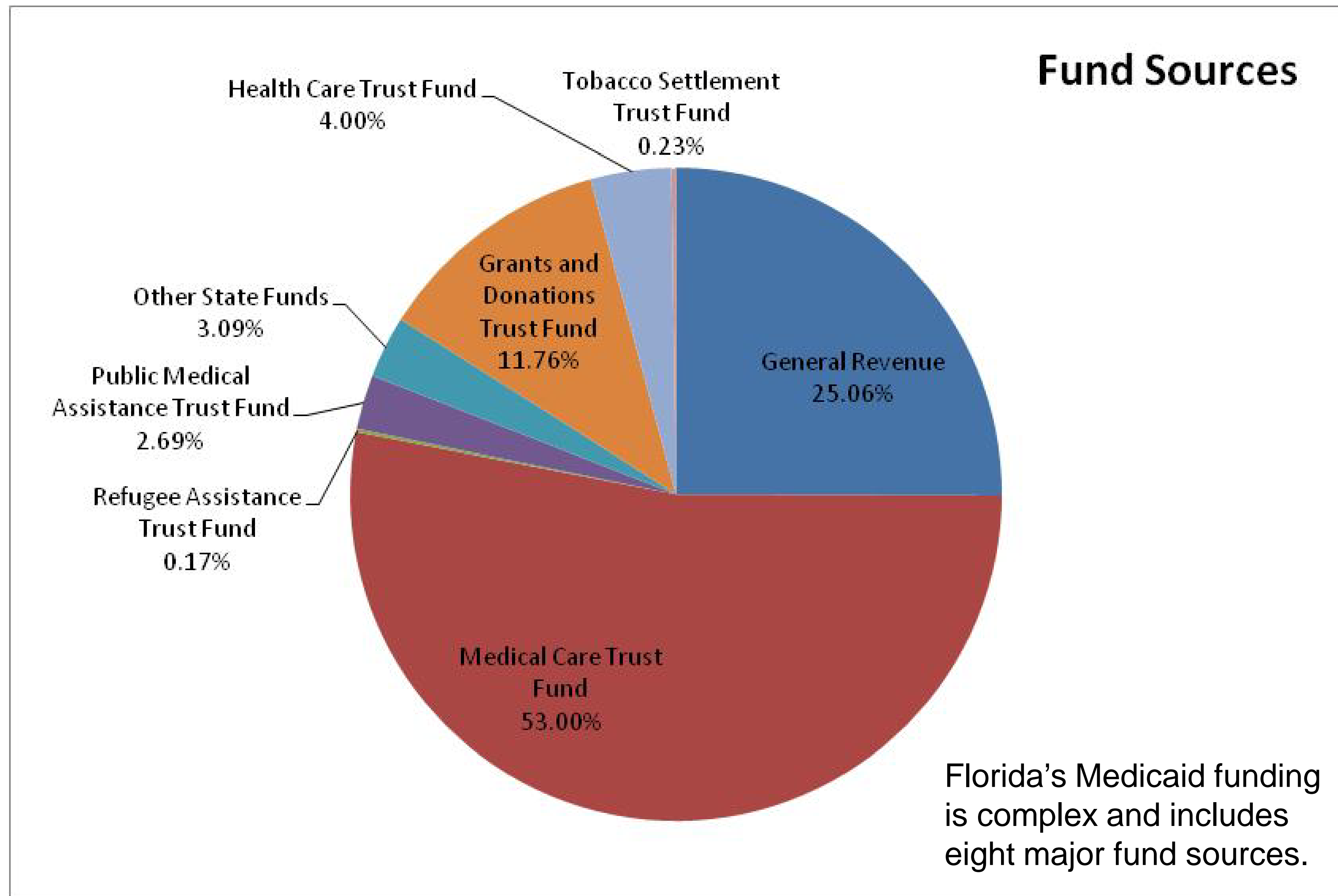
Decomposing the FY 2011-12 Estimate

($ millions)	TOTAL	GR
FY 2010-11 Appropriation Base	18,518.6	3,441.1
FY 2011-12 Estimate	22,094.9	5,536.8
Difference	(3,576.3)	(2,095.7)

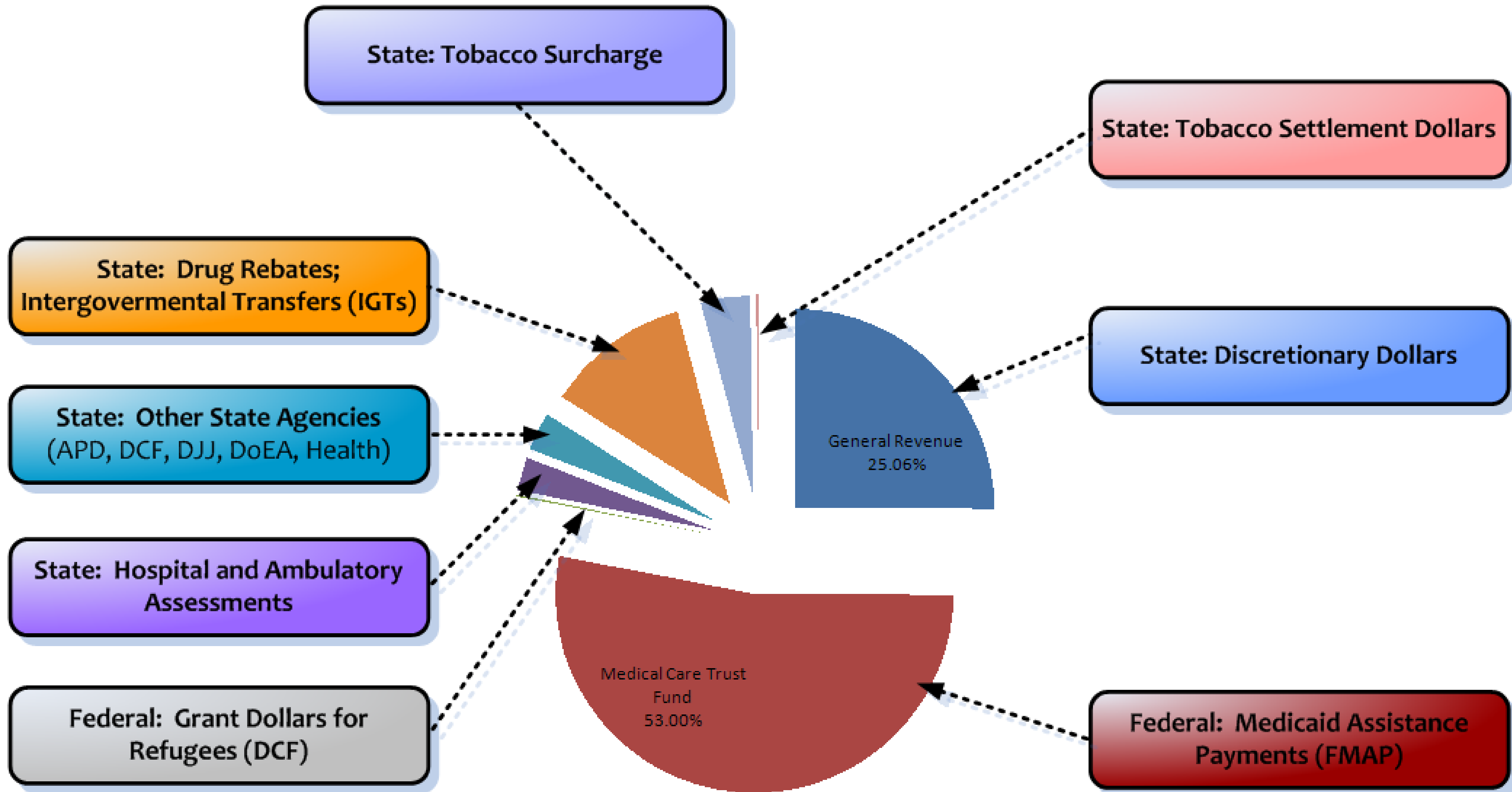
Of the Total…	TOTAL	% of Total Estimate	GR	% of Total Estimate
Medically Needy	$1,448,157,776	6.6%	$605,705,261	10.9%
MEDS AD	$982,917,425	4.4%	$420,441,615	7.6%

Type of Change…	TOTAL	% of Total Change	GR	% of Total Change
Caseload	$1,270,678,240	35.5%	$241,857,698	11.5%
Price Level	$605,047,808	16.9%	$187,699,076	9.0%
Utilization	$1,700,678,052	47.6%	$307,557,820	14.7%
FMAP Change	$0	0.0%	$1,358,658,617	64.8%
Total	$ 3,576,404,100	100%	$ 2,095,773,211	100%

All Sources for FY 2011-12...



Funding Source Detail...



Federal Medical Assistance Percentage

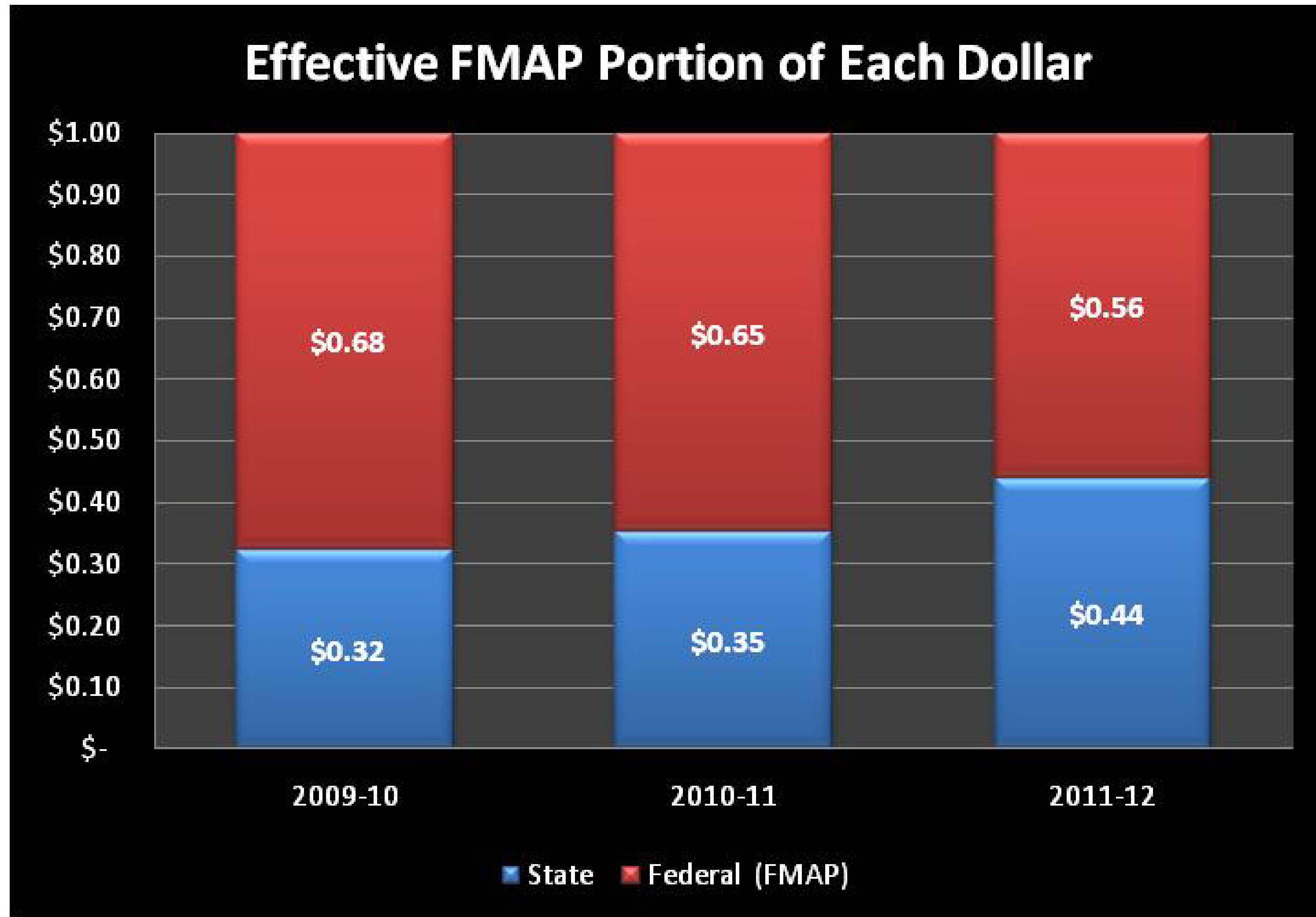
- The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal share, or state share.

- Generally determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes than the national average. The key metrics are Florida personal income and population compared to the nation as a whole.

- For Federal Fiscal Year 2011, regular FMAPs—that is, excluding the impact of a temporary increase—range from 50.00% to 74.73%.

- As a result of the American Recovery and Reinvestment Act and its extension, states received a temporary FMAP increase from October 1, 2008 through June 30, 2011.

Shares...



Under ARRA, all states received a temporary increase (through June 30, 2011) in their FMAP as well as additional amounts for the states facing the highest unemployment rates.

Grants & Donations Trust Fund

	2010-11	2011-12	Difference	% Increase
Estimated Expenditures to Maintain Share:	$2,214.0	$2,598.4	**$384.4**	
Revenue Sources:				
IGTs for LIP, DSH, Buybacks, Exemptions	$1,444.2	$1,801.2	$357.0	24.7%
Drug Rebates	$750.7	$778.2	$27.4	3.7%
Overpayments, Fraud and Recoupment	$19.1	$19.0		
	$0.0	$0.0	$0.0	

1) The Medicaid Program will effectively need an additional $357 million in IGTs to make the Grants & Donations portion of the new 2011-12 estimate funded. If this is not possible, policy makers will have to make decisions regarding rate adjustments which are currently supported by IGTs or backfilling the hole with General Revenue or other similar strategies.

2) Because it is based on (and intertwined with) the current Medicaid structure, the IGT component will be one of the more challenging financial pieces to address under Medicaid Reform.

Stimulus Adjustment

- The Legislature originally budgeted General Revenue dollars for FY 2010-11 with the understanding that the enhanced FMAP would be removed on December 31, 2010.

