The Florida Senate

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Committee on Health, Aging and Long-Term Care Senator Charlie Clary, Chairman

MEDICAID MEDICALLY NEEDY PROGRAM REVIEW

SUMMARY

Florida's Medically Needy Program was established effective July 1, 1986, by the 1984 Legislature, as a component of the Florida Health Access Act. The purpose of the program was to provide short-term medical assistance to Floridians who had catastrophic medical expenses.

To complete the review, Senate staff interviewed headquarters staff of the Department of Children and Family Services (DCFS), headquarters staff of the Florida Medicaid Program, reviewed Medically Needy Program data, and held focus groups with district DCFS eligibility staff.

Although eligibility criteria are quite restrictive, the program is fulfilling its basic purpose of providing short-term medical assistance to Floridians with catastrophic medical expenses. There are very few quick, easy, inexpensive modifications that can be made to the Medically Needy Program within the constraints of complex federal rules that govern program operations. The program could be somewhat liberalized to cover additional individuals, although any changes which increase caseload would also increase costs to the state.

BACKGROUND

This report is a result of the review of the Medically Needy eligibility category of the Florida Medicaid Program. Items reviewed were the process of determining a person's Medicaid eligibility, the services being paid for by Medicaid under the Medically Needy category, and the relationship between the Medically Needy Program and the Medicaid Buy-in standards in the federal Ticket to Work and Work Incentives Improvement Act of 1999.

The review was prompted by complaints by Florida residents about the program, alleging that:

- Eligibility requirements for the program prevent individuals who had worked prior to becoming disabled from accessing the program;
- Eligibility standards are being applied inconsistently around the state;
- Eligibility requirements prevent the program from assisting some individuals who have catastrophic medical expenditures; and
- Individuals who are permanently disabled, receiving Social Security Disability Insurance and awaiting Medicare coverage are not eligible.

Medicaid and the Medically Needy Program

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The Department of Children and Family Services (DCFS) is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups).

Individuals who are elderly or disabled, whose incomes are under 100 percent of the federal Poverty Level (FPL) are an optional coverage group eligible for Medicaid under s. 409.904(1), F.S. Payments for services to individuals in the optional categories are subject to the

availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S. In the 1992 special session of the Legislature, proviso language in the amended General Appropriations Act reduced the Medicaid eligibility level for elderly and disabled persons from 100 percent FPL to 90 percent FPL.

The federal Medicaid law establishes a Medically Needy eligibility category that allows states to provide Medicaid to families and individuals who have more income than allowed for Medicaid eligibility under the other mandatory or optional categorical eligibility groups described in the Social Security Act, but who have significant health care expenses. The federal Omnibus Budget Reconciliation Act (OBRA) of 1981 amended the Social Security Act to allow states more flexibility in defining the term "medically needy" and permitted states to vary Medicaid services by eligibility group.

Florida's Medically Needy Program (currently authorized in s. 409.904(2), F.S.) was established effective July 1, 1986, by the 1984 Legislature, as a component of the Florida Health Access Act. The purpose of the program was to provide short-term medical assistance to Floridians who had catastrophic Medical expenses.

The current statutory authority for the Medically Needy Program is as follows:

> " (2) A family, a pregnant woman, a child under age 18, a person age 65 or over, or a blind or disabled person who would be eligible under any group listed in s. 409.903(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in this group, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person in this group, which group is known as the "medically needy," is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled."

The Medically Needy Program was projected to serve approximately 108,000 individuals per year at a cost of $127 million, in 1986. The Medicaid expansions in the Health Care Access Act were originally funded by a 1.5 percent assessment on hospital revenues, plus $20 million general revenue, with the funds being deposited in the Public Medical Assistance Trust Fund.

