

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 7109      PCB HHSC 11-02      Medicaid

**SPONSOR(S):** Health & Human Services Committee, Schenck

**TIED BILLS:** HB 7107      **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	11 Y, 6 N	Calamas	Gormley
1) Appropriations Committee	15 Y, 8 N, As CS	Pridgeon	Leznoff

### SUMMARY ANALYSIS

HB 7109 conforms current law to the new provisions created in HB 7107 by repealing current provisions of law at specific landmarks when managed medical assistance, managed long-term care and managed long-term care for persons with developmental disabilities are implemented statewide; modifying duties of the Agency for Persons with Disabilities (APD), the Department of Elderly Affairs (DOEA) and the Aging Resource Centers once the Medicaid managed long-term care and managed long-term care plans are implemented in each region; developing parts within Chapter 409, and repealing other outdated provisions.

Recipients statewide may opt out of the Medicaid program and use their Medicaid financial assistance to pay for their share of cost in any employer sponsored health insurance plan or, upon federal approval, to pay for other insurance or related products providing access to health care services created pursuant to state law, such as products in Florida's Health Choice Program or any state exchange.

HB 7109 makes some immediate changes to Medicaid managed care. Managed care plans statewide are required to use a uniform accounting method to report medical and nonmedical costs to the Agency for Health Care Administration (AHCA). AHCA is given specific guidance on the operation, maintenance and use of the Medicaid Encounter Data System. AHCA is directed contract with a provider service network (PSN) to serve as a third party administrator for the Medipass program in all counties with less than two prepaid plans.

Provider service networks statewide may still remain fee-for-service for a limited period of time, but with a shared savings settlement. AHCA is required to conduct annual reconciliations to determine the amount of cost savings achieved by fee-for-service PSNs.

The bill authorizes AHCA to establish payments for Medicare Advantage Special Needs members who are also eligible for Medicaid and to develop payments for Medicaid only covered services for which the state is responsible. The bill also provides certain regulatory relief to nursing homes so that they can prepare for the implementation of long-term care managed care.

The bill changes the methodology for the calculation of Medicaid rates for hospitals. Additionally, AHCA is directed to develop by 2013, a plan to convert inpatient hospital rates to a prospective system that uses diagnosis related groups (DRG).

AHCA is directed to develop a plan for enrolling the Medically Needy in Medicaid managed care and immediately seek necessary federal approval. AHCA is also directed to seek federal approval for and implement upon approval, a contract with a PSN to immediately provide care management and coordination statewide for the Medically Needy Program. Enrollees will have six months of continuous coverage and pay their share of cost to the PSN as their share of premium. The contract will expire when the Medically Needy are transitioned into Medicaid managed care.

The bill creates a limitation on noneconomic damages for the negligence of practitioners providing services and care to Medicaid recipients.

The bill does not appear to have a fiscal impact on state or local governments.

Except as otherwise provided, the bill is effective when HB 7107 or similar legislation is passed and becomes law.

**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

**STORAGE NAME:** h7109c.APC

**DATE:** 3/28/2011

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. EFFECT OF PROPOSED CHANGES:

##### **Current Situation**

##### **Medicaid**

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elder Affairs. Key characteristics<sup>1</sup> of Florida's Medicaid program are as follows:

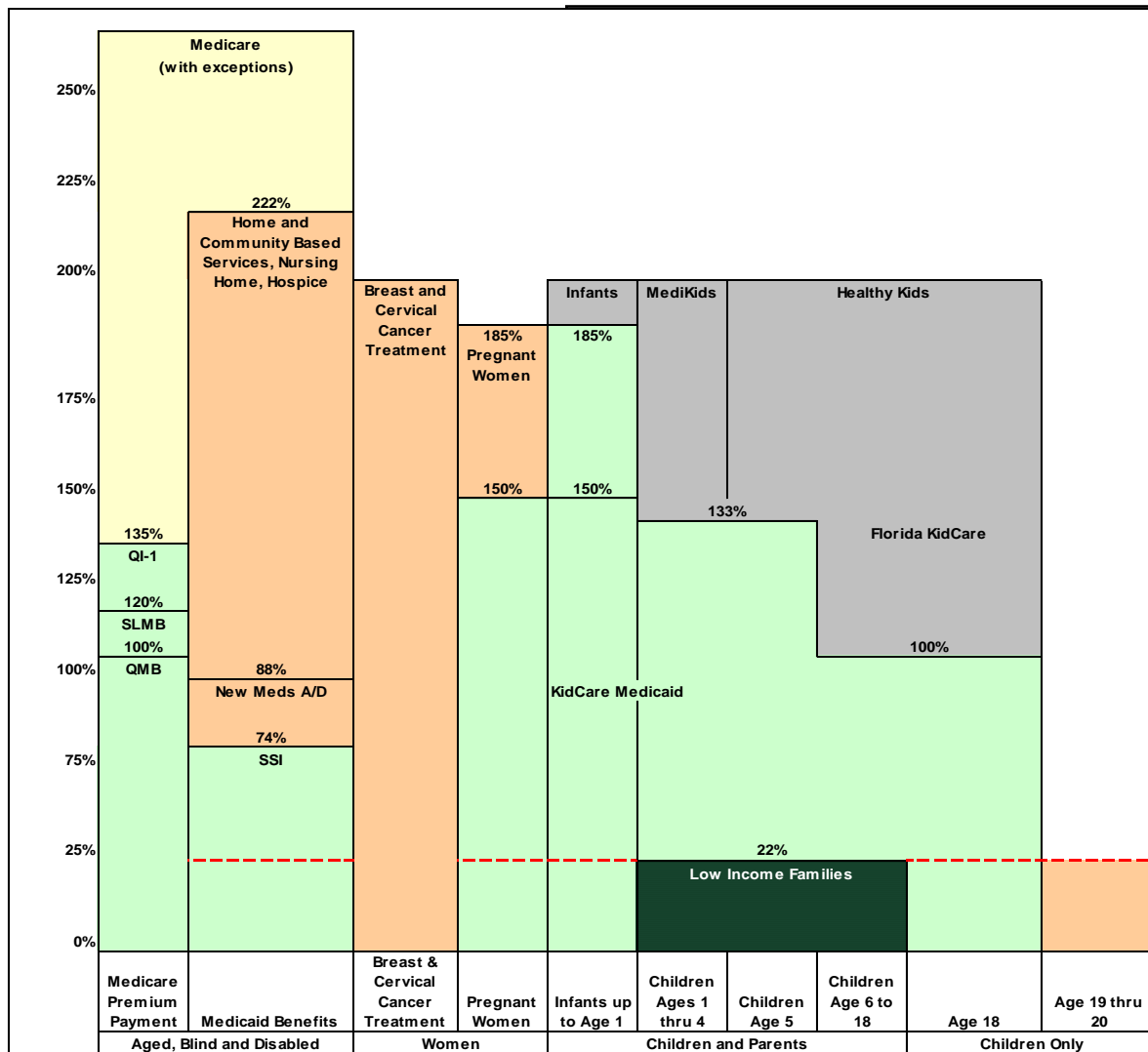
- Over 2.9 million enrolled recipients.
- \$20.3 billion estimated spending in Fiscal Year 2010-2011.
- \$7000 estimated per recipient spending in Fiscal Year 2009-2010.
- Over half the childbirths in Florida are paid for by the Medicaid program.
- Over 1.9 million of the 2.9 million recipients are enrolled in some type of Medicaid managed care.
  - 1.1 million in HMOs
  - 196,000 in PSNs
  - 613,000 in Medipass
- 936,000 of the 2.9 million recipients are enrolled in fee-for-service Medicaid
- 24 managed care organizations, including 19 HMOs and 6 PSNs.
- 100,000 fee-for-service providers

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. In the chart below, the yellow and light green sections are mandatory populations by federal law. States can add eligibility groups, with federal approval. In the chart below, the orange sections show the groups Florida has added over the years. Once these optional groups are part of the Medicaid program the entitlement applies to them as well.

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<sup>1</sup> Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Medical Home Task Force, September 2009.



The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.<sup>2</sup> States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.<sup>3</sup>

States do have some flexibility. States can ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has 20 separate waiver programs for distinct populations, services and service delivery models.