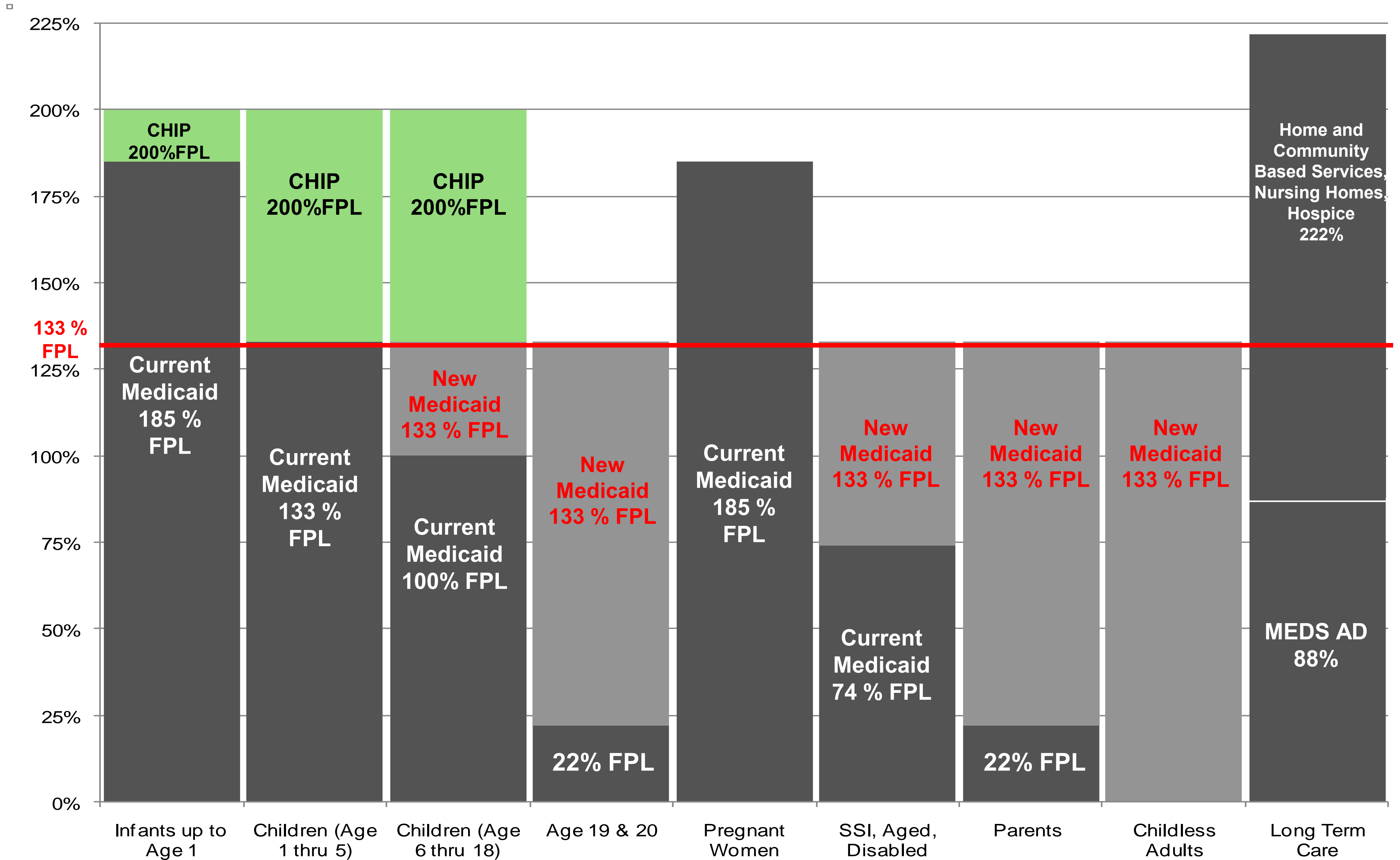
- Congress subsequently extended the enhanced rate on a declining basis through June 30, 2011. This means that fewer General Revenue dollars are needed than originally anticipated.

- The Long-Range Financial Outlook assumed that the $606.2 million benefit would be available to fund the Medicaid Program in 2011-12 by offsetting the need for additional General Revenue.

- The revised estimate increases the need this year, effectively reducing the projected benefit next year to $437.2 million ($387.1 million attributable to AHCA and $50.1 million attributable to other agencies). This is a loss to the available funds for FY 2011-12 of $169.0 million, requiring replacement by General Revenue.

Current and Future Medicaid / CHIP Eligibility Levels

(Graphic Prepared by the Agency for Health Care Administration)



Federal Health Care Reform – Preliminary Cost

		Total: Impact of Enrollment and FMAP Changes to Title XIX and Title XXI	*Total: Impact of Increased Rates for Primary Care Practitioners*	*Grand Total All Elements*
SFY 2013-2014	State Cost	$158,879,693	$0	$158,879,693
	Total Cost	$1,674,253,547	$519,188,723	$2,193,442,270
	Enrollment	431,381	n/a	431,381
SFY 2014-2015	State Cost	$509,498,895	$209,399,938	$718,898,833
	Total Cost	$5,462,729,535	$1,114,644,276	$6,577,373,811
	Enrollment	1,401,985	n/a	1,401,985
SFY 2015-2016	State Cost	$627,310,272	$426,559,810	$1,053,870,082
	Total Cost	$7,999,513,146	$1,208,844,864	$9,208,358,010
	Enrollment	2,049,055	n/a	2,049,055
SFY 2016-2017	State Cost	$789,272,387	$434,247,793	$1,223,520,180
	Total Cost	$8,420,587,344	$1,224,594,921	$9,645,182,265
	Enrollment	2,156,899	n/a	2,156,899
SFY 2017-2018	State Cost	$987,670,312	$441,957,526	$1,429,627,838
	Total Cost	$8,418,454,530	$1,212,437,860	$9,630,892,390
	Enrollment	2,156,899	n/a	2,156,899
SFY 2018-2019	State Cost	$1,054,293,927	$444,625,186	$1,498,919,113
	Total Cost	$8,416,211,946	$1,210,496,389	$9,626,708,335
	Enrollment	2,156,899	n/a	2,156,899

Graphic prepared by the Agency for Health Care Administration.

TANF

- The caseload forecast was only marginally changed from the current estimate. For the families with an adult and families with an unemployed parent groups, the forecasts assumes falling caseloads beginning in FY 2012-13 as the economy improves.

	Relative Caregiver	Child only Cases	Families with adult	Unemployed Parent	Total Caseloads
FY 2009-10	19,449	18,083	17,863	3,000	58,395
FY 2010-11	18,852	18,145	18,145	2,832	57,973
FY 2011-12	18,852	18,145	18,237	2,765	57,999
FY 2012-13	18,852	18,145	17,082	2,369	56,448
FY 2013-14	18,852	18,145	15,012	1,841	53,850

- With regard to expenditures, the new forecast for the current year is higher than the forecast adopted last August by $0.6 million ($23.1 million less than the appropriation). Total expenditures for assistance payments are now estimated to be $188.0 million this fiscal year. For FY 2011-12, expenditures will be essentially flat at an estimated $187.6 million (-0.2%), a reduction of $23.5 million from the current year appropriation of $211.1 million.

KidCare

- Caseload projections under the new forecast are slightly lower than the estimates adopted last July. Upward revisions in the Children's Medical Services caseload projections were more than offset by downward revisions to Healthy Kids and Medikids caseloads.

KIDCARE ENROLLMENT PROJECTIONS – November, 2010

	FY09-10	FY10-11	FY11-12	FY12-13	FY13-14
HEALTHY KIDS – Title XXI	189,113	205,667	222,325	238,034	251,264
HEALTHY KIDS – non-Title XXI	18,611	19,581	19,974	20,538	21,114
MEDIKIDS	28,728	34,937	40,384	43,977	46,212
CMS	22,672	23,386	24,750	26,250	27,750
TOTAL	259,124	283,571	307,433	328,799	346,340

- For the current fiscal year the program is projected to end the year with a General Revenue surplus of $5.1 million. For FY 2011-12, the projected expenditures for General Revenue are $12.7 million greater than the current year appropriation, but this revised amount is $9.9 million less than expected in July.

Lee Memorial Health System
Lee County, Florida
Summary of Employee Health Plan

Background of Jon Cecil

Jon Cecil is the Chief Human Resources Officer for Lee Memorial Health System. Employed with Lee Memorial Health System since 1972, Jon is responsible for the overall planning, development, implementation and operations of the comprehensive Human Resources functions for the System.

Jon is a Fellow in the American College of Healthcare Executives - Certified Healthcare Executive (CHE); a member of the Voluntary Hospital Association Southeast - Human Resources Executive Council; American Society for Healthcare Human Resources; Florida Society for Healthcare Human Resources; and Society for Human Resources Management. He participates on a number of national, state and local committees and task forces related to Human Resources.

Lee Memorial Health System Employee Health Plan

Focusing on quality, access and cost, Lee Memorial Health System manages our employee health plan through the annual analysis of data. By clearly defining our top risks—including stress, cardiovascular issues, diabetes and obesity—we are able to create programs and a health plan that serve our employees and their dependents, while targeting preventive care. Preventive care and maintaining employee wellness is crucial for cost-savings.

As the largest employer in Southwest Florida, Lee Memorial Health System employs more than 9,500 health care and support personnel. We also are the largest public health system in the state of Florida without taxing authority or any local tax revenue. In addition, we are the 7th largest public health system in the United States. We are recognized as an employer of choice, and we believe our benefit program is fundamental to attracting and retaining the highest quality staff to serve our community.

In 2009, we updated our health plan to drive higher utilization of our health system's services and technology—we now have 99 percent utilization of our services for in-network care—in order to control quality of care, as well as cost. Again, with a focus on preventive medicine to reduce catastrophic illnesses, we offer our employees:

- Lab work – standard lab work is free of charge
- Annual physical – formerly a $25 co-pay, in 2011 is now offered free of charge
- Diagnostic procedures – discounted rate for employees
- Mail order pharmacy which offers a number of generic prescriptions for chronic illnesses free of charge for 90-day supplies
- Pre-diabetes, diabetes, weight management and smoking cessation courses and tools
- Employee Wellness Program
- Optional vision and dental plans are available for additional cost

We have found that 15 percent of our employees and dependents account for 85 percent of our annual health plan expense.

The cost per employee or family for coverage on our health plan is tiered—full-time, part-time, tobacco use, tobacco free and salary range. While the employees' share of health care costs has risen 14 percent nationally over the last year as shown in the recent Kaiser study, the costs for our employees only rose between $2 and $10 per pay period. Additionally, the annual cost of our mid-tier, tobacco free family plan totals $3,004 in out-of-pocket expenses compared to the $12,000 out-of-pocket expenses found in health care plans elsewhere in our area.

In 2011, we added the Employee Wellness Program, which empowers our employees to take a more active role in their health through:

- A Wellness Report Card. Created after lab work is completed, this report explains the lab work and highlights any risk factors.
- On-site Wellness Coaches, who are available to help employees create action plans to tackle any health issues.
- Healthy Bucks, which is a VISA debit card loaded with $150 that can be used toward membership at our Wellness Centers, healthy food options in our cafeterias or a number of other programs. To qualify, employees must complete their annual wellness physical with a physician. Employees are encouraged to develop wellness plans with their primary care physician.
- Ongoing support, which helps our employees achieve success in their health care goals and manage high blood pressure, diabetes or any other chronic health issues.
- Lee Memorial Health System has two Wellness Centers with discounted rates for employees.
- Our Employee Assistance Program—counseling services—work in conjunction with our Wellness Coaches to better assist our employees with behavior modification focused on their health goals. Stress management is one of the key focuses.

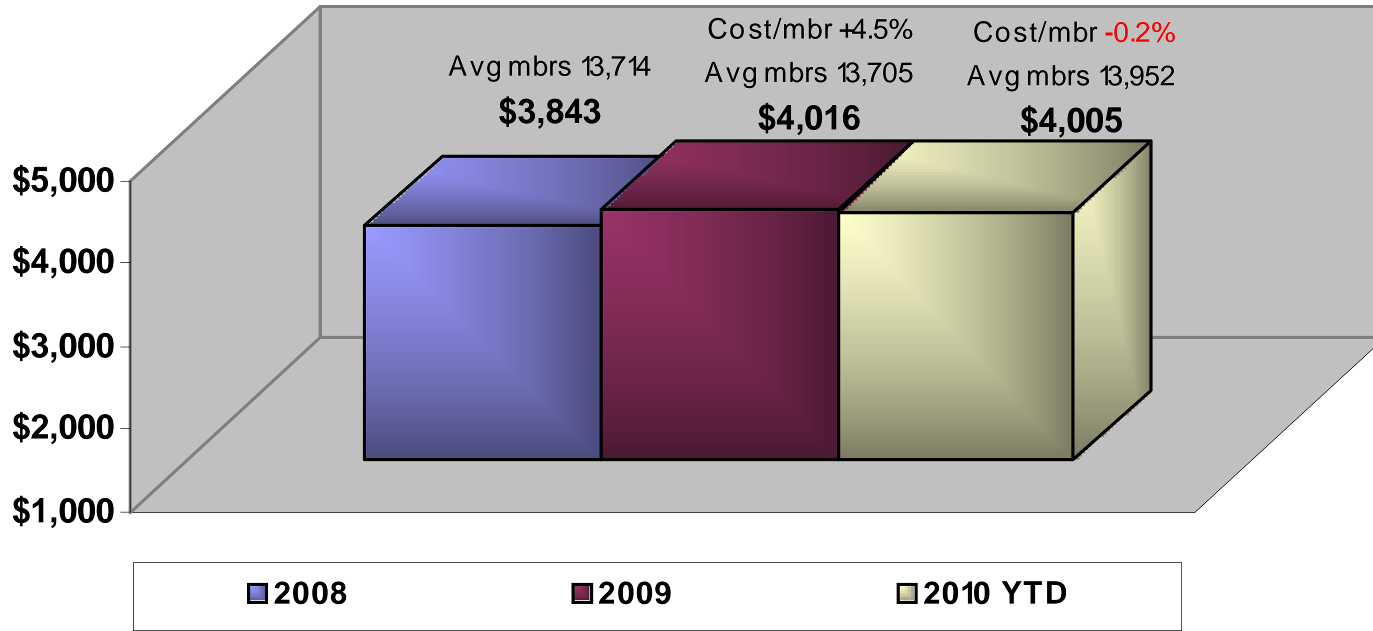
To further combat the increasing cost of health care, especially costly Emergency Department visits, we provide immediate and free access to care through our Employee Health Clinics. Located in each of our hospital facilities, our Clinics are staffed with Nurse Practitioners (ARNPs) who work, under physician supervision, to diagnose, treat and prescribe medication to our employees. The cost-saving benefits of our Clinics extend throughout our health system and our community.

- Early intervention and care prevents the exacerbation of ailments, and costly trips to the ED or a hospital admission
- Employees can get care immediately without having to take paid time off to tend to their illness. For example, a nurse who contracts conjunctivitis can immediately visit the Employee Health Clinic to start treatment, leave with their prescription drugs at no charge and return to work usually the next day after diagnosis. In the past, employees may have to be out 3 or more days and use their paid time off
- The health system is able to provide less interrupted care to our community; costs are saved by not having to cover staff with more expensive replacements
- Having detected potential heart attacks and strokes, multiple cases of breast cancer and other serious health issues, our Employee Health Clinics have saved lives through immediate care. In many cases, employees were not aware of their chronic physical condition when they came to the clinic for minor illnesses
- Access to our Clinics is now available to organizations in our community

We use a Third Party Administration firm to adjudicate claims, but we manage our plan internally through a Health Plan Committee in order to keep our focus on our employees and our risks. The Committee closely manages the claims processing and service, reviews aggregate data and recommends plan design changes each year. They assure the excellent quality, access and affordable cost to our employees and their families while being stewards of our health system's resources.