Eligibility Requirements

To become eligible for the Medically Needy Program, an individual must meet the categorical criteria for Medicaid, that is, be a low-income family with children; a caretaker relative or parent of a dependent child; a pregnant woman; a dependent child; or be aged, blind or disabled; and have incurred catastrophic medical expenses to the extent that income, after medical costs are deducted, in the month in question, is reduced to $180 ($241 for a couple), and have assets which do not exceed $5,000 ($6,000 for a couple). Income and asset levels increase with family size. At the point in time each month that incurred medical expenses exceed the amount necessary to reduce gross income to $180, the individual becomes eligible for Medicaid for the remainder of that month only. A person eligible for the Medically Needy Program is eligible for all Medicaid services with the exception of services in a skilled nursing facility or an intermediate care facility for the developmentally disabled, and home and community-based services.

The current Medically Needy income standard ($180) is set at 100 percent of the AFDC program payment standard. A state may not base its Medically Needy income standard on a needs standard or a standard other than the AFDC payments standard that was in effect July 1996, however, the state may set the Medically Needy income level up to 133 1/3 percent of the AFDC standard in effect as of July 1996. In addition, the state may increase the standard in effect in July 1996 by the Consumer Price Index increases since that date. The Medically Needy asset limit is $5,000 for an individual and $6,000 for a couple. These asset limits are set by the state.

On October 31, 2000, the federal Department of Health and Human Services published, in the Federal Register, a Notice of Proposed Rulemaking regarding the Medically Needy Program. The proposed rules will allow states to use less restrictive methodologies in determining eligibility for the Medically Needy Program, allowing states to disregard portions of a person's income necessary to pay for food, clothing or housing.

Different calculations for Medically Needy Program eligibility are applied to applicants depending on whether the applicant is eligible under the aged/disabled (SSI-related) or the family/dependant child (TANF-related) portion of the program, and whether the applicant has earned income or unearned income. Under the SSI-

related standard, the first $20 in unearned income is disregarded. The Medically Needy income standard is then subtracted from the remaining income to determine the share of cost the applicant must pay in order to be determined eligible for the program. For example, in the situation of an elderly or disabled couple, whose total unearned income is $1,000 per month the calculation would be as follows:

Unearned Income:	$1,000
Disregard	$ -20
Countable Income	$ 980
Medically Needy Income Standard	$ -241
Share of Cost	$ 739

The couple would therefore be required to incur $739 in medical expenses to become eligible for the Medically Needy Program.

Under TANF-related Medically Needy Program standards, in some instances the first $200 of earned income is disregarded, and one half the remaining income is also disregarded. Under this program, the calculation for a family of two with an income of $1,000 per month would be as follows:

Earned income:	$1,000
Disregard	$ -200
	$ 800
50% Disregard	$ -400
Countable Income	$ 400
Medically Needy Income Standard	$ -241
Share of Cost	$ 159

The family would therefore be required to incur $159 in medical expenses to become eligible for the Medically Needy Program. It is likely, however, that since Florida has expanded eligibility for the Kidcare program to 200 percent of the Federal Poverty Level (200% of FPL for a family of two is $1,875 per month), that the child would be eligible for ongoing Kidcare coverage.

The "Ticket to Work and Work Incentives Improvement Act of 1999"

The federal "Ticket to Work and Work Incentives Improvement Act of 1999" was signed into law on December 17, 1999. It allows states to provide Medicaid coverage to certain disabled persons who are transitioning from public assistance to gainful employment. The program will be phased in nationally over a three-year period beginning January 1, 2001.

Under the Act, effective October 1, 2000, states will have the option to provide Medicaid coverage to people ages 16-64 who are disabled but who are able to work. Under the program, states will have the option to permit working individuals to "buy-in" to Medicaid. If a state provides Medicaid coverage to individuals described above who return to work, the state may also opt to continue to provide coverage to certain individuals whose improved medical condition would otherwise make them ineligible.

Individuals covered under these options could "buy into" Medicaid coverage by paying premiums or other cost-sharing charges on a sliding fee scale based on an individual's income. The state would be required to make premium or other cost-sharing charges the same for both of these two new eligibility groups.