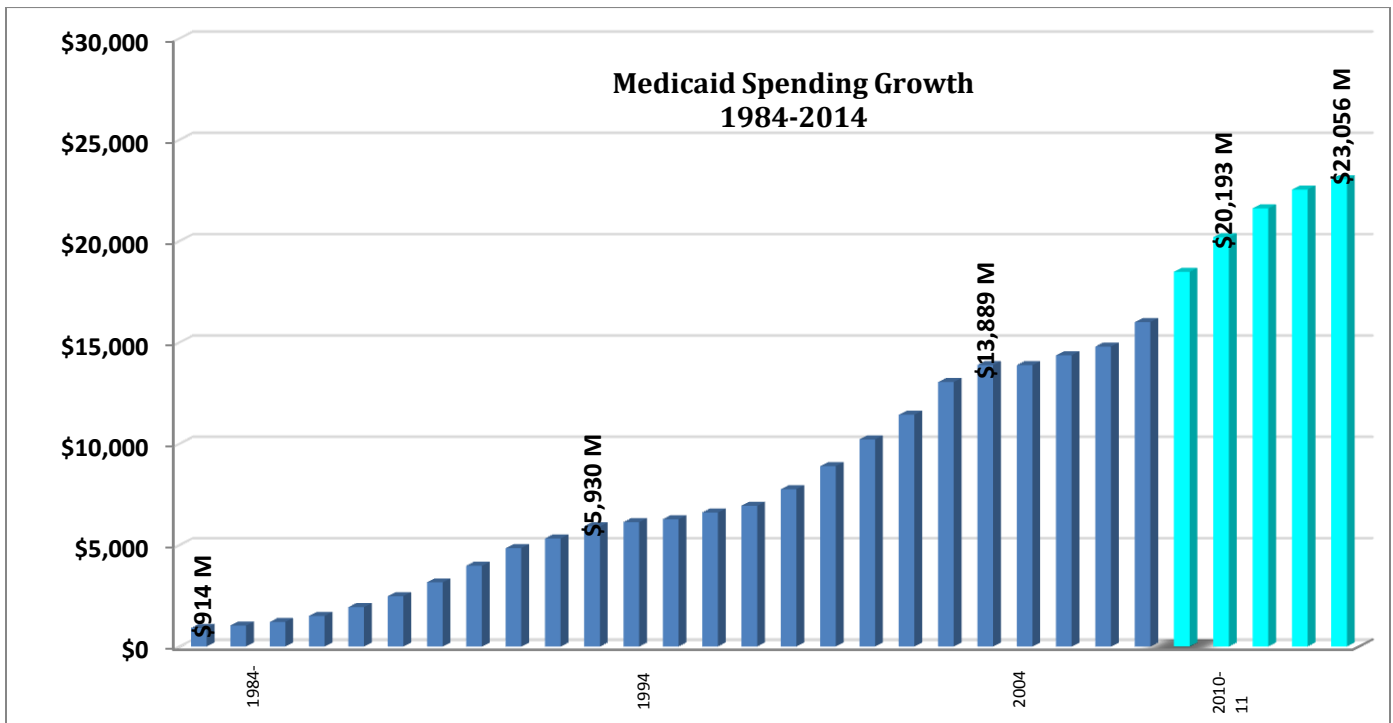
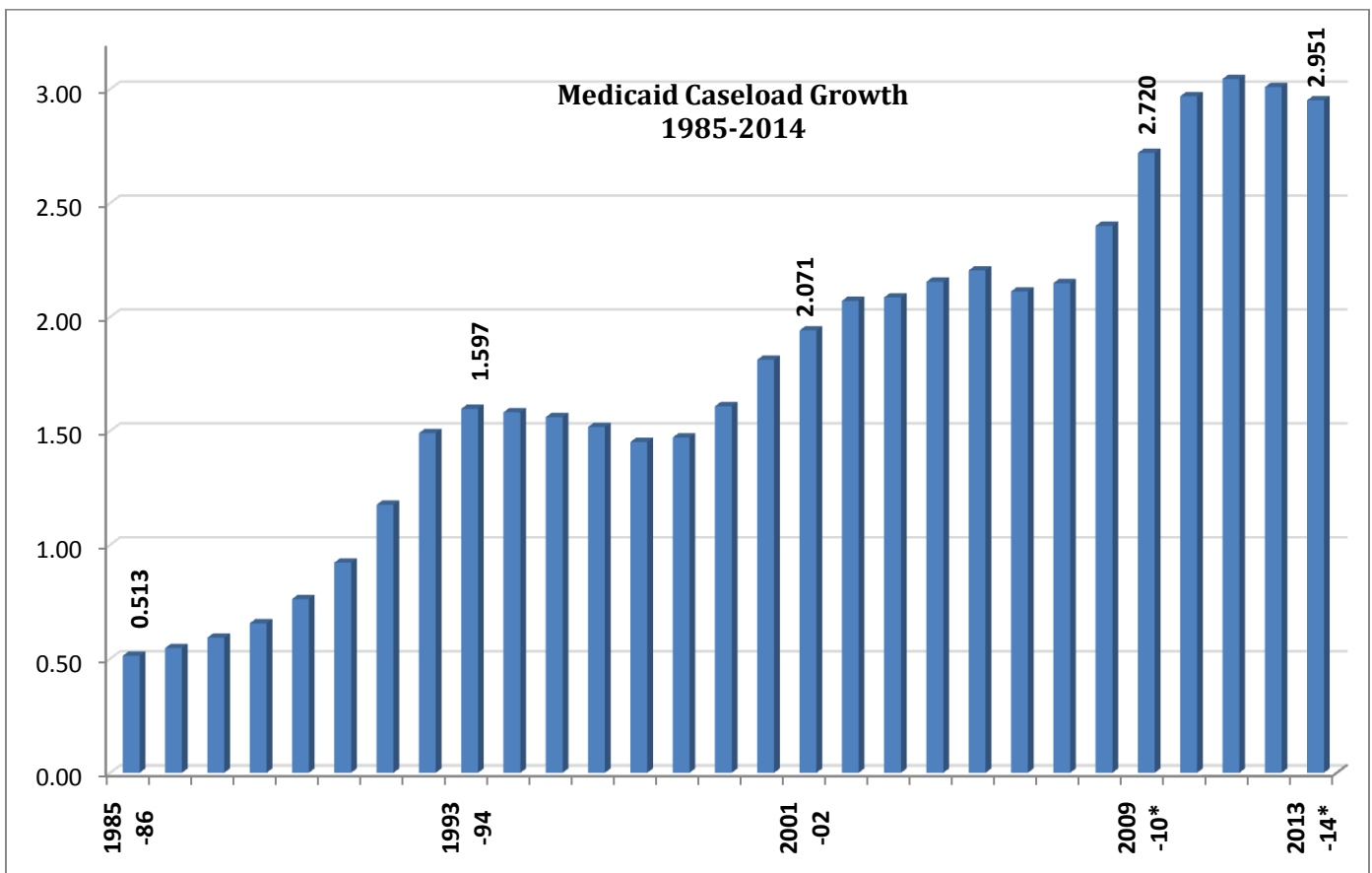
Florida Medicaid is the second largest single program in the state, behind public education, representing 28 percent of the total FY 2010-11 budget. Medicaid General Revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures.