By practicing preventive care and offering our employees easy access to care, our health care costs per member per year did not increase this year. We kept our costs stable without reducing the benefits to our employees. In fact, we believe our benefits plan is more comprehensive and focused on the health and well-being of our employees so that we have healthy caring employees caring for our patients.

Net Medical Plan Cost History Per Member Per Year (PMPY)

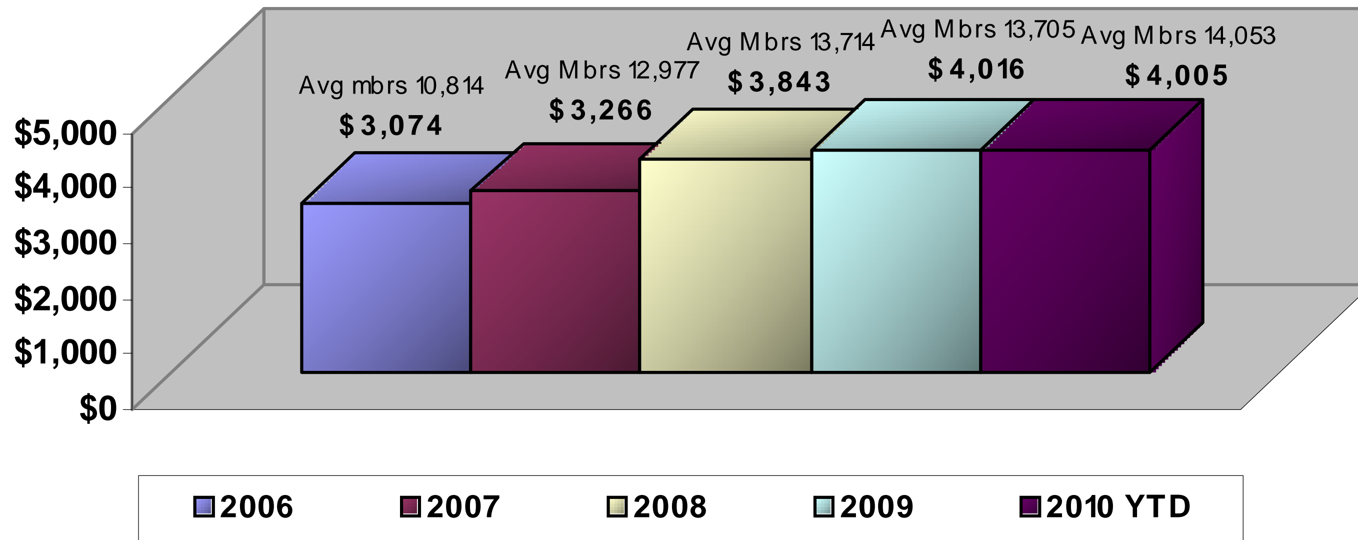


PMPY costs are not based on lagged enrollment

Net Cost = Total Cost – Specific Stop Loss Reimbursements – Employee Contributions

Calculations are based on information provided by Lee Memorial, Web-TPA, and HCC Benefits

Net Medical Plan Cost History Per Member Per Year (PMPY)



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Calculations are based on information provided by Lee Memorial, Web-TPA, and HCC Benefits

MEDICAL

HIGHLIGHTS of Medical Benefits: Refer to the Summary Plan Description at Intralee/HR Dept./Benefits for additional benefits

Service	Lee Health Plan If offered at LMHS you must use LMHS Services to be Covered
Annual Deductible	
▪For one person	$350
▪For your family	$1,050
Annual Out-of-Pocket Maximum	
▪For one person	$2,500
▪For your family	$7,500
Doctor's Office Visits	
▪Primary care	$25 Copayment
▪Well woman	$25 Copayment
▪Well adult	$25 Copayment
▪Well child	$25 Copayment
▪Specialists	$60 Copayment
Diagnostic Tests at LMHS	
▪Simple x-ray	$50.00 co-pay
▪ MRI, CAT Scan, other Diagnostics	10% after annual deductible
▪Labs	$0 copayment – free **You must use LMHS for Coverage**
Hospital Inpatient Care	
▪LMHS Facility	$100 Copayment Per Day Max $500 Per Admission
Physical / Occupational Therapy (Max. 24 visits annually)	$0 copayment for 12 visits, thereafter 10% per visit after Annual Deductible
Emergency Treatment	
▪Emergency room	10% after Annual Deductible
▪Ambulance (Not covered unless an emergency)	10% after Annual Deductible
Urgent Care	
▪Lee Convenient Care	$25 Copayment
Prescription Drugs	
Retail Pharmacy	
Generic supply •	$10 for 30-day supply
Preferred •	30% coinsurance (min. $30, max. $60) for 30 day supply
Non-Preferred	50% coinsurance (min. $60, max. $125) for 30-day supply *(must use participating pharmacies)*
LMHS Mail-Order Pharmacy •	
Generic •	$20 for 90-day supply
Preferred •	$50 for 90-day supply
Non-Preferred	$100 for 90-day supply
	Must use LMHS Services for J Code Drugs
	(1st 90-day generic drug supply is FREE. Many generic diabetic, cholesterol, and cardiovascular medications are FREE as well at the LMHS Mail Order Pharmacy.)

You must use LMHS Services for Coverage.

6 Medical Insurance

Highlights of Medical Benefits: Refer to the *Summary Plan Description* at **IntraLee/HR Dept. /Benefits** for additional benefits.

Lee Memorial Health Plan	
Service	If offered at LMHS, you must use LMHS services to be covered
Annual Deductible	
■ For one person	$350
■ For your family	$1,050
Annual Out-of-Pocket Maximum	
■ For one person	$2,500
■ For your family	$7,500
Doctor's Office Visits	
■ Primary care	$25 copay
■ Wellness visit	Employee wellness visit as specified in Plan SPD covered without copay once in a plan year.
■ Specialists	$60 copay *The employee wellness visit is an added benefit this year at no cost to the employee. See the details of what is included in this visit inside the front pocket of this booklet.*
Diagnostic Tests at LMHS	
■ Simple X-ray	$50 copay
■ MRI, CAT scan, other diagnostics	10% after annual deductible *You must use LMHS services for an MRI, CAT scan or other service*
■ Labs	$0 copay *You must use LMHS for lab coverage* *Be sure your provider sends any lab specimens to the LMHS lab.*
Hospital Inpatient Care	
■ LMHS facility	$100 copay per day Max $500 per admission
Physical/Occupational Therapy (Max. 24 visits annually)	$0 copay for 12 visits; thereafter, 10% per visit after annual deductible
Emergency Treatment	
■ Emergency room	10% after annual deductible
■ Ambulance (not covered unless an emergency)	10% after annual deductible
Urgent Care	
■ Lee Convenient Care	$25 copay
Prescription Drugs Retail Pharmacy	
■ Generic supply	$10 for 30-day supply
■ Preferred	30% coinsurance (min. $30, max. $60) for 30-day supply
■ Non-preferred	50% coinsurance (min. $60, max. $125) for 30-day supply *(must use participating pharmacies)*
LMHS Mail-Order Pharmacy	
■ Generic	$20 for 90-day supply
■ Preferred	$50 for 90-day supply
■ Non-preferred	$100 for 90-day supply *Must use LMHS services for J Code Drugs* **(First 90-day generic drug supply is FREE. Many generic diabetic, cholesterol, and cardiovascular medications are FREE, as well at the LMHS Mail-Order Pharmacy.)*

proof 2

LEE MEMORIAL
HEALTH SYSTEM

2010 EMPLOYEE BI-WEEKLY PREMIUMS

Bi-weekly Premiums	2010 Tier 1	2010 Tier 2	2010 Tier 3
	$30k	*$75k*	*$75K or More*
Lee Health Plan – FT	**Tobacco - Free**		
Employee Only	$23.01	$33.00	$42.90
Employee + Children	$32.33	$46.20	$64.35
Employee + Spouse	$57.79	$72.60	$91.52
Employee + Spouse*	$107.79	$122.60	$141.52
Employee + Family	$69.30	$84.48	$107.25
Employee + Family*	$119.30	$134.48	$157.25
* Includes $50 charge for spouses with access to coverage thru their employer.			
Lee Health Plan- PT	**Tobacco - Free**		
Employee Only	$46.04	$66.00	$85.80
Employee + Children	$57.75	$79.20	$100.10
Employee + Spouse	$92.40	$118.80	$143.00
Employee + Spouse*	$142.40	$168.80	$193.00
Employee + Family	$115.50	$145.20	$171.60
Employee + Family*	$165.50	$195.20	$221.60
* Includes $50 charge for spouses with access to coverage thru their employer.			
Lee Health Plan – FT	**Tobacco - User ***		
Employee Only	$27.20	$39.00	$50.70
Employee + Children	$36.51	$52.20	$72.15
Employee + Spouse	$61.97	$78.60	$99.32
Employee + Spouse*	$111.97	$128.60	$149.32
Employee + Family	$73.48	$90.48	$115.05
Employee + Family*	$123.48	$140.48	$165.05
* Includes $50 charge for spouses with access to coverage thru their employer.			
Lee Health Plan- PT	**Tobacco - User***		
Employee Only	$54.41	$78.00	$101.40
Employee + Children	$66.12	$91.20	$115.70
Employee + Spouse	$100.77	$130.80	$158.60
Employee + Spouse*	$150.77	$180.80	$208.60
Employee + Family	$123.87	$157.20	$187.20
Employee + Family*	$173.87	$207.20	$237.20
* Includes $50 charge for spouses with access to coverage thru their employer.			

2011 LEE MEMORIAL HEALTH SYSTEMS
BENEFITS Biweekly Premiums

Lee Health Plan	Salary to $30,000	Salary $30,000 to $75,000	Salary $75,000 and up
Full Time Tobacco Free	**Biweekly Emp.**	**Biweekly Emp.**	**Biweekly Emp.**
Employee Only	$25.31	$36.30	$47.19
Employee & Children	$35.56	$50.82	$70.79
Employee & Spouse	$63.57	$79.86	$100.67
Employee & Spouse + $50.00	$113.57	$129.86	$150.67
Employee & Family	$76.23	$92.93	$117.98
Employee & Family + $50.00	$126.23	$142.93	$167.98
Full Time Tobacco User			
Employee Only	$29.92	$42.90	$55.77
Employee & Children	$40.16	$57.42	$79.37
Employee & Spouse	$68.17	$86.46	$109.25
Employee & Spouse + $50.00	$118.17	$136.46	$159.25
Employee & Family	$80.83	$99.53	$126.56
Employee & Family + $50.00	$130.83	$149.53	$176.56
Part Time Tobacco Free			
Employee Only	$50.64	$72.59	$94.38
Employee & Children	$63.53	$87.12	$110.11
Employee & Spouse	$101.64	$130.68	$157.30
Employee & Spouse + $50.00	$151.64	$180.68	$207.30
Employee & Family	$127.05	$159.72	$188.76
Employee & Family + $50.00	$177.05	$209.72	$238.76
Part Time Tobacco User			
Employee Only	$59.85	$85.80	$111.54
Employee & Children	$72.73	$100.32	$127.27
Employee & Spouse	$110.85	$143.88	$174.46
Employee & Spouse + $50.00	$160.85	$193.88	$224.46
Employee & Family	$136.26	$172.92	$205.92
Employee & Family + $50.00	$186.26	$222.92	$255.92

Healthy Bucks *from*

LEE MEMORIAL
HEALTH SYSTEM

On behalf of Lee Memorial Health System, congratulations on taking this crucial first step in building a healthier future. As an employee enrolled in the LMHS Health Plan, you have taken your first step to wellness. One of the benefits included in the LMHS Health Plan this year is a wellness exam with no copay. Inside the front cover of your Benefits Enrollment Booklet you will find a description of your wellness exam and a Lab slip to get your Lab work completed at a LMHS Lab.

As an employee of LMHS enrolled in the health plan, you get a free wellness exam.

As you begin your journey to better health, the following are the steps towards a healthier future:

Step one: is to get the Lab work completed.
Step two: is to make an appointment with your physician in our network for your wellness exam.
Step three: is to have a detailed conversation with your physician regarding your Lab work and wellness exam results.

Please note: If you prefer, as a courtesy to your physician, you can call **1-239-573-4508** and make an appointment to have your wellness exam with Sal Lacagnina D.O., our LMHS VP of Health and Wellness. Results will be sent to your physician and continuing care will be with your physician.

In addition, as a fourth step in your journey to better health, you will receive mailed confidentially to your home a Wellness Report with the results of your wellness exam to keep for your records and to use to create a Wellness Action Plan.

Once you have your exam, you can make an appointment with one of our LMHS Wellness Coaches to develop your Wellness Action Plan. To make an appointment with a Wellness Coach, just call **1-239-573-4508**. In addition, we have an on-site EAP counselor who can work in conjunction with your Wellness Coach on behavior changes to support your Wellness Action Plan. Use the same telephone number to make an appointment with an EAP counselor.

What are Healthy Bucks and How Do I Qualify?

Healthy Bucks are $150 that are loaded on a VISA card for you to use for LMHS wellness programs that have been designated as Healthy Bucks eligible programs. You qualify to receive this VISA card when you (the employee) complete your wellness exam between January 1, 2011, and December 31, 2011. After the LMHS Benefits group is notified that the exam is completed, the VISA card will be mailed to your home address. The $150 can be used for you or your family members as long as they are for LMHS designated Healthy Bucks programs.

What Can I Purchase with Healthy Bucks?

Lee Health Solutions

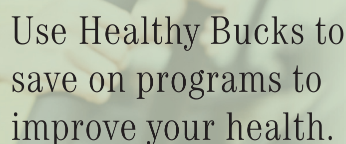
Lee Health Solutions offers a variety of programs to help you improve and maintain a healthy lifestyle. If you struggle with your weight or your inability to quit smoking or have been told you have pre-diabetes or diabetes, we can help. Our staff consists of Certified Diabetes Educators, Registered Nurses and Registered Dietitians, all with a passion to help you improve your health. Offerings include:

- Comprehensive diabetes classes available at all four LMHS campuses at convenient times
- Pre-Diabetes Counseling
- Weight Management Counseling
- Lighten-Up Lee (lunchtime weight management group sessions on site at LMHS)
- Freedom From Smoking (in partnership with the Lee Center for Rehabilitation and Wellness)

Some of these program offerings do not require Healthy Bucks for attending, as they are already covered by the LMHS health plan. You may, however use Healthy Bucks for course material and other offerings that can be paid for through our Healthy Bucks program.

For more information, please call **573-5720**.

Together, we can make a difference.



Exercise – LMHS Wellness Centers

Having trouble fitting exercise in? Healthy Bucks can be used January 1, 2011, at our Wellness Centers. Both The Wellness Center of Cape Coral and Lee Center for Rehabilitation & Wellness – Ft. Myers are offering programs and services identified as Healthy Bucks programs. Both centers are offering a 10% discount on retail value for Healthy Bucks programs.

