SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL:	SB 930
INTRODUCER:	Senator Jones
SUBJECT:	Optional Medicaid Payments
DATE:	March 11, 2006
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Favorable**
2.			HA	
3.			WM	
4.				
5.				
6.				

I. Summary:

This bill allows a Medicaid recipient in a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, or a state mental hospital whose income and assets do not exceed a specified amount to retain a monthly personal allowance of $45 per month (up from the current $35 per month), which is deducted from the individual's income when determining the patient's responsibility for the cost of care. Legislative appropriations currently set the monthly personal allowance for Medicaid recipients in these facilities.

This bill amends s. 409.904, F.S.

II. Present Situation:

The Florida Medicaid Program

The Florida Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida's Medicaid Program provides health care coverage and services to over 2.2 million Floridians at a cost of over $15 billion in fiscal year 2005-06.

Medicaid is the largest program providing medical and health related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services on a statewide basis;
- Sets the rate of payment for services; and

- Administers its own program.

The Agency for Health Care Administration (AHCA) is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some services are mandatory services that must be covered in any state that participates in the Medicaid program. Other services are optional. A state may choose to include optional services in its state Medicaid plan, but such optional services must be offered to all individuals statewide who meet Medicaid eligibility criteria. 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 ch. 216, F.S.

Medicaid Eligibility Determination

In Florida, the Department of Children and Families (DCF) determines eligibility for low-income children and family programs, and institutional care programs. The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) program.

The Department of Children and Families determines Medicaid eligibility for non-SSI groups. Each eligibility group has different income and asset requirements. Specifically, DCF determines eligibility for the following groups:

- **Low-income families with children.** Florida provides Medicaid to parents or specified relatives and children in low-income families. Specified relatives include grandparents, aunts, uncles, first cousins, and others who are within the fifth degree of relationship to the child.

  Children up to age 18 and their parents or specified relatives may be eligible for Medicaid if countable income does not exceed the income limits and countable assets are not above $2,000.

  - Individuals that are receiving Temporary Cash Assistance (TCA) are eligible for Medicaid. Individuals that are eligible for TCA, but choose not to receive it, may still be eligible for Medicaid.
  - Families that lose Medicaid eligibility due to earned income may be eligible for up to 12 additional months of Medicaid, if they meet certain requirements.
  - Families that lose Medicaid eligibility due to child support or alimony may be eligible for four additional months of Medicaid.

- **Children only.** Florida provides Medicaid services for children only. The income limits for most of these programs vary based on the age of the child. Only the income of the child and parent(s) is counted when determining the child's eligibility.

  Families that wish to apply for Medicaid just for their children may do so through the KidCare program. The KidCare application can be mailed, and does not require an

interview with DCF. Children who do not qualify for Medicaid may be eligible for other KidCare coverage if income is less than 200 percent of the Federal Poverty Level and will be referred to Florida Healthy Kids for this determination.

- **Pregnant women.** Florida provides Medicaid coverage for pregnant women. When determining eligibility for pregnant women, the unborn child is always counted when looking at the income limit for the family. Women that are found eligible for Medicaid remain eligible throughout the pregnancy and for the two months following the birth of the child, as long as the mother remains a resident of Florida.

- **Non-citizens with medical emergencies.** Non-citizens who would be Medicaid-eligible on all factors other than their citizenship status may be eligible for Medicaid to cover medical emergencies, including the birth of a child. Before Medicaid may be authorized, applicants must provide proof from a medical professional stating that the treatment was due to an emergency condition. The proof must also include the dates of the emergency. Non-citizens who are in the United States for a temporary reason, such as tourists, students, or those traveling for business, are not eligible for Emergency Medical Assistance.

- **Elderly and/or disabled individuals not currently receiving SSI.** Florida has several programs designed to provide Medicaid to low-income individuals who are either elderly (65 or older) or disabled. This is referred to as SSI-Related Medicaid.

  Many aged or disabled people also have Medicare benefits. These individuals can still qualify for Medicaid (known as dual eligibles); however, Medicaid will only pay for services after Medicare has paid.

Beyond these mandatory eligibility groups, the Medicaid program may pay for other optional eligibility groups under s. 409.904, F.S. (e.g., Medically Needy, women with certain cancers, etc.). Medicaid eligibility for these optional groups often has special participation requirements. One of the most common requirements is that the individual pay a portion of the cost of care before Medicaid will pay for the remaining costs. This is known as the recipient's "patient responsibility."

Monthly Personal Allowances

For Medicaid recipients who reside in a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, or a state mental hospital, Medicaid eligibility rules require that most of their personal income is to be paid to the facility for their patient responsibility. The Medicaid program then pays the balance of the cost of care to the facility until the Medicaid fee rate is met. In order to be eligible for this personal allowance, a Medicaid recipient in these facilities must have an income that does not exceed 300 percent of the SSI income standard and must meet the assets standards established under federal and state law.

Medicaid allows recipients in residential settings to retain a modest sum of money from their income before calculating their patient responsibility to be used for personal needs outside of what is required to be supplied by the facility (i.e., those expenditures outside of expenses for

necessities such as food, shelter, and health-related care and treatment that are reimbursed to the institutional care provider). This personal allowance is, at least in theory, protected by law to ensure that the recipient controls the disposition of that money either to the extent that he or she is able to do so, or that the money is held or spent in the best interests of the recipient. It is not to be used for the necessities of life, which are provided for with other monies in the government programs, nor used for the benefit exclusively of others or for any inappropriate benefit to anyone who manages the money for a recipient.

The Florida Medicaid Program's ability to exclude the monthly personal allowance from the calculation of a person's share of cost is established in s. 409.904, F.S. Currently, the amount that may be retained for the personal allowance is based on appropriations. In FY 2005-06, the monthly personal allowance is $35 per month.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.904, F.S., requiring the monthly personal allowance to be $45 per month for Medicaid recipients in a licensed nursing facility, a licensed intermediate care facility for the developmentally disabled, or a state mental hospital. This allowance is deducted from the person's income when determining the patient's responsibility for the cost of care. The personal allowance would no longer be set based on appropriations.

Section 2. Provides an effective date of July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Agency for Health Care Administration

The bill will allow Medicaid recipients in licensed nursing facilities, licensed intermediate care facilities for the developmentally disabled and state mental hospitals to be able to keep $45 monthly to pay for their personal needs instead of the $35 currently allowed. The additional $10 per month allowance would increase Medicaid expenditures by $5,726,880 ($2,361,765 General Revenue) in FY 2006-07.

The Agency for health Care Administration estimates that the bill may have a minimal fiscal effect on DCF and on the Agency for Persons with Disabilities to administer the change.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.