METHODOLOGY

The review examined the:

- History of the program;
- Current state and federal regulations regarding the Medically Needy Program;
- Department of Children and Family Services Headquarters and field operations relating to Medically Needy eligibility determinations;
- Expenditures and utilization of medical services under the program; and
- Ticket to Work and Work Incentives Improvement Act of 1999.

To complete the review, Senate staff interviewed headquarters staff of the Department of Children and Family Services (DCFS), headquarters staff of the Florida Medicaid Program, reviewed Medically Needy Program data, and held focus groups with district DCFS eligibility staff.

FINDINGS

Enrolled vs. Eligible Individuals

When an individual makes application for public assistance in Florida, the individual is screened for all programs available through DCFS. If an individual appears to be potentially eligible for the Medically Needy Program, she/he will be "enrolled' in the program, but is not actually placed on Medicaid until she/he has met "share of cost", that is, until she/he has, in a given

month, accumulated enough incurred medical expenses to reduce income to the Medically Needy income standard. On the date the individual incurs the expense, which reduces net income to the Medically Needy standard, the person becomes a Medically Needy "eligible" and is given Medicaid for the remainder of the month. At the time that an individual switches from "enrolled" status to "eligible" status, DCFS staff issue a written confirmation of this, which the individual may use until the individual's Medicaid eligibility is electronically activated in the Medicaid Management Information System, a process which usually takes two days. Some providers accept this written confirmation in place of a Medicaid card and provide services, others do not.

Bills that are used in full to meet share of cost are not eligible for Medicaid reimbursement, however, if a bill for a medical expense is concurrent with the date of Medically Needy eligibility (such as a hospital or pharmacy bill) that bill will be paid, unless it is used in full to meet share of cost.

Caseload and Expenditure Data for the Medically Needy Program

DCFS does not keep longitudinal data on the number of "enrolled" versus "eligible" individuals under the Medically Needy Program, however a snapshot of the September, 2000 DCFS eligibility files indicated that 183,000 individuals were currently classified as "enrolled". According to the Medicaid Program, for Fiscal Year 1999-2000, 110,219 individuals appeared on the Medicaid eligibility files under the Medically Needy eligibility category. Of the individuals who were placed on the Medicaid eligibility file, claims were actually paid on behalf of 55,535 individuals, for a total program cost of approximately $172 million. The average monthly expenditure per Medically Needy recipient was approximately $654; the average length of eligibility was 2.39 months per recipient per year.

Annual Months of Medically Needy Eligibility FY 99-00

Ages	Number of Recipients	Eligible Months	Eligible Months Per Year
Under 1	8,327	32,324	3.88
1-10	8,965	11,930	1.33
11-20	9,558	16,235	1.70
21-30	19,349	37,214	1.92
31-40	24,369	54,438	2.23
41-50	16,474	42,771	2.60
51-60	9,059	27,341	3.02
61-70	7,585	22,474	2.96
71-80	4,443	12,153	2.74
81-90	1,845	5,290	2.87
91-100	237	753	3.18
Unknown	7	22	3.14
Total	110,218	262,945	2.39

Program Operation

The operation of Florida's Medically Needy Program is split between the Medicaid Program, the Economic Self-Sufficiency program of the Department of Children and Family Services, and the Office of Disability Determination at the Department of Health. federal regulations (42 CFR 431.10, "Single State Agency") require that the designated single state Medicaid agency (AHCA in Florida) be the only agency with authority to promulgate policies on matters affecting Medicaid. In practice in Florida, Medically Needy Program policy is disseminated by DCFS, after approval of these policies by the Medicaid Program. Eligibility workers at DCFS interview potential recipients, collect information about their financial and medical situations and place applicants on the program as they become eligible. The Department of Health Office of Disability Determination evaluates whether or not an applicant for the Medically Needy Program meets medical disability criteria for eligibility. Once an individual is actually on the program, Medicaid pays claims for services which fall within the eligibility period.