If you make time for your favorite TV shows, how about walking on a treadmill or lifting weights while watching.

Our Wellness Centers offer a 10% discount on retail value.

1. Six months of membership at our LMHS Wellness Centers can be paid for with Healthy Bucks. Yes – six full months or you can use $33 of Healthy Bucks to pay for one month of membership. Remember, this could be for you or your family members.
2. Personal Training purchased as a package or individually in one-hour and half-hour sessions are eligible for Healthy Bucks. If you have never had a session with a personal trainer – now is the time!
3. At the Wellness Center of Cape Coral, swimming lessons as a package or private lessons are eligible for Healthy Bucks.
4. Assessments such as Body Age, Fitness, Body Composition, and specialized exercise sessions for weight management, Diabetes or Cardiac Rehab are all covered under our Healthy Bucks at both LMHS Wellness Centers.
5. Massage therapy is another covered service. Some consider this a luxury. Massage therapy can now be covered with Healthy Bucks. See the list of services at each of our LMHS Wellness Centers.
6. In addition, you may want to purchase equipment such as Yoga Mats, Yoga Bricks, Yoga Straps, Zumba Bells, Aqua Dumbbells, Health and Fitness DVDs. All are available at our Wellness Center of Cape Coral, and Healthy Bucks can be used to cover the costs.

Nutrition

Here are five great tips to help you practice good nutrition and use Healthy Bucks for services offered by our Food and Nutrition departments.

1. Keep an eye on your portions. Think about using a snack-size ziplock bag when taking food to the office or giving food to children. The snack-size bag is about right for most foods and would be considered a regular portion.
2. Eat a wide variety of foods in moderation focusing on calorie-controlled choices high in fiber, low in fat and sodium.
3. In order to make healthy eating part of your routine for you and also family members, our Food and Nutrition departments are offering items in our cafes eligible for Healthy Bucks.
4. Daily, each cafe will feature a variety of specialty selections identified for Healthy Bucks use. These choices will meet specific criteria approved by our Dietitians to be healthy meal choices.
5. In addition, Food and Nutrition will offer a service where Outpatient Dietitians provide Medical Nutrition Therapy for conditions where your physician orders special dietary restrictions such as gluten free, fat/cholesterol restrictions, lactose restrictions, etc. This service will be offered at $45 per hour. This is particularly a helpful service if you have specialized nutritional needs.

Use your Healthy Bucks for food and nutrition services.

Healthy Bucks

Everyone benefits from our new Healthy Bucks program. There is a selection in this program for you and members of your family. It also directs you to learn more about the programs currently offered at LMHS that focus on wellness. Remember, we started this with the fact that you are taking a crucial first step in a healthier future for you and your family.

By offering the programs eligible for Healthy Bucks, LMHS is investing in your future. You just need to take the basic steps mentioned in your journey to wellness.

Happy walking!

Be sure to review the detailed listing on back for services you can purchase with Healthy Bucks.

Invest in your future by using your Healthy Bucks from LMHS.

Healthy Bucks $150 VISA Credit Card

Healthy Bucks can be used for LMHS programs for yourself or your family members that focus on the following:

- Weight Management
- Stress Reduction
- Regular Exercise
- Pre-Diabetes Management
- Good Nutrition and Medical Nutrition Therapy

Services Offered for Healthy Bucks – January 1, 2011

Lee Health Solutions – The following are offered:

Pre-Diabetes Counseling – Individualized counseling with a Certified Diabetes Educator $60/hour
Lighten Up Lee – Weekly lunchtime weight management group class $5 /session
Weight Management Program – 9-month individual program (Must meet requirements) $27/materials

Food and Nutrition Services – The following are offered in the cafes:

Categories	Calories (KCal)	Fat in grams (g)	Sodium in milligrams (mg)	Range of Pricing
Main Dish / Entrée / Lunch & Supper	<500	<18	<600	$2.75-$4.25
Breakfast Entrée	<300	<8	<300	$1.65-$3.75
Side Items	<250	<6	<300	$0.65
Breads / Snacks / Desserts	<200	<6	<200	$.70-$1.50
Soups	<225	<8	<600	$1.05
Featured Meal of the Day	<800	<30	<1000	$4.00-$5.50

Wellness Centers – *The following are offered at both centers:*

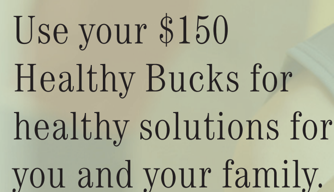
6-Month Membership $150
Monthly Membership $33
Personal Training 3 pack Intro $125
Personal Training 1 hour $50
Personal Training 1/2 hour $25

The Wellness Center of Cape Coral will also offer the following:

Swimming Lessons 4 package (1/2 hr) $30 member/ $45 non-member
Swimming Lessons 8 package (1/2 hr) $60 member/ $90 non-member
Private Swimming Lessons 8 package $200
Body Age Assessment $35 member/ $60 non-member
Inversion Therapy 10 package $50
Assist Stretching ½ hour session $28
Fitness Assessment $25
Massage Therapy – 30-minute Swedish $40
Massage Therapy – 60-minute Swedish $65
Chair Massage (15-minute minimum) $1/minute
Dumbbells (1 lb. to 15 lbs.) $10-$15 pair
Resistance Bands $12-18 each
Yoga Mats $15-25 each
Yoga Bricks $ 8-15 each
Yoga Straps $6-10 each
Zumba "Bells" $15 set
Aqua Dumbbells $15 – 20 pair
Health and Fitness DVDs Varies

Lee Center for Rehabilitation & Wellness – Ft. Myers will offer the following:

Fitness Assessment $40
Body Composition $10
Weight Management Exercise Program $150
Diabetes Exercise Program $120
Cardiac Rehab Phase III Exercise Program $150
Massage Therapy – 30-minute Swedish $40
Massage Therapy – 60-minute Swedish $65
Massage Therapy – 30-minute Therapeutic $50
Massage Therapy – 60-minute Therapeutic $80
Chair Massage (15-minute minimum) $1/minute
TRX Training Class $30
Ballroom Dancing $40



Biography

JON C. CECIL, FACHE
Chief Human Resources Officer
Human Resources

Address: Lee Memorial Health System
636 Del Prado Boulevard
Cape Coral, FL 33990

Phone: 239 772-6597

Fax: 239 574-0261

E-mail: jon.cecil@leememorial.org

LEADERSHIP RESPONSIBILITIES

Jon Cecil is responsible for the overall planning, development, implementation, and operations of a comprehensive Human Resources function for Lee Memorial Health System. The current employee count for our organization now exceeds 9,500 employees; it is the largest employer in Southwest Florida. Lee Memorial Health has been recognized and awarded the Employer of Choice™ by the Herman Group. Lee Memorial joined only 11 other organizations nationally including four other health care organizations that received this award. In addition, Lee Memorial Health System was awarded the Premier Health Care Employer by J. Walter Thompson, Inc. and has received the AARP award for being a Best Employer for Workers over 50 for three years in a row.

Jon is responsible for strategic planning, operations, policies and procedure related to employment; human resources information systems; compensation and benefits; labor relations; performance management; workforce planning; employee relations; the human resources service center, and the Flex Staffing services. He assures compliance with all applicable labor, equal opportunity and other rules and regulations related to the workforce.

Additionally, Mr. Cecil serves as liaison to four Auxiliaries and volunteer organizations with over 4,000+ volunteers; has administrative responsibility for the operations of four LMHS Child Development Centers with over 500 children enrolled; and is responsible for the Employee Health and Employee Clinics for the System as well the Organizational Effectiveness and Leadership Development departments.

PROFESSIONAL EXPERIENCE

Mr. Cecil joined Lee Memorial Hospital in 1972 as a management trainee and held various management and administrative positions. He was promoted to Vice President of Human Resources in 1987.

With the affiliation of Sarasota Memorial Hospital and Lee Memorial Health System in 1997, he accepted the additional position of regional Vice President for Support Services of both health systems.

In January 1999, he assumed the responsibility as the System's Chief Human Resources Officer.

Biography

EDUCATION

Nova Southeastern University
1979 MS Public Management
University of Florida
1972 BS Business Administration

AFFILIATIONS/CERTIFICATIONS/AWARDS

- *Fellow - American College of Healthcare Executives*
- *Society of Human Resources Management*
- *American Society for Healthcare Human Resources Administration*
- *Florida Society for Healthcare Human Resources Administration*
- *Voluntary Hospital Association, Southeast Human Resources Executive Council*
- *Voluntary Hospital Association "Tomorrow's Workforce" National Collaborative*
- *HR Executive Magazine – 2004 HR Executive Honor Roll Award recipient*
- *American Business Awards (Stevie National Awards) – 2005 Winner – Best Human Resources Executive*
- *State of Florida service recognition by Governor Jeb Bush*
- *Horizon Council of Lee County Medical Committee*
- *EUSA (Employers United for a Stronger America) – Secretary, Board of Directors*
- *The Foundation for Lee County Public Schools, Inc. - Lee County, FL – Board of Directors*

PUBLICATIONS

- *Inside the Minds: Human Resources Leadership Strategies – Fifteen Ways to Enhance HR Value in Your Company*

RECENT PRESENTATIONS

- *Tomorrow's Workforce workshops – Dallas, New Orleans, Atlanta*
- *"Achieving Exceptional Business Performance Through Workforce Excellence" national live TV broadcast - Dallas*
- *"Meeting JCAHO Staffing Effectiveness Standards through Spider Diagrams" - Orlando*
- *"HR Metrics" – Tampa*
- *"Recognizing the Seven Drivers of Employee Satisfaction" – Connecticut Hospital Association, Hartford, CT*
- *"Employer of Choice"™ Site Visit presentations for Lakeland Regional Medical Center, Lakeland, FL, Lincoln General Hospital, Rustin, LA, Aspen Hospital, Aspen, CO, St. Tammany Parish Hospital, Covington, LA, University Community Hospital, Tampa, FL, Riverside Healthcare System, Newport News, VA, Akron Medical Center, Akron, OH, St. Lukes Regional Medical Center, Boise, ID.*
- *SS LMHS Vision – Orlando*
- *"What Gets Measured, Gets Done" – VHA HR Executives Forum*
- *University of Florida – Master of Health Administration Program (MHA) – Gainesville, Florida*
- *VHA – Tomorrow's Work Force Collaborative – HR Metrics – "What Gets Measured Gets Done"*
- *Honeycomb Worldwide – Engaging the Workforce – Interactive Web Presentation*

Biography

- *HR Leaders Summit –* *"Evaluating and Improving Upon the Efficiency of Your Workforce"*
- *REO 2005 –* *Southwest Florida's Economic Forecast – Workforce Development: Where are the Jobs & Recruiting and Retention Strategies*
- *FSHHRA/FSHET Sixth Annual, Joint Education Conference* *– HR Performance Metrics*
- *Workforce Optimization Summit I* *- Bozeman, MT – The Role of a Chief Human Resources Officer*
- *Third Annual Strategic HR Leadership Summit* *– Las Vegas*
- *The Healthcare Roundtable* *– Sarasota, FL – Journey with Tom Olivo and Beyond*
- *HR in Healthcare Conference* *– New York, NY – Aligning Healthcare Strategies*
- *CEO Roundtable –* *Cost Savings and Revenue Enhancement – Orlando, FL*
- *American College of Healthcare Executives* *– Career Positioning – Proactively Managing your Professional Development – Ft. Myers, FL*
- *The Healthcare Roundtable –* *Balancing Clinical Workforce Productivity, Quality of Care and the Patient Experience – Dallas, TX*

Demographic Information on Nursing Home Residents by Level of Care for Calendar Year 2009

Demographics		Skilled Nursing	Intermediate Care I[1]	Intermediate Care II[2]	Persons Receiving Services Paid for by Medicaid Co-Payments	Persons Who Switched Between Levels of Care (Excluding Skilled Nursing)	Persons Who Switched Between Levels of Care (Including Skilled Nursing)	Total
Total Number of Residents		**11,337**	**38,945**	**928**	**635**	**4,301**	**12,485**	**68,631**
Age	Median Age	82.0	82.0	84.0	72.0	80.0	80.0	81.0
	Mean Age	76.5	78.3	80.9	70.7	77.4	77.2	77.7
Gender	Male	34.8%	34.0%	28.4%	45.0%	35.3%	35.0%	34.4%
	Female	65.2%	66.0%	71.4%	55.0%	64.7%	65.0%	65.6%
	Unknown	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Died During Calendar Year	No	66.1%	69.1%	49.2%	60.0%	72.0%	76.7%	69.8%
	Yes	33.9%	30.9%	50.8%	40.0%	28.0%	23.3%	30.2%
Long-Term Care Minimum Data Set (MDS) Indicators[3]								
Resident has support person positive about discharge								
No		82.2%	84.3%	84.9%	30.0%	82.7%	85.6%	83.7%
Yes		17.8%	15.7%	15.1%	70.0%	17.3%	14.4%	16.3%
Overall change in self-sufficiency care needs								
No change or deteriorated - receives more support		96.2%	95.9%	95.9%	80.8%	95.1%	96.2%	95.8%
Improved - receives fewer supports, needs less restrictive level of care		3.8%	4.1%	4.1%	19.2%	4.9%	3.8%	4.2%
Cognitive skills for daily decision-making								
Independent - decisions consistent/reasonable		19.3%	17.5%	12.2%	44.5%	18.7%	17.6%	18.0%
Modified Independence - some difficulty in new situations only		19.3%	20.7%	20.5%	20.9%	23.2%	19.7%	20.4%
Moderately Impaired - decisions poor; cues/supervision required		40.3%	42.9%	42.8%	25.8%	40.4%	43.7%	42.3%
Severely Impaired - never/rarely made decisions		21.0%	18.9%	24.5%	8.7%	17.7%	19.0%	19.2%
Activities of Daily Living (ADL) Functional Rehabilitation Potential								
None of the below		42.2%	39.2%	41.0%	78.4%	46.2%	42.5%	41.1%
Resident or staff believe resident is capable of increased independence in at least some ADLs, resident is able to perform tasks/activity slowly, and/or there is a difference in ability from morning to evening		57.8%	60.8%	59.0%	21.6%	53.8%	57.5%	58.9%
Received Hospice Care								
No		91.9%	92.1%	89.2%	94.0%	93.8%	95.4%	92.8%
Yes		8.1%	7.9%	10.8%	6.0%	6.2%	4.6%	7.2%
Cardiovascular Condition – Arteriosclerotic Heart Disease, Cardiac Dysrhythmias, Congestive Heart Failure, and/or Other Cardiovascular Disease								
No		25.9%	26.6%	23.7%	43.8%	27.7%	28.4%	27.0%
Yes		74.1%	73.4%	76.3%	56.2%	72.3%	71.6%	73.0%
Stroke – Cerebrovascular Accident/Stroke and/ or Transient Ischemic Attack								
No		46.8%	45.9%	45.1%	75.0%	47.8%	46.6%	46.6%
Yes		53.2%	54.1%	54.9%	25.0%	52.2%	53.4%	53.4%
Muscoskeletal – Missing Limb, Osteoporosis, and/or Pathological Bone Fracture								
No		57.3%	57.6%	57.5%	76.9%	61.5%	61.0%	58.6%
Yes		42.7%	42.4%	42.5%	23.1%	38.5%	39.0%	41.4%

Demographics	Skilled Nursing	Intermediate Care I[1]	Intermediate Care II[2]	Persons Receiving Services Paid for by Medicaid Co-Payments	Persons Who Switched Between Levels of Care (Excluding Skilled Nursing)	Persons Who Switched Between Levels of Care (Including Skilled Nursing)	Total
Paralysis – Hemiplegia/Hemiparesis, Paraplegia, Quadriplegia, and/or Traumatic Brain Injury							
No	64.1%	64.3%	64.3%	84.5%	65.7%	64.7%	64.6%
Yes	35.9%	35.7%	35.7%	15.5%	34.3%	35.3%	35.4%
Neurological Condition – Aphasia, Cerebral Palsy, Multiple Sclerosis, Parkinson's Disease, and/or Seizure Disorder							
No	57.3%	57.5%	62.0%	83.1%	59.4%	57.1%	57.8%
Yes	42.7%	42.5%	38.0%	16.9%	40.6%	42.9%	42.2%
Dementia – Alzheimer's Disease and/or dementia other than Alzheimer's Disease							
No	27.3%	25.5%	22.7%	62.9%	29.5%	28.4%	26.8%
Yes	72.7%	74.5%	77.3%	37.1%	70.5%	71.6%	73.2%
Mental Health - Anxiety Disorder, Depression, Manic Depression Bipolar Disease, and/or Schizophrenia							
No	16.4%	14.6%	13.2%	39.0%	16.0%	15.0%	15.3%
Yes	83.6%	85.4%	86.8%	61.0%	84.0%	85.0%	84.7%

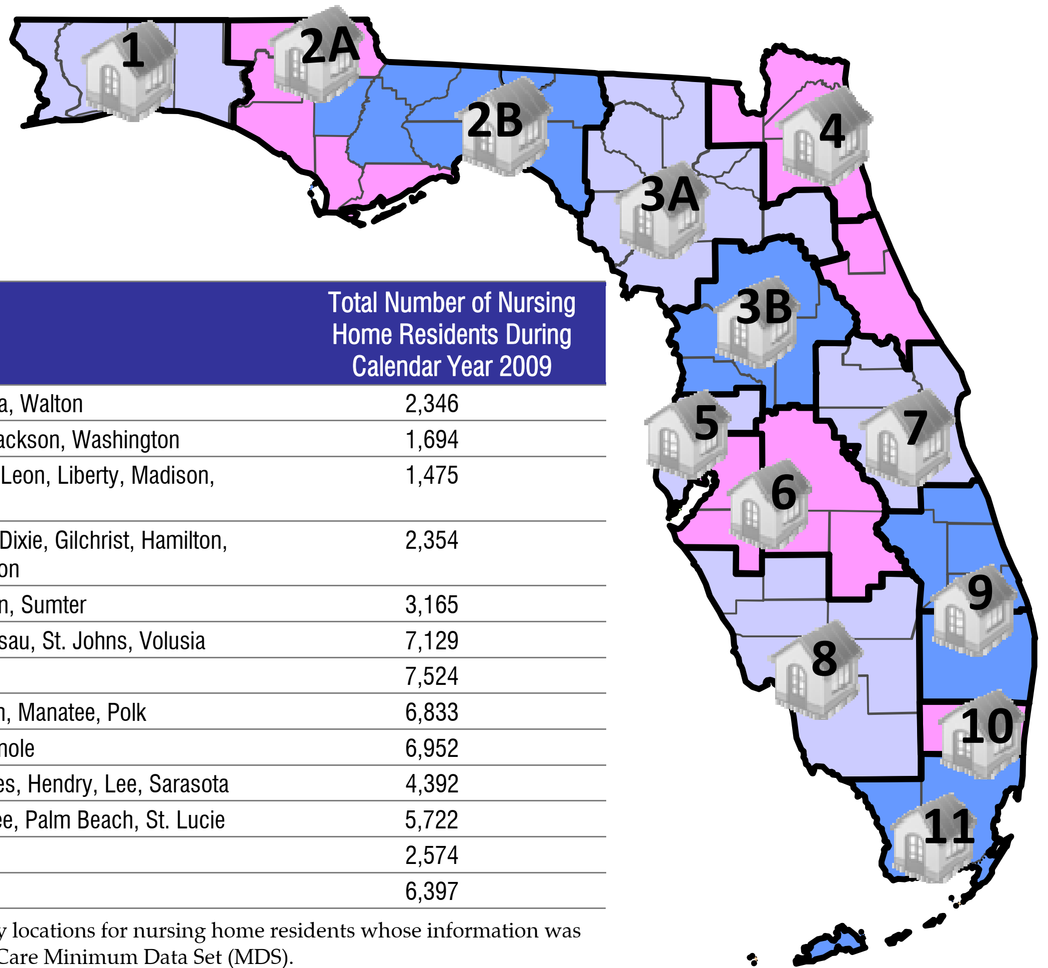
[1] Intermediate Care I residents are incapacitated mentally or physically and require extensive health related care and services.

[2] Intermediate Care II residents are mildly incapacitated or ill to a degree which requires medical supervision, but limited health related care and services.

[3] The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicaid and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. Information on all indicators was not available for all clients.

Source: OPPAGA analysis of information provided by the Agency for Healthcare Administration and consultation with the Florida State University's Claude Pepper Center.

Location of Nursing Home Residents by Medicaid Area Offices for Calendar Year 2009[1]



Medicaid Area Office	Total Number of Nursing Home Residents During Calendar Year 2009
Area 1– Escambia, Okaloosa, Santa Rosa, Walton	2,346
Area 2A – Bay, Franklin, Gulf, Holmes, Jackson, Washington	1,694
Area 2B – Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla	1,475
Area 3A – Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union	2,354
Area 3B – Citrus, Hernando, Lake, Marion, Sumter	3,165
Area 4 – Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	7,129
Area 5 – Pasco, Pinellas	7,524
Area 6 – Hardee, Highlands, Hillsborough, Manatee, Polk	6,833
Area 7– Brevard, Orange, Osceola, Seminole	6,952
Area 8 – Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	4,392
Area 9 – Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	5,722
Area 10 – Broward	2,574
Area 11 – Miami-Dade, Monroe	6,397

[1] This data does not include 10,074 county locations for nursing home residents whose information was not recorded in the federal Long-Term Care Minimum Data Set (MDS).

Source: OPPAGA analysis of data provided by the Agency for Healthcare Administration.

Demographic Information on Nursing Home Residents by Level of Care for Calendar Year 2009

Demographics		Skilled Nursing	Intermediate Care I[1]	Intermediate Care II[2]	Persons Receiving Services Paid for by Medicaid Co-Payments	Persons Who Switched Between Levels of Care (Excluding Skilled Nursing)	Persons Who Switched Between Levels of Care (Including Skilled Nursing)	Total
Total Number of Residents		**11,337**	**38,945**	**928**	**635**	**4,301**	**12,485**	**68,631**
Age	Median Age	82.0	82.0	84.0	72.0	80.0	80.0	81.0
	Mean Age	76.5	78.3	80.9	70.7	77.4	77.2	77.7
Gender	Male	3,948	13,231	264	286	1,520	4,368	23,617
	Female	7,387	25,705	663	349	2,781	8,114	44,999
	Unknown	1	6	1	0	0	3	11
Died During Calendar Year	No	7,489	26,903	457	381	3,098	9,580	47,908
	Yes	3,848	12,042	471	254	1,203	2,905	20,723
Long-Term Care Minimum Data Set (MDS) Indicators[3]								
Resident has support person positive about discharge								
No		7,008	25,433	586	128	2,771	8,832	44,758
Yes		1,513	4,731	104	299	578	1,483	8,708
Overall change in self-sufficiency care needs								
No change or deteriorated - receives more support		9,097	31,669	756	407	3,421	10,547	55,897
Improved - receives fewer supports, needs less restrictive level of care		363	1,355	32	97	176	413	2,436
Cognitive skills for daily decision-making								
Independent - decisions consistent/reasonable		1,810	5,768	96	224	673	1,921	10,492
Modified Independence - some difficulty in new situations only		1,812	6,816	161	105	834	2,147	11,875
Moderately Impaired - decisions poor; cues/supervision required		3,782	14,127	337	130	1,451	4,775	24,602
Severely Impaired - never/rarely made decisions		1,974	6,245	193	44	637	2,073	11,166
Activities of Daily Living (ADL) Functional Rehabilitation Potential								
None of the below		3,604	11,851	284	338	1,552	4,392	22,021
Resident or staff believe resident is capable of increased independence in at least some ADLs, resident is able to perform tasks/activity slowly, and/or there is a difference in ability from morning to evening		4,930	18,388	408	93	1,806	5,948	31,573
Received Hospice Care								
No		8,701	30,424	703	474	3,375	10,457	54,134
Yes		764	2,610	85	30	222	504	4,215
***Cardiovascular Condition** – Arteriosclerotic Heart Disease, Cardiac Dysrhythmias, Congestive Heart Failure, and/or Other Cardiovascular Disease*								
No		2,349	8,381	178	225	979	3,019	15,131
Yes		6,729	23,095	574	289	2,557	7,621	40,865
***Stroke** – Cerebrovascular Accident/Stroke* and/ or Transient Ischemic Attack								
No		4,415	15,104	358	386	1,733	5,116	27,112
Yes		5,016	17,783	435	129	1,893	5,857	31,113
***Muscoskeletal** – Missing Limb, Osteoporosis, and/or Pathological Bone Fracture*								
No		4,730	16,666	397	269	1,960	6,009	30,031
Yes		3,528	12,278	294	81	1,226	3,839	21,246

Demographics	Skilled Nursing	Intermediate Care I[1]	Intermediate Care II[2]	Persons Receiving Services Paid for by Medicaid Co-Payments	Persons Who Switched Between Levels of Care (Excluding Skilled Nursing)	Persons Who Switched Between Levels of Care (Including Skilled Nursing)	Total
Paralysis* – *Hemiplegia/ Hemiparesis, Paraplegia, Quadriplegia, and/or Traumatic Brain Injury							
No	6,045	21,139	510	435	2,381	7,096	37,606
Yes	3,386	11,748	283	80	1,245	3,877	20,619
Neurological Condition* – *Aphasia, Cerebral Palsy, Multiple Sclerosis, Parkinson's Disease, and/or Seizure Disorder							
No	5,401	18,923	492	428	2,155	6,265	33,664
Yes	4,030	13,964	301	87	1,471	4,708	24,561
Dementia* – *Alzheimer's Disease and/or dementia other than Alzheimer's Disease							
No	2,255	7,384	157	220	939	2,792	13,752
Yes	6,003	21,555	534	130	2,247	7,056	37,525
Mental Health* - *Anxiety Disorder, Depression, Manic Depression Bipolar Disease, and/or Schizophrenia							
No	1,542	4,817	105	201	580	1,645	8,890
Yes	7,889	28,070	688	314	3,046	9,328	49,335

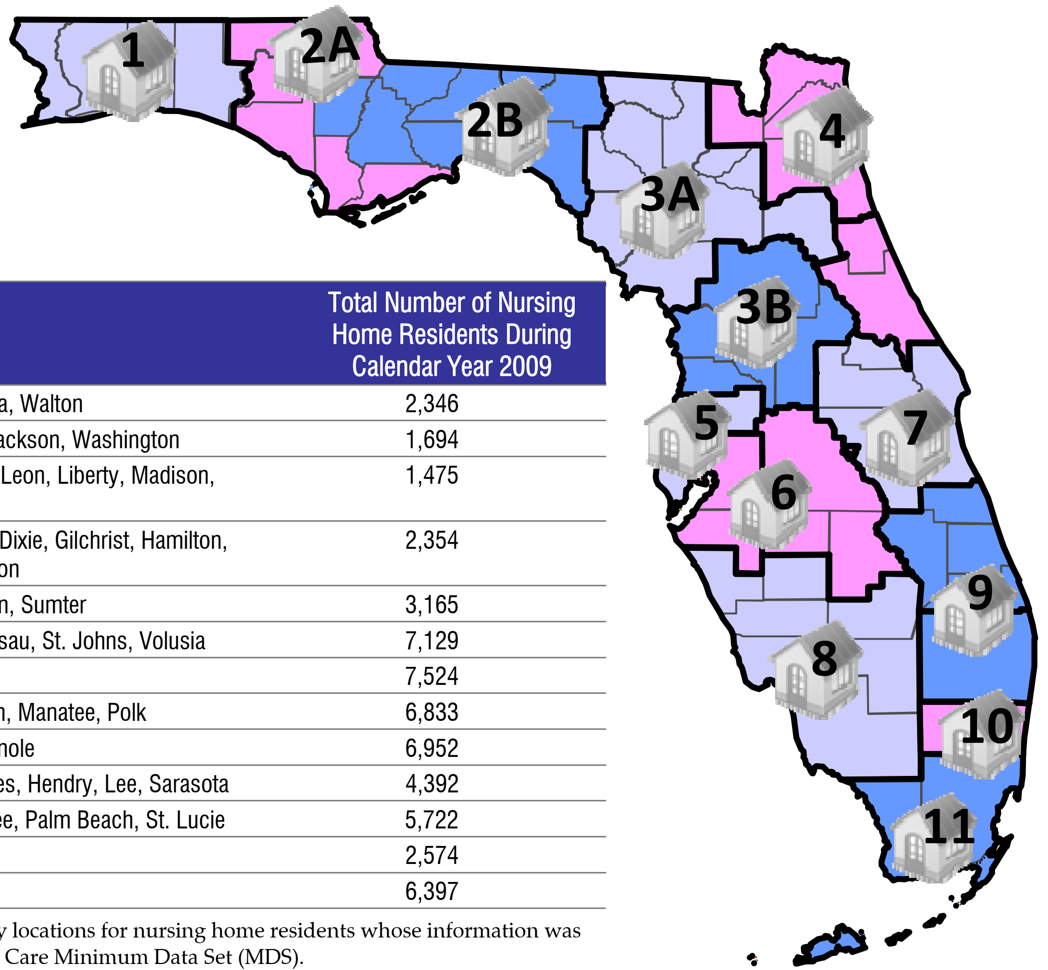
[1] Intermediate Care I clients are incapacitated mentally or physically and require extensive health related care and services.

[2] Intermediate Care II clients are mildly incapacitated or ill to a degree which requires medical supervision, but limited health related care and services.

[3] The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicaid and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. Information on all indicators was not available for all clients.

Source: OPPAGA analysis of information provided by the Agency for Healthcare Administration and consultation with the Florida State University Pepper Center.