As earlier stated, the Medically Needy Program allows Medicaid only for the days remaining in a month after the point in time during the month that the person has incurred medical expenses which reduce gross income to the Medically Needy income standard. Each month the worker and the applicant must array unpaid medical bills and determine which bills are counted to gain eligibility. In some cases the applicant and the worker may decide that the applicant will not consider bills in a current month in favor of delaying both the application and needed medical services until the first of a subsequent month in order to gain a full month's coverage for the applicant.

DCFS staff does not collect data that describes which types of medical events lead to Medically Needy eligibility. Anecdotally, however, workers report that the most common situations are those in which an individual or family has experienced an episode of expensive hospital inpatient or emergency care. DCFS staff also

report that the program is often used by elderly and disabled persons who regularly have high prescription drug costs. Since a person who is Medically Needy remains eligible for the remainder of the month, Medicaid subsequently pays for other medical care the person receives during the eligibility period.

Utilization of Medicaid Services by Medically Needy Recipients

Service	FY 99-00 Annual Cost	Percent of Total
Hospitals	$81,808,960	48%
Prescriptions	$63,500,042	37%
Physicians	$13,231,350	8%
Medicare Deductibles	$3,730,306	2%
All Other Services	$9,670,245	6%
Total	$171,940,904	100%

Some applicants (often individuals with chronic medical conditions or disabilities) have regular medical expenses. These applicants often arrange to receive their medical care at the first of each month in order to meet share of cost early in the month and thereby gain more or less continuous coverage.

Differences Between DCFS Districts

DCFS headquarters policy staff disseminates Medically Needy Program policy statewide. Policies, procedures and eligibility standards are standardized and do not vary by district. Some DCFS districts, however, have specialized Adult Payments staff, who deal exclusively with eligibility for programs affecting aged and disabled individuals. It is difficult to make comparisons between districts' implementation of the program, since Medically Needy eligibility is almost entirely based on the individual applicant's economic circumstances in the month of application and medical expenses in prior months. These factors change month-to-month, and invariably change when an individual moves across county lines. Since eligibility determination for the Medically Needy Program is different for every applicant, it requires a high degree of experience and creativity on the part of the eligibility worker. Workers who have been involved with the program eventually develop networks of contacts in the medical profession in their communities whose assistance they rely upon in tracking and updating applicant medical expenses. In some cases, a recipient may encounter a DCFS worker who is less skilled and experienced in the process of sequentially arraying an applicant's medical bills or in working with hospitals, pharmacists and physicians in the local community.

Attitudes about the Medically Needy Program

Workers and supervisors working with the Medically Needy Program express frustration due to what they perceive as difficult working conditions. Training is limited, turnover in some districts is often high, and pay is comparatively low. Often workers have recently completed college degrees in Social Work or other human services fields; becoming a DCFS eligibility worker is often their first job. On the other hand, individuals applying for Medically Needy assistance are experiencing medical crises, have crushing medical bills, and have generally been determined ineligible for other medical assistance programs, rendering them frustrated, frightened and confused. Workers expressed pride in being able to help applicants who are in difficult circumstances to gain assistance, but would like to see the eligibility process for Medically Needy become simpler and more user-friendly for themselves and applicants. This is particularly true for applicants who have chronic conditions and whose medical expenses show little variation. Since coverage lasts only until the end of the month, the eligibility process must be repeated each month that an individual desires to be on the program, a process which is unnecessarily burdensome for both applicants and workers.