Location of Nursing Home Residents by Medicaid Area Offices for Calendar Year 2009[1]



Medicaid Area Office	Total Number of Nursing Home Residents During Calendar Year 2009
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Area 10 – Broward	2,574
Area 11 – Miami-Dade, Monroe	6,397

[1] This data does not include 10,074 county locations for nursing home residents whose information was not recorded in the federal Long-Term Care Minimum Data Set (MDS).

Source: OPPAGA analysis of data provided by the Agency for Healthcare Administration.

Transitioning Nursing Home Residents to Community Placements

A small percentage of people receiving nursing home services may have the potential to return to community placement. As shown in Exhibit 1, our analysis of 53,026 people who received nursing home services in calendar year 2009 found that approximately 1.3%, or 713 people, had the potential to transition to community placements based on their federal Long-Term Care Minimum Data Set assessment.[1] These individuals had a support person who was positive about discharge and showed improvement in self sufficiency care needs by needing fewer supports or a less restrictive level of care.[2]

Exhibit 1
A Small Percentage of Individuals Receiving Medicaid-Funded Nursing Home Services May Have the Potential to Return to the Community, Based on Calendar Year 2009 Data

Level of Nursing Home Care	Persons who Received Nursing Home Care with a Minimum Data Set Assessment[1]	Potential to Return to Community[2]	
		Number[3]	Percentage
Skilled Nursing	8,516	120	1.4%
Intermediate Care I	30,157	409	1.3%
Intermediate Care II	690	10	1.5%
Persons Who Switched Between Intermediate Care I and II[4]	3,349	65	1.9%
Persons Who Switched Between Skilled Nursing and Intermediate Care I and II[4]	10,314	109	1.1%
Total	**53,026[3]**	**713**	**1.3%**

[1] The federal Long-Term Care Minimum Data Set (MDS) is a standardized screening and assessment tool of health status that is the primary assessment for all residents in a Medicaid and/or Medicare-certified long-term care facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. MDS indicator information was not available for 14,970 individuals who received nursing home care during calendar year 2009.

[2] Individuals classified as having the potential for transition to the community had a support person who was positive about discharge, showed improvement in self-sufficiency care needs by needing fewer supports or a less restrictive level of care, and did not receive hospice services or die during calendar year 2009.

[3] The total (53,026) excludes 376 individuals who received only services paid for by Medicaid co-payments, also known as 'crossover' services, which are typically for short-term rehabilitation stays in a nursing home.

[4] These categories may also include individuals that received services paid for by Medicaid co-payments, also known as 'crossovers', in addition to other levels of care.

Source: OPPAGA analysis of Agency for Health Care Administration data.

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[1] The federal Long-Term Care Minimum Data Set (MDS) is a standardized screening and assessment tool of health status that is the primary assessment for all residents in a Medicaid and/or Medicare-certified long-term care facility. The MDS contains items that measure physical, psychological, and psychosocial functioning.

[2] People with the potential to transition to the community did not receive hospice services or die during calendar year 2009.

As shown in Exhibit 2, transitioning people to community placements could save Florida an estimated $10.8 million in general revenue. To estimate these cost savings, we analyzed Fiscal Year 2008-09 Medicaid caseload and expenditure data to determine the monthly unit cost for nursing home and related care and deducted the estimated monthly cost for community-based support ($1,486.98 − the average Nursing Home Diversion rate for September 2010 through August 2011).[3] Cost savings could be overstated if people with the potential to return to the community could not find a place to live, whether at a private residence or assisted living facility, or returned to the nursing home within 12 months.

Exhibit 2
The State Could Save an Estimated $10 Million Over 12 Months by Identifying and Transitioning All Nursing Home Residents with the Greatest Potential to Return to Community Placements

Level of Nursing Home Care	Fiscal Year 2008-09 Caseload	Percentage of Persons with Potential to Return to the Community	Estimated Caseload with Potential to Return to the Community	Monthly Unit Cost Medicaid Expenditures[1]	Average Monthly Cost to Serve in Community[2]	Annual Estimated Net Cost Savings[3]	Annual General Revenue Savings[4]
Skilled Nursing	9,842	1.4%	139	$4,821.07	$1,486.98	$5,552,148	$2,425,733
Intermediate Care I	32,595	1.3%	437	4,391.05	1,486.98	15,221,032	6,650,069
Intermediate Care II	1,230	1.5%	18	4,385.28	1,486.98	620,294	271,007
Persons Who Switched Between Intermediate Care I and II	2,143	1.9%	42	3,729.39	1,486.98	1,118,717	488,767
Persons Who Switched Between Skilled Nursing and Intermediate Care I and II	5,940	1.1%	63	4,379.81	1,486.98	2,185,730	954,945
Total						**$24,697,921**	**$10,790,522**

[1] Unit cost was derived by dividing the total Medicaid expenditures, including nursing home and other services, by the total caseload.

[2] We used the average Nursing Home Diversion rate for September 2010 through August 2011 as an estimate of the cost to the state to provide ongoing community-based support services after the nursing home resident was transitioned to the community.

[3] The net cost savings were estimated by subtracting the Nursing Home Diversion program's average monthly rate from the Medicaid unit cost and multiplying by 12 for a full year of savings.

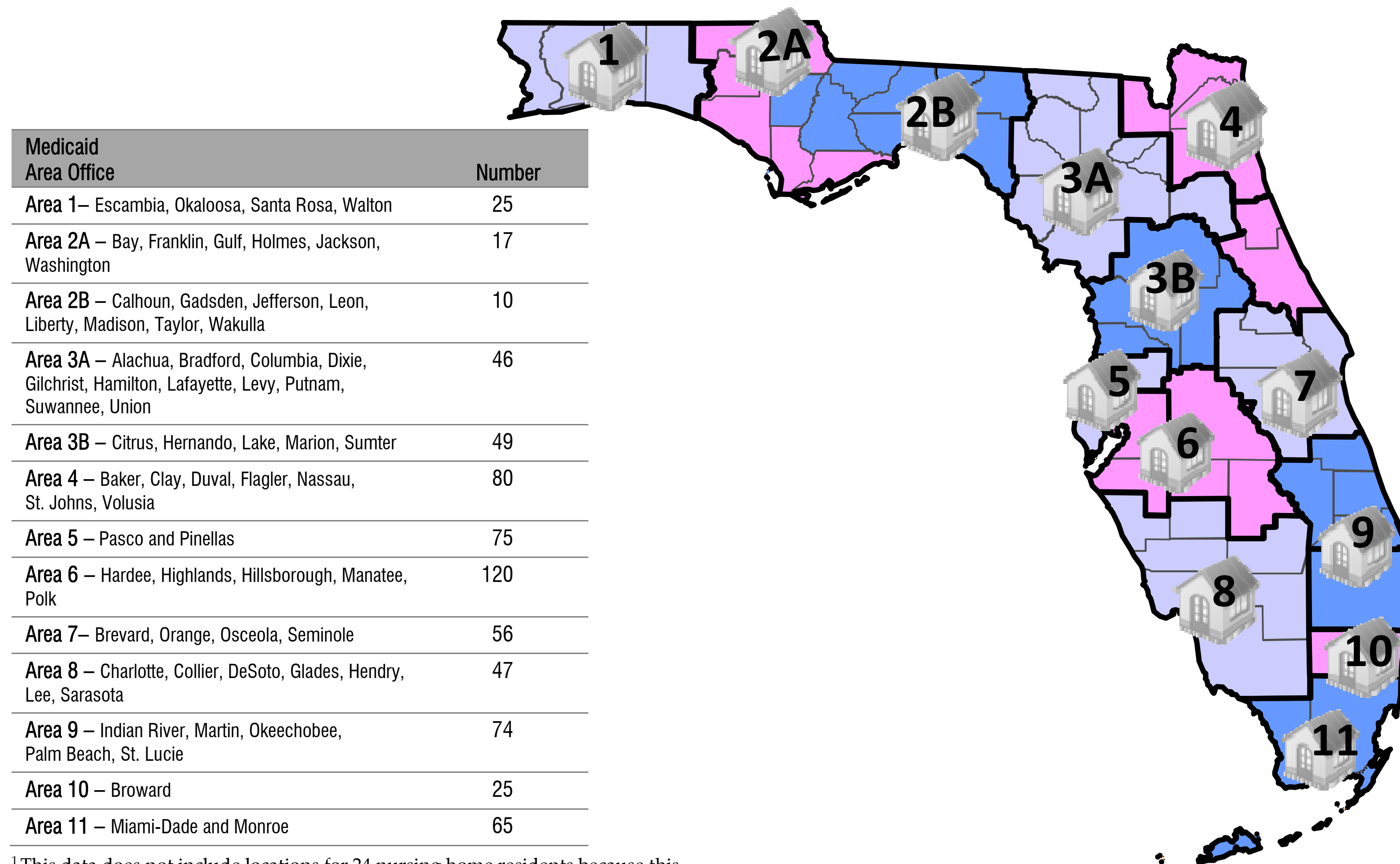
[4] The annual general revenue savings is based on the Federal Medicaid Assistance Percentage (FMAP) of 43.69%.

Source: OPPAGA analysis of Agency for Health Care Administration data.

[3] Due to data limitations, we used Fiscal Year 2008-09 caseload and expenditures data. The calendar year 2009 data containing Minimum Data Set (MDS) information included duplicate claims and could not be used to estimate cost savings. In addition, the Fiscal Year 2008-09 data was not matched with corresponding MDS assessment data, so we could not estimate cost savings based on information specific to the individuals identified as having the potential to transition out of a nursing home.

As shown in Exhibit 3, the number of people with potential to transition to community placements in calendar year 2009 varied by geographic location, ranging from 10 people in Medicaid Area 2B (Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla counties) to 120 in Medicaid Area 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk counties).

Exhibit 3
The Number of Persons with Potential to Transition to the Community Varied by Geographic Location in Calendar Year 2009



Medicaid Area Office	Number
Area 1– Escambia, Okaloosa, Santa Rosa, Walton	25
Area 2A – Bay, Franklin, Gulf, Holmes, Jackson, Washington	17
Area 2B – Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla	10
Area 3A – Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union	46
Area 3B – Citrus, Hernando, Lake, Marion, Sumter	49
Area 4 – Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	80
Area 5 – Pasco and Pinellas	75
Area 6 – Hardee, Highlands, Hillsborough, Manatee, Polk	120
Area 7– Brevard, Orange, Osceola, Seminole	56
Area 8 – Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	47
Area 9 – Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	74
Area 10 – Broward	25
Area 11 – Miami-Dade and Monroe	65

[1] This data does not include locations for 24 nursing home residents because this information was not recorded in the federal Long-Term Care Minimum Data Set assessment.

Source: OPPAGA analysis of Agency for Healthcare Administration data.

Florida's Optional Medicaid Benefits

Medicaid is a federal-state program that provides health and long-term care services to certain categorically eligible individuals and families. Under federal Medicaid rules, states must offer certain services known as mandatory benefits and have the flexibility to offer other services known as optional benefits. While optional benefits are not required under federal law, states receive federal matching funds to offset the cost to provide them.

Optional Benefits Offered in Florida's Medicaid Program

The optional benefits offered to Medicaid beneficiaries can be grouped into three categories.

- **Optional Clinical Services:** This category of optional benefits includes clinical services, such as adult dental and podiatric services that would not otherwise be available to Medicaid beneficiaries.
- **Optional Provider Types:** This category of optional benefits includes qualified non-physician providers that provide services to Medicaid beneficiaries.
- **Optional Facilities:** This category of optional benefits includes alternative service delivery locations that provide services to beneficiaries in less restrictive community settings or provide services in locations to enhance beneficiaries' access to services.

Exhibit 1 lists the optional benefits that Florida's Medicaid program provide to beneficiaries, grouped by these three categories. It also shows the number and percentage of Florida's Medicaid beneficiaries who used each optional benefit, the average annual cost per beneficiary, and general revenue and total expenditures associated with each benefit in Fiscal Year 2009-10.[1] Utilization and costs varied by benefit.

[1] The enrollments and expenditures represent claims received for Fiscal Year 2009-10 through September 2010. Since providers have up to one year to submit claims for the fiscal year that ended June 30, 2010, final enrollments and expenditure data for the fiscal year may be higher.

Exhibit 1

In Fiscal Year 2009-10, the Percentage of Florida's Medicaid Beneficiaries Who Used Optional Benefits Varied by Benefit

Florida's Optional Medicaid Benefits		Beneficiaries who Received the Benefit	Total Medicaid Population who Received the Benefit	Average Annual Cost Per Beneficiary	Total General Revenue Expenditures	Total Expenditures
Optional Clinical Services	Adult Dental	74,506	2.85%	$341	$8,146,674	$25,430,508
	Adult Health Screening	30,152	1.15%	93	572,944	2,814,066
	Assistive Care[1]	12,371	0.47%	2,261	0	27,971,469
	Adult Hearing	6,277	0.24%	526	1,065,254	3,298,989
	Adult Vision (eyeglasses)	127,943	4.90%	107	4,333,530	13,702,187
	Chiropractic	10,273	0.39%	131	274,449	2,814,066
	Community Mental Health	36,620	1.40%	1,511	16,963,405	55,337,602
	Durable Medical Equipment	292,867	11.21%	414	39,128,051	121,252,094
	Early Intervention (0-3 years)	13,828	0.53%	496	0	6,863,756
	Healthy Start[2]	47,025	1.80%	340	0	15,998,197
	Home and Community-Based Services Waivers	82,851	3.17%	13,250	6,434,018	1,097,743,023
	Hospice Care	18,684	0.72%	19,165	63,019,186	358,075,466
	Optometric (eye diseases)	99,494	3.81%	73	2,172,953	7,228,721
	Podiatry	25,399	0.97%	158	817,671	4,016,066
	Prescribed Drugs	1,208,493	46.26%	945	81,216,795	1,142,281,029
	Primary Care Case Management (MediPass)	1,111,941	42.57%	18	6,410,999	19,865,999
	Targeted Case Management[3]					
	Disease Management (multiple contracts)	354,230	13.56%	244	27,985,225	86,480,918
	Adult Drugs, Alcohol, and Mental Health	9,438	0.36%	1,607	4,905,720	15,163,960
	Children's Medical Services	58,525	2.24%	174	3,304,028	10,210,265
Optional Provider Types	Physician Assistant	70,760	2.71%	$ 99	$ 2,271,551	$7,032,376
	Registered Nurse First Assistant	25,967	0.99%	322	1,700,818	8,353,724
Optional Facilities or Service Delivery Location	Ambulatory Surgical Centers	49,902	1.91%	$358	$ 5,777,713	$17,854,489
	Birth Center	962	0.04%	604	187,996	580,949
	County Health Department Clinic	259,656	9.94%	468	39,018,081	121,602,411
	Dialysis Facility	1,704	0.07%	10,344	5,699,019	17,626,411
	Intermediate Care Facilities/Developmentally Disabled	2,865	0.11%	115,120	65,825,740	329,817,687
	Intermediate Nursing Facility Care	52,168	2.00%	37,945	640,567,452	1,979,503,868
	School-Based Therapies	14,486	0.55%	4,268	0	61,823,290
	State Mental Hospital[4]	75	0.003%	111,529	0	8,364,712
	Sub-acute Inpatient Psychiatric Program for Children	936	0.04%	55,315	0	51,775,137

[1] In Florida's Medicaid program, the assistive care optional benefit provides services similar to those offered as the optional benefit personal care services in other states. Florida's benefit is only available for persons residing in assisted living, congregate care, or other supported living facilities that offer 24-hour support, and uses beneficiaries' general revenue-funded Optional State Supplemental (OSS) payments as the state funding to qualify for federal matching funds. Florida received permission from the federal government to limit this benefit to certain individuals who reside in certain settings. Generally, when states offer personal care services as an optional benefit, the benefit must be available to all qualifying beneficiaries, regardless of their residential setting.