SSI and OSDI Programs Interaction with the Medically Needy Program

Individuals who are disabled may be eligible for federal economic assistance under either the Supplemental Security Income program (SSI) or the Social Security Disability Insurance (SSDI) program. For most people, the medical requirements for disability payments are the same under both programs and the same process determines a person's disability. Individuals eligible for SSI economic assistance also automatically receive Medicaid coverage. SSI cash payments are based on an individual's economic need, but do not exceed $512 per month. For Medicaid purposes, a spouse or parent's income is deemed to be available to an applicant. If the total family income exceeds the SSI standard, the individual is ineligible for SSI, but may qualify for the Medical Assistance Only eligibility group (MEDS-A/D) which provides Medicaid only, with no cash assistance. The MEDS-A/D income limit was set at 100 percent FPL in Florida until 1992, when the limit was reduced to 90 percent FPL ($627 per month for an individual, $844 per month for a family) in proviso language in the General Appropriations Act in the special session of the Legislature. Individuals over these income limits are ineligible for Medicaid, leaving the Medically Needy Program as the only option available to gain medical assistance.

Individuals who have enough creditable quarters of work experience and who become disabled may be eligible for SSDI. To be eligible for SSDI a person must have worked and paid Social Security taxes, be medically disabled and wait five calendar months to receive benefits after having been determined eligible.
Individuals who are receiving SSDI do not receive Medicaid (unless their disability benefit is below the SSI or MEDS-A/D income standard) but are eligible to receive Medicare after a two-year waiting period. Cash benefits an individual will receive under Social Security Disability Insurance are based on an individual's work history and wages. If an individual has end-stage renal disease, there is no two-year waiting period for Medicare.

Surviving the two-year Medicare waiting period often represents a major challenge for individuals on Social Security Disability Insurance. Due to the disabling condition, these individuals often have higher medical expenses, and few resources to meet these expenses. Since the Medically Needy Program requires, prior to eligibility, that the individual have incurred medical expenses that consume all but $180 of monthly income, nearly all of an individual's SSDI income must be spent on medical expenses in order to gain Medicaid coverage.

For FY 1998-99, Medicaid estimated that there were approximately 16,000 individuals in the two-year waiting period for Medicare coverage in Florida. Based on the estimated per person cost projected for FY 2000-2001, the cost of extending Medicaid eligibility to this group could be as much as $121 million per year. Expansion of Medicaid to this group (excluding all other applicants with similar incomes) would require a federal waiver.

Implementation of a Medicaid Buy-in Program Under the "Ticket to Work and Work Incentives Improvement Act of 1999"

During the 2000 Legislative Session, the Florida Legislature considered proposed legislation that would have implemented the Medicaid "buy-in" provisions of the Ticket to Work and Work Incentives Improvement Act of 1999. The proposal received unanimous approval in substantive committees; however, due in part to concerns regarding potential cost to the state, the proposed language was ultimately replaced with language mandating that the Agency for Health Care Administration conduct a cost and feasibility study regarding a Medicaid "buy-in" program for working individuals with disabilities. The mandate states that:

> "The Agency for Health Care Administration is directed to conduct a cost and feasibility study regarding the implementation of the federal "Ticket to Work and Work Incentive Act of 1999" in Florida and to report its findings to the Speaker of the House of Representatives and the President of the Senate no later than December 1, 2000."

To oversee the study, a steering committee was established that included representatives from the Agency for Health Care Administration, Department of Children and Family Services, Vocational Rehabilitation, Social Security Administration, legislative staff, and advocates. The study included a review of actions other states have taken to implement a "buy-in" program for working individuals with disabilities and a survey of potential participants in a "buy-in" program to collect information related to the cost of service. As part of the study, the Agency for Health Care Administration also sponsored two public forums for the purpose of soliciting input from consumers and advocates.

The comments at the town hall meetings, which were held in Winter Park and Miami, indicated that there is strong support from consumers and providers for a "buy-in " program. Individuals attending the forums represented a wide cross section of the disability community and expressed concerns centering on the fear of going to work and losing health insurance.

Estimating the potential costs of implementing the Medicaid buy-in provisions of the Act has proven difficult for states. A central question in determining the potential cost of the Ticket to Work Act has been whether the program can be structured to allow only current disabled Medicaid recipients who desire to return to work to enter the program, and thus be cost neutral or produce cost savings to the state. The Agency for Health Care Administration is working with the federal Health Care Financing Administration regarding the feasibility of limiting the program to individuals currently on Medicaid who begin working or receive additional salary or wages due to raises or increased hours at work.