[2] In Florida, the Healthy Start optional benefit provides enhanced services for pregnant women and children to age three. Services include information and referral, service needs assessment, care coordination, psychosocial, nutritional and smoking cessation counseling, childbirth, breastfeeding, parenting support and education, and home visits.

[3] In Florida, the targeted case management optional benefit helps certain beneficiaries gain access to needed medical, social, educational, or other services.

[4] In Florida, the state's mental hospital optional benefit is a specialty placement for elders who meet eligibility requirements for institutional care and who also need inpatient psychiatric services.

Source: OPPAGA analysis of AHCA claims data.

Other States' Optional Medicaid Benefits

As shown in Exhibit 2, all states do not offer the same optional Medicaid benefits that Florida's Medicaid program offers. Some states historically have not offered some of the optional benefits that are part of Florida's Medicaid program while other states have recently (within the past two fiscal years) decided to eliminate some of these benefits. We contacted Medicaid program staff in six states that either have eliminated some of the optional benefits that Florida provides within the past two years or historically have not offered many of the optional benefits that Florida provides.[2] Program staff that we interviewed reported that their states eliminated optional services because they had already implemented other cost reductions, such as reducing provider payments. Further, states cannot reduce costs by changing Medicaid eligibility rules based on provisions in the federal Patient Protection and Affordable Care Act of 2010.[3, 4] Program staff also told us that reducing optional benefits could result in cost-shifting which could potentially offset savings. However, none of the program staff reported that their state had determined whether cost-shifting had occurred as a result of changes to the optional benefits. Also shown in Exhibit 2, beginning in federal Fiscal Years 2010 and 2011, some states will place new limits or restrictions on certain optional benefits.

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[2] These states were California, Georgia, Michigan, Nevada, Utah, and Washington.

[3] The federal health reform's Patient Protection and Affordable Care Act prohibits state Medicaid programs from reducing their eligibility standards for any category of beneficiaries who were served by Medicaid as of March 2010, until January 1, 2014, for adults and September 30, 2019, for children.

[4] Pending federal clarification of the Patient Protection and Affordable Care Act provision that prohibits states from reducing Medicaid eligibility standards, states may not be able to eliminate or change certain optional benefits that are provided to beneficiaries when they meet specific eligibility criteria.

Exhibit 2
All States Do Not Offer the Same Optional Medicaid Benefits Available in Florida's Medicaid Program

Florida's Optional Medicaid Benefits[1]	States That Do Not Provide Optional Medicaid Benefit	Summary of States' Restrictions or Limitations on Optional Benefits Effective in Federal Fiscal Years 2010 and 2011
Optional Clinical Services		
Adult Dental ▪ Acute emergency procedures to alleviate pain or infection including incision and drainage of an abscess and taking x-rays needed to make a diagnosis ▪ Full and partial dentures and related procedures	▪ Alabama, Arizona, Arkansas, California, Colorado, Delaware, Massachusetts, Tennessee, Utah, Washington *State Medicaid Programs that Do Not Provide Dentures:* ▪ Alabama, Arizona, Arkansas, Colorado, Delaware, Georgia, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, New Hampshire, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, West Virginia	▪ Hawaii – eliminated all but emergency services ▪ Minnesota – placed limits on x-rays and dentures ▪ New Mexico – reduced frequency of panoramic and intra oral x-rays to once every five years ▪ Ohio – restricted dental visits ▪ Oregon – reduced services and denture coverage ▪ Virginia – added prior authorization requirements for certain services
Adult Health Screening[2] ▪ Annual routine physical exam, without regard to medical necessity, to detect and prevent disease, disability, or other health condition	▪ Alabama, Arizona, Arkansas, California, Delaware, Kansas, Michigan, New Mexico, West Virginia, Wisconsin, Wyoming	*No changes*

Florida's Optional Medicaid Benefits[1]	States That Do Not Provide Optional Medicaid Benefit	Summary of States' Restrictions or Limitations on Optional Benefits Effective in Federal Fiscal Years 2010 and 2011
Adult Hearing ▪ Diagnostic testing and evaluation, hearing aids, hearing aid fitting and repair, and cochlear implants	*State Medicaid Programs that Do Not Provide Hearing Aids:* ▪ Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Michigan, Mississippi, North Carolina, Oklahoma, Pennsylvania, Tennessee, Utah, Virginia, Washington, West Virginia	*No changes*
Adult Vision ▪ Eyeglasses and repairs, prosthetic eyes, and contact lenses for persons with aphakia (a condition commonly related to cataracts)	▪ Kentucky, Louisiana, Maryland, Michigan, Nevada, Oklahoma, Oregon, Utah, Vermont, Virginia, Washington	▪ New Mexico – limited routine services and eyeglasses to once every 36 months ▪ Wyoming – extended the time between eyeglass replacements
Assistive Care[3] *Similar to personal care services in other states, but in Florida, only available for persons residing in assisted living, congregate care, or other supported living facilities that offer 24-hour support* ▪ Assistance with activities of daily living (e.g., bathing, dressing), assistance with instrumental activities of daily living (e.g., shopping, phone calls), and assistance with self-administered medication and health support	*State Medicaid Programs that Do Not Provide Personal Care Services:* ▪ Alabama, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Mississippi, Ohio, Pennsylvania, South Carolina, Tennessee, Vermont, Virginia, Wyoming	*State Medicaid Programs that Imposed New Limits to their Personal Care Services* ▪ District of Columbia – limited personal care to 1,040 hours per year ▪ Minnesota – added utilization controls on assistive care services ▪ Nevada – added prior authorization requirements for personal care ▪ North Carolina – added utilization controls for personal care ▪ Washington – reduced personal care based on acuity level and for services associated with incontinence and special diets
Chiropractic ▪ Screening, manual manipulation of the spine, and spinal x-rays	▪ Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Kansas, Louisiana, Maryland, Michigan, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, Oklahoma, Rhode Island, Tennessee, Utah, Virginia, Washington, Wyoming	▪ Minnesota – limited to 12 visits per year
Community Mental Health ▪ Mental health and substance abuse services including assessments; treatment planning; medical and psychiatric services; individual, group, and family therapies; community support; behavioral services for children and adolescents; therapeutic foster care; and group care	▪ Pennsylvania	▪ Virginia – expanded prior authorization requirements
Durable Medical Equipment (DME) and Supplies ▪ Equipment that can be used repeatedly such as ambulatory assistive equipment (e.g., canes, crutches), wheelchairs, hospital beds, commodes, and orthotics ▪ Consumable and disposable supplies such as diabetic supplies (blood glucose meters, strips, and syringes), enteral nutrition supplements, ostomy and urological supplies, and oxygen and related equipment	▪ Arizona – does not offer insulin pumps, percussive vests, cochlear implants, or bone- anchored hearing aids ▪ California – does not offer incontinence creams and washes ▪ Mississippi – does not offer prosthetics and orthotics	▪ California – placed a cap on the number of DMEs ▪ Nevada – limited diapers and incontinence pads to six per day ▪ New Mexico – reduced the frequency and amounts of disposable medical supplies that can be provided ▪ Ohio – restricted incontinence supplies for adults ▪ Virginia – modified limits for incontinence supplies ▪ Washington – eliminated bath support equipment, enteral nutrition, automated blood pressure cuffs, and placed new quantity limits on incontinence and diabetic supplies and non-sterile gloves

Florida's Optional Medicaid Benefits[1]	States That Do Not Provide Optional Medicaid Benefit	Summary of States' Restrictions or Limitations on Optional Benefits Effective in Federal Fiscal Years 2010 and 2011
Early Intervention (birth-three years) ▪ Screening, psychosocial and medical evaluation, and medically necessary services for identified delays in cognition, physical, motor, sensory, self-help, and adaptive development, communication, and social and emotional development	*Information not available* [4]	*No changes*
Healthy Start [5] ▪ Enhanced services for pregnant women and children from birth to age three including information and referral services; needs assessment; care coordination; psychosocial, nutritional, and smoking cessation counseling; childbirth, breastfeeding, and parenting support and education; and home visits	▪ New Hampshire, North Carolina, Washington *Information not available for:* ▪ Indiana, Maine, Nebraska, Vermont, West Virginia	*No changes*
Home and Community-Based Services Waivers ▪ Services in the home or assisted living facility for persons who would otherwise require institutional care ▪ Specific services available vary depending on the program[6]	*All states provide this benefit*	*No changes*
Hospice Care ▪ Palliative care and support services for terminally ill patients and their families provided by an interdisciplinary team to meet physical, emotional, spiritual, and social stresses associated with end-stage illness and bereavement	▪ Connecticut, New Hampshire, Oklahoma, Washington (for adults only)	▪ Kansas – limited to 210 days
Optometric ▪ Treatment of eye diseases through consultation and referral, evaluation and management, general and special ophthalmologic services; pathology and laboratory services, post-operative management, and eye exams for reported vision problems, illnesses, diseases, or injuries	*All states provide this benefit*	*No changes*
Podiatry ▪ Routine foot care for a person being treated for metabolic disease, circulatory impairment, or a condition associated with desensitization of leg or feet	▪ Alabama, Alaska, Arizona, California, Connecticut, Nevada, New York, Washington, Wyoming	▪ New Hampshire – required prior authorization
Prescribed Drugs ▪ Most prescription drugs for out-patient settings, injectable drugs, and certain non-prescription drugs such as aspirin when prescribed, specific iron supplements, vaginal antifungal creams, and specific smoking cessation products	▪ Washington – for adults and for co-payments for dual eligibles	▪ California – limited to six per month ▪ Washington – restricted prescriptions to treat colds and coughs

Florida's Optional Medicaid Benefits[1]	States That Do Not Provide Optional Medicaid Benefit	Summary of States' Restrictions or Limitations on Optional Benefits Effective in Federal Fiscal Years 2010 and 2011
Primary Care Case Management (MediPass) ▪ Primary care providers provide or arrange for primary care or other necessary services on a 24-hour basis	▪ Alaska, Arizona, California, Delaware, District of Columbia, Hawaii, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Rhode Island, Tennessee, Vermont, Wisconsin, Wyoming	*No changes*
Targeted Case Management Disease Management Adult Drugs, Alcohol, and Mental Health Children's Medical Services ▪ Staff help beneficiaries gain access to needed medical, social, educational, or other services	▪ Delaware ▪ Virginia – discontinued its disease management benefit	▪ Maine – established functional eligibility limits on case management
Optional Provider Types		
Physician Assistant ▪ Services provided by a licensed physician assistant under the supervision of a physician	*All states provide this benefit*	*No changes*
Registered Nurse First Assistant ▪ Services provided by a licensed registered nurse first assistant under the supervision of a physician	▪ California	*No changes*
Optional Facilities		
Ambulatory Surgical Centers ▪ Scheduled, elective, medically necessary surgical care for beneficiaries who do not require hospitalization; services including administration and facility use, blood and related products, diagnostic and therapeutic services associated with the procedure, surgical dressings and surgery supplies, materials for anesthesia, and nursing and technical services	▪ New Hampshire, Rhode Island, Vermont	*No changes*
Birth Center[7] ▪ Facilities provide obstetrical, gynecological, and family planning services including prenatal exams and related services, labor management, delivery, new born assessment, family planning, and gynecological services	▪ Alabama, Indiana, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, Ohio, Oklahoma, Virginia, Wisconsin, Wyoming *Information not available for:* ▪ Delaware, Georgia, Hawaii, New Jersey, Rhode Island, South Dakota, Tennessee	*No changes*
County Health Department Clinic ▪ Primary and preventive outpatient care provided by physicians, dentists, and other qualified medical personnel including adult health screening, child health check-ups, dental services, family planning, immunizations, medical primary care, obstetric care, and nursing services	▪ Rhode Island, Wisconsin	No changes

Florida's Optional Medicaid Benefits[1]	States That Do Not Provide Optional Medicaid Benefit	Summary of States' Restrictions or Limitations on Optional Benefits Effective in Federal Fiscal Years 2010 and 2011
Dialysis Facility ▪ In-center hemodialysis, administration of certain injectable drugs, home peritoneal dialysis, routine laboratory tests, dialysis-related supplies, and ancillary items	*Information not available* [4]	No changes
Intermediate Care Facilities/Developmentally Disabled ▪ Facility-based care for eligible individuals including basic wardrobe, dental care, food and supplements, durable medical equipment, eyeglasses, hearing aids, nursing services, rehabilitative care, room and board, training and help with daily living skills, therapy, and transportation services	▪ New Hampshire	No changes
Intermediate Nursing Facility Care ▪ Facility-based 24-hour a day nursing and rehabilitation services for persons who meet institutional care eligibility requirements	*All states provide this benefit*	No changes
School-Based Therapies ▪ Health services referenced in students' Individual Education Plans or Individual Family Support Plans provided by school districts	▪ Washington, Wyoming	▪ Kansas – eliminated attendant care in schools
State Mental Hospital ▪ Specialty placement for elders who meet eligibility requirements for institutional care and need inpatient psychiatric hospitalization receive medically necessary physician, nursing, dietary pharmaceutical, personal care, rehabilitative, and restorative services	*Information not available* [4]	No changes
Sub-Acute Inpatient Psychiatric Program for Children ▪ A maximum of 120 days of inpatient psychiatric services for persons age 17 years or younger; services include utilization management and aftercare and community referrals to reduce relapses and to reduce acute inpatient psychiatric admissions	*All states provide this benefit*	▪ Nevada – added medical necessity criteria

[1] While these services are optional for adults, under federal Medicaid rules, children must receive all medically necessary services.

[2] Under the federal Patient Protection and Affordable Care Act, each state Medicaid program will receive a one percentage point increase in its FMAP for certain preventative services recommended by the U.S. Preventive Services Task Force and for recommended adult immunizations if offered without copayments, starting January 1, 2013.

[3] In Florida's Medicaid Program, the assistive care optional benefit uses beneficiaries' general revenue-funded Optional State Supplemental (OSS) payments as the state funding to qualify for federal matching funds. Florida received permission from the federal government to limit this benefit to certain individuals who reside in certain settings. Generally, when states offer personal care services as an optional benefit, the benefit must be available to all qualifying beneficiaries regardless of their residential setting.

[4] While other states offer these services, a comprehensive list of all states that do or do not offer this benefit was not available.