Options to Improve the Medically Needy Program

After reviewing the Medically Needy Program, it is the conclusion of staff that there are very few quick, easy, inexpensive modifications which can be made within the constraints of current federal rules that govern program operations. However, under the rules proposed October 31, 2000, the program could be liberalized to cover

additional individuals, although any changes which increase caseload would also increase costs to the state.

1. Florida could increase the Medically Needy income standard and then adjust the standard annually by the Consumer Price Index. It is also possible to do either of these separately. Current federal rules require the Medically Needy Income standard to be benchmarked to the 1996 AFDC standards (this may soon change). The maximum standard a state may currently use is 133 1/3% of the 1996 AFDC standard; Florida currently uses 100% of the AFDC standard. In addition, federal law allows states to increase the standard by the CPI each year. Since the standard is used to determine the amount of medical expenses a person must incur to become eligible for the Medically Needy Program, an increase in the income standard operationally means that an applicant must incur fewer expenses to become eligible for the program. Most DCFS staff interviewed felt that this would not significantly increase the number of people ultimately made eligible for the program. DCFS is currently in the process of extracting gross incomes and share of cost for this year's Medically Needy Program participants; these data will allow Medicaid to make an estimate of the actual cost of increasing the income standard.

2. Florida could increase the Income Standard for the Medical Assistance Only program (MEDS-AD) to 100 percent of the Federal Poverty Level for aged and disabled individuals, thereby increasing the number of individuals who qualify for full Medicaid coverage without having to meet the spenddown requirement of the Medically Needy Program.

   The MEDS-AD income standard was reduced from 100 to 90 percent of FPL as a Medicaid budget reduction in the 1992 Special Session. The legislature could restore this income level to the pre-1992 level. The state could also raise the effective income standard by increasing the disregard applied before income is counted toward the standard. Both of these changes would increase the number of individuals eligible under MEDS-AD for full, categorical Medicaid coverage.

3. Florida could implement the Ticket to Work Medicaid Buy-in program. This program would serve a subset of the Medically Needy population – disabled individuals who are able to work but do not currently do so due to a fear of losing Medicaid and the supportive services it provides. These new federal Medicaid provisions are generating substantial interest nationwide and there is a major interest by the disability advocacy community for this expansion in the next session. If the program can be limited to individuals currently receiving Medicaid who would continue on the program indefinitely, this program should produce some savings from the premiums collected. In addition, it is likely that some of the individuals in the program would gain access to employer-sponsored health care coverage, producing more savings. If, however, the program serves individuals who are not currently on Medicaid, the caseload expansion will be at additional cost. States which have implemented similar programs, without restricting eligibility to current recipients, report that 90% of the program participants are current Medicaid recipients.

4. Florida could request permission from the Health Care Financing Administration to allow DCFS workers, in the instance of an individual with a chronic condition, whose physician certifies that medical expenses are regular and on-going, to calculate projected medical expenses based on average past medical expenses without requiring the applicant to produce the same documentation each month.

RECOMMENDATIONS

1. Increase the Medically Needy income standard and then adjust the standard annually by the Consumer Price Index.

2. Implement the Ticket to Work Medicaid Buy-in program for individuals currently on Medicaid who desire to return to work.

3. Request permission from the Health Care Financing Administration to allow DCFS workers, in the instance of an individual with a chronic condition, whose physician certifies that such expenses will be ongoing, to calculate projected medical expenses based on average past medical expenses without requiring the applicant to produce documentation each month.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
Committees on Health, Aging and Long-Term Care; Budget; and Fiscal Policy, 404 South Monroe Street, Tallahassee, FL 32399-1100, (850) 487-5824 SunCom 277-5824

MEMBER OVERSIGHT
Senators Saunders and Silver