[5] Other states offer between one and nine of the following support services: prenatal risk assessment, smoking cessation, substance abuse treatment, targeted care management, home visiting, psychological counseling, health education, nutritional counseling, and dental care. Under the federal Patient Protection and Affordable Care Act, by October 1, 2010, states must provide smoking cessation services to pregnant women and cannot require a co-payment.

[6] See *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, OPPAGA Report No. 10-10, January 2010, for a summary of each of Florida's home and community-based waiver services programs.

[7] Under the federal Patient Protection and Affordable Care Act, birth center services became a mandatory Medicaid service as of March 2010.

Source: OPPAGA analysis of Kaiser Family Foundation's Medicaid Benefits On-Line Database, Kaiser Family Foundation's 2010 *Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, and other research on state Medicaid program's optional benefits.

Florida Medicaid Reform 1115 Waiver Extension Request:
An Update

History

In 2005, the Florida Legislature authorized the Agency, through Section 409.91211, Florida Statutes, to:

- Seek experimental, pilot, or demonstration project waivers, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program.
- Implement the Medicaid Managed Care Pilot program in Broward County and Duval County.
- Expand into Baker, Clay, and Nassau Counties within 1 year after the Duval County program becomes operational.

Pursuant to this statute, the Agency requested and was granted a Section 1115 Research and Demonstration Waiver to implement the program. The initial approval period for the waiver was for 5 years starting July 1, 2006, through June 30, 2011. Under a section 1115 waiver, states are provided with the option to request a 3 year extension after the initial 5 year period.

The 1115 waiver allows Florida Medicaid to conduct a demonstration Pilot requiring managed care plan enrollment for most Medicaid eligibles in certain areas of the state.

The current Medicaid Reform Waiver expires June 30, 2011.

Legislative Direction

On April 30, 2010, the Florida Legislature passed Senate Bill (SB) 1484. Within this bill, the Florida Legislature directed the Agency to seek approval of a 3 year waiver extension in order to continue operation of the 1115 waiver in Baker, Broward, Clay, Duval, and Nassau counties. The Agency was directed to submit the extension request by no later than July 1, 2010.

- The Agency was not authorized to amend the waiver.
- An extension would maintain the program in the current geographic areas of operation.
- Any expansion into new geographic areas or substantial changes would require Legislative authorization.
- Experience to date shows that operational changes can be made within the framework of the approved waiver.
- The Agency is required to report monthly to the Legislature on progress in negotiating the terms of the waiver extension.

Current Status of Waiver Extension Request

The Agency submitted a 3-year waiver extension request to the Centers for Medicare and Medicaid Services on June 30, 2010. The waiver extension request can be viewed by clicking on the link below.

Florida Medicaid Reform 1115 Waiver Extension Request: An Update

Florida 1115 Research and Demonstration Waiver Extension Request, June 30, 2010 [4.00MB PDF]

Cover Letter to CMS FL 1115 Extension Request (June 30, 2010) [379KB PDF]

On August 17, 2010, the Centers for Medicare and Medicaid Services (CMS) advised the Agency that they would review and process the State's request to renew the Reform Demonstration under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the State.

August 17, 2010 Letter from CMS [531KB PDF]

This notification was not a denial of the waiver request, but CMS notification to the state that they will process the request under the section 1115(a) authority. This authority allows CMS to request changes/ amendments to the terms and conditions of the waiver. Under 1115(a) there is no prescribed timeframe by which CMS must process a waiver request.

More recently, Correspondence has been received from CMS requesting additional information to supplement or further clarify information previously provided by the state in our renewal applications. Formal correspondence relating to anticipated changes to the approval terms has not been received. Potential changes noted informally include: removing authorities not used (such as not granting retroactive eligibility), changes to the opt-out program and changes to the criteria regarding expansion to additional geographic areas. We continue to anticipate that the nature and extent of any changes will be clarified in additional formal requests for information.

Low-Income Pool

- The waiver extension request included continuation of the $1 billion a year in the Low Income Pool (LIP) Program.
- The Agency has continued to work with CMS to finalize the hospital Upper Payment Limit (UPL) calculation. In addition, discussions have been held regarding the use of waiver savings to support the continuation of the $1 billion per year of LIP funds.
- Preliminary hospital UPL calculations, by itself, do not indicate the support for $1 billion of LIP funds. As a result, CMS has noted the potential to use savings generated under the waiver to fund the $1 billion dollar request.
- CMS has indicated that the Special Terms and Conditions for the LIP Program will be modified; however it is unknown what specific modifications and criteria will be necessary to incorporate the waiver savings as additional funding for the LIP Program.
- At this time, there is no indication that CMS will not grant the extension of the $1 billion of LIP funds. It is unknown when we will receive confirmation from CMS.

AMENDMENTS/OPTIONS FOR THE FUTURE

The waiver extension, even if approved to maintain the current program, would not preclude the state from requesting future program modifications or require the state to maintain the waiver for the full extension period.

- CMS can authorize a temporary extension of the waiver if negotiations extend beyond June 30, 2011.

Florida Medicaid Reform 1115 Waiver Extension Request: An Update

- Temporary extensions are authorized for 30 day increments until waiver negotiations are finalized.

Florida Medicaid Intergovernmental Transfer Technical Advisory Panel: An Update

History:

The 2010 Legislature passed Senate Bill 1484 (Chapter 2010-144, Laws of Florida) which directed the Agency for Health Care Administration to appoint members and convene a technical advisory panel to advise the Agency in the study and development of intergovernmental transfer distribution and the best methods for ensuring the continued availability of intergovernmental transfers as part of any expansion of prepaid managed care in the Medicaid program.

The Agency was required to submit a report on the intergovernmental transfer methodologies developed to the Speaker of the House of Representatives, the President of the Senate, and the Governor by January 1, 2011.

As directed by law, the Agency Secretary selected nine members to serve on the Intergovernmental Transfer Technical Advisory Panel (Panel). The Members included representatives from hospitals, medical schools, local governments, and managed care plans. The Agency staff served as a facilitator for the Panel.

The Panel convened eleven public meetings via conference call or face-to-face between July 20, 2010 and December 16, 2010. Minutes and documents pertaining to those meetings can be found on the Agency's website at the following link:

http://ahca.myflorida.com/Medicaid/igt/index.shtml

The Panel's report was submitted to the Governor, Speaker of the House of Representatives and President of the Senate on January 6, 2011.

Current Situation:

Currently, IGTs are primary used in hospital FFS rates for the purpose of funding the exempt portion and authorized buybacks of inpatient and outpatient hospital rates. The General Appropriations Act (GAA) each year authorizes specifically qualifying hospitals to be exempt from specific limitations within the rate setting process. This is called the Exemption program. To be exempt from the limitations, hospitals must meet specific thresholds such as Medicaid and charity care volume benchmarks provided in the GAA. In addition, beginning July 2008, the Legislature authorized the use of IGTs to fund buybacks. Buybacks are the process of receiving local government funded match to fund the state portion of specific rate reductions that had been adopted to reduce the hospital rates.

Currently, the managed care rate setting process does not use IGTs as a funding source. A managed care capitation rate is a prospective rate that is determined based on historical data and is projected based on trends and risk of the population. Under FFS, the hospital receives direct payment related to the service and individual. Under a capitated methodology, rate development includes historical utilization of hospital services. However, hospital utilization can change due to plan negotiations or recipient and provider practices. The methodology used for calculating capitated managed care rates includes the current value of FFS hospital inpatient exemptions and buybacks.

Since the IGTs provided for "buy-backs" or "exempt rates" have been specifically tied to the funds used for fee-for-service hospital payments made through the Hospital Inpatient or Hospital Outpatient categories in the GAA, the "holding harmless" of the managed care capitation rate and the Prepaid Health Plan category has, of necessity, been funded through General Revenue.

Florida Medicaid Intergovernmental Transfer Technical Advisory Panel: An Update

Since a significant portion of funding for hospital rates is through IGTs, the state (and the participating hospitals) receives the benefit of the federal matching funds supporting these services without the associated General Revenue expenditure.

Since IGTs do not currently fund the Prepaid Health Plan (managed care) category of the Medicaid budget, the state share of corresponding services provided to beneficiaries enrolled in managed care plans are paid for with General Revenue (and the corresponding federal matching funds).

Models Reviewed by Panel:

This report includes three models prepared by Panel members and submitted for purposes of the report.

- The first model provided a distribution method of the hospital supplemental capitation based on historical utilization for qualifying hospitals by plan by area of the state. The model provides a distribution method of the hospital supplemental capitation based on historical utilization for qualifying hospitals by plan by area of the state. A distribution model would be a prospective regional rate and would need refinements and adjustments each period to adjust for changes in utilization of the qualifying hospitals.
- The second model provided an alternative billing process, Shadow Billing, which allows for the non-exempt rate to be paid by the managed care organization and a second FFS payment made by the state for the exempt and buyback portion of the hospital rate.
- The third model provided for a county specific program that mirrors the current FFS process and directs any expansion of managed care within the Medicaid program to the FFS PSNs.

The panel focused on the first model. The second and third models as well as options for expanding the Physician UPL were not reviewed in detail by the Panel and only discussed at a high level by the Panel members.

In addition, the Panel addressed payment and methodology options that could be used to expand the Physician Upper Payment Limit (Physician UPL) program which allows Medical Schools to provide state certified match and receive increased payment for qualifying services rendered by approved staff.

None of the models proposed were approved by the Panel as models that are ready for implementation, and these models do not address all concerns pertaining to the funding of the payments.

Any model or methodology to implement a hospital supplemental capitation payment or physician supplement payments would be subject to federal CMS authority prior to implementation.

Main Issues Considered by Panel:

- Counties’ willingness or ability to provide the IGTs as the funding source for the purpose of supporting managed care.

- Need for mechanism to ensure that funds provided by local governments will be used by health plans to support equitable rates to and utilization of the contributing localities' facilities and to provide services to recipients in the donor counties.

- Preservation of Physician Supplemental payments for the medical schools.

Panel Report Concluding Comments:

The Panel was unable to provide resolution to the issues outlined in the legislation of "negotiations with the Centers for Medicare and Medicaid Services and appropriate safeguards for appropriate implementation of any developed payment methodologies." However the concerns and discussions of the Panel did provide significant benefit to the Agency.

The Agency has attempted to complete the task provided by the legislation to "develop a methodology to ensure the availability of intergovernmental transfers in any expansion of prepaid managed care in the Medicaid program."

Any model or methodology to implement a hospital supplemental capitation payment or physician supplement payments would be subject to federal CMS authority prior to implementation.

The Agency is of the opinion that the development of methodologies for managed care payments for both the hospital supplemental payments and physician supplemental payments that include IGTs is possible. However, based on deliberations of the Panel, there were issues about which members expressed concerns regarding IGT funding that may be a barrier to implementing a model. Until this issue is successfully resolved, sufficient funds may not materialize.

Medicaid Payments for Incarcerated Medicaid Eligible Inmates: An Update

History

Historically, in Florida, when an individual who receives Medicaid through the Department of Children and Families is incarcerated, and notification of incarcerated Medicaid recipients is timely, benefits are terminated at the end of a month when such notification is made. When released, the individual must reapply for Medicaid.

Currently, the Florida Medicaid program makes no payments for medical services provided to incarcerated recipients. In general Medicaid payments for medical services for individuals that are incarcerated are not eligible for federal funding with the exception of institutional services. At the state's option, state may pay for institutional services rendered to inmates who are admitted to a medial institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

Legislative Direction

SB 1456 directed the state to implement a "suspension" eligibility span for recipients upon incarceration so that, rather than terminate the individuals Medicaid eligibility, that eligibility would be suspended for the length of incarceration in order to expedite redetermination of eligibility once the recipient was released from incarceration.

SB 1456 also amended statute by creating s. 409.9025, F.S. The new statute indicated that Florida Medicaid is not precluded from providing medical assistance for inpatient hospital services furnished to an inmate at a hospital outside of the premises of the inmate's facility to the extent that federal financial participation is available. Currently, these medical services are funded through general revenue funds appropriated to the Department's of Correction and Juvenile Justice, and/or local government funding for city or county jails.

Current Status

Update on Suspension of Eligibility

The Agency worked with the Department of Children and Families (DCF) to develop a mechanism by which DCF can communicate an "incarceration span" to the Agency which will allow the state to hold the individual as eligible, or "open" during the time of their incarceration. Statute and subsequent policy regarding a "suspension" or "incarceration span" is designed to ensure a smoother transition back into the community upon release, and to allow the released individual immediate (or close to) access to medication they may need to maintain their physical or psychological health. In effect, DCF would treat the release as a change on an active case and create or recreate eligibility based on the individual's circumstances upon release. If the individual in not eligible upon release no coverage is created. This "suspension" or "incarceration span" will also serve to facilitate determination of eligibility while the recipient remains incarcerated, should such a determination be needed for reimbursement of inpatient hospital expenses.

Medicaid Payments for Incarcerated Medicaid Eligible Inmates: An Update

Update on Payment of Inpatient Hospital Services

To ensure the availability of federal financial participation, the Agency submitted a request to federal CMS for verification of the availability of federal funds. The Agency also sought guidance as to whether federal approval was required to implement this option.

Correspondence received from federal CMS (attached) noted that federal funding is available and that a State Plan Amendment is not required. However, CMS also noted that eligibility must be determined for each inmate in accordance with Florida eligibility standards, particularly since incarceration could trigger a change in status since the individual is no longer part of a household. If the individual is no longer the caretaker of the child for whom they were previously responsible they likely would not meet the most basic of eligibility criteria unless pregnant or disabled.

The Agency is continuing to work with DCF to determine whether individuals would remain Medicaid eligible and thus could be covered for inpatient services while incarcerated. Because the state does not cover any compensable expenses for incarcerated individuals, we do not currently have a policy or Rule governing who would qualify as a Medicaid eligible incarcerated individual.

Based on information provided by DCF, individuals covered by Medicaid at the time of their incarceration could potentially be considered "eligible," at least for twelve months or until their next annual recertification period. As a result, we are unable to anticipate the number that might continue to be eligible outside of that period as there would be no detail as to the household situation before or during the incarceration. However, when an SSI eligible individual is incarcerated, he/she would lose their SSI benefit and thus lose their automatic Medicaid eligibility.

As a result, it is anticipated that, at this point in time, there would be few current eligible (e.g., pregnant women and children) Medicaid beneficiaries that would remain eligible for Medicaid when incarcerated. This would likely change if Medicaid would expand and/or cover childless adults (as under the Affordable Care Act).

Recently, the Agency was notified by the Department of Corrections (DOC) that they had identified 2 inmates who they believed would be Medicaid eligible who had incurred hospital expenses. The DOC is working with DCF to further explore the potential eligibility of the identified inmates. If a determination is made that the inmates are, in fact, current Medicaid eligible, we will arrange for Medicaid reimbursement for incurred inpatient hospital expenses and use these test cases an example to develop a process for payment.

Exec CMS. FL Inmate Ltr. 9.09.10.pdf