Florida's Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. The growth in Florida's Medicaid population and expenditures is shown in the figures below.<sup>4</sup>

<sup>2</sup> s. 409.905, F.S.

<sup>3</sup> s. 409.906, F.S.

<sup>4</sup> *Supra*, note 1.



Current estimates indicate the program will cost \$20.3 billion in FY 2011-2012. By FY 2013-2014, the estimated program cost is \$23.6 billion. Florida has made numerous and repeated efforts to control costs in the program.<sup>5</sup> Since 1996, the Legislature has reduced \$5.2 billion from the program through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives. For

<sup>5</sup> See: Florida Medicaid Budget Reduction History, presented by staff of the House Health Care Appropriations Committee in the Select Council on Strategic and Economic Planning, October 7, 2009.

example, approximately 40 percent of the Medicaid prescription drug budget is funded by manufacturer rebates.

### Medicaid and Federal Health Care Reform

The U.S. Congress passed the Patient Protection and Affordable Care Act (PPACA),<sup>6</sup> and President Barack Obama signed the bill into law on March 23, 2010.<sup>7</sup> Key policy areas of reform include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs. Several of these changes will affect the Florida Medicaid program.

Medicaid currently focuses on covering low-income children, pregnant women, and adults who are elderly or have a disability. The federal reform act increases the mandatory population to all adults, regardless of whether they are disabled or elderly, up to 133 percent of the poverty level. The reform law would finance the expansion by raising the federal match rate for the new groups. States would still have to pay a share for the new groups, but it would be smaller than for existing groups. However, the additional federal match is time-limited.

In addition, the federal reform law imposes a mandate on individuals to buy insurance, or pay a tax penalty. Currently, many uninsured individuals are eligible for Medicaid coverage, but are not enrolled. The existence of the federal mandate to purchase insurance will result in many eligibles coming forward and enrolling in Medicaid who had not previously chosen to do so. While these eligibles are currently entitled to Medicaid coverage, their participation will result in increased costs and would not likely have occurred without the catalyst of the federal mandate.

Element	Affordable Care Act <sup>8</sup>
Mandatory Expansion	Expand eligibility to 133% FPL (\$29,326 for a family of 4), including non-disabled adults in 2014
FMAP/ Expansion	Enhanced federal matching funds for expansion population: <ul style="list-style-type: none"><li>• 100% CY 2014</li><li>• 100% CY 2015</li><li>• 100% CY 2016</li><li>• 57.44% + 34.3 = 91.74% CY 2017</li><li>• 57.44% + 33.3 = 90.74% CY 2018</li><li>• 57.44% + 32.3 = 89.74% in CY 2019 and beyond</li></ul>
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program 1/1/2015 (through regular annual eligibility redetermination process)
FMAP/ CHIP Transition	Anticipated enhanced FMAP for CHIP Population begins 10/1/2015 (134% Federal Poverty Level and above) <ul style="list-style-type: none"><li>• 10/1/2015: 70.21+23.0=93.21%</li></ul>
Increased Rate for Practitioners	100% federal funded increase to select codes for primary care providers for 2013 and 2014. This impacts approximately 35% of primary care codes under the Florida Medicaid Program.

<sup>6</sup> Pub.L. No. 111-148, 124 Stat. 119 (2010)

<sup>7</sup> PPACA is currently being challenged as unconstitutional by Florida and 25 other states. The law was declared unconstitutional by the court in Florida v. HHS --- F.Supp.2d ---, 2011 WL 285683 (N.D.Fla.). However, the ruling was stayed and the matter is on appeal to the United States Court of Appeals for the Eleventh Circuit, Case No. 11-11021-HH.

<sup>8</sup> Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 13, 2010.

The costs of federal reform to Florida Medicaid will be significant. Florida is expected to have over 708,000 new enrollees from the expanded federal reform population in 2014, at a cost of \$2.8 billion (of which \$150 million will be paid by the state), bringing the total cost of Medicaid that year to \$24.9 billion. By 2019, Florida Medicaid will have over 1.7 million additional enrollees, at an additional cost of over \$7 billion (of which \$1 billion will be paid by the state).<sup>9</sup> In subsequent years, the state share may increase.

Federal reform will create additional costs unrelated to caseload expansion. For example, the law increases the minimum federal rebate for brand drugs from 15.1 percent to 23.1 percent and requires that 100 percent of this portion of rebates be withheld by the federal government rather than the current procedure of sharing rebate revenue with the states. This provision will cost Florida approximately \$37 million annually at current levels. The FY 2010-2011 impact will be a loss in rebate general revenue of \$39.8 million.<sup>10</sup> This will be a recurring loss. Additionally, when the federal enhanced payments to primary care providers expire in 2014, it is estimated that continuing the payments will cost the state \$247.9 million in 2015.

### Medicaid Managed Care

Florida, like other states, turned to managed care for improving access to care, containing costs and enhancing quality. As of March 1, 2011, 67 percent of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models. Florida uses at least 16 different managed care models, including prepaid health plans Health Maintenance Organizations (HMOs), primary care case management (MediPass)<sup>11</sup>, provider service networks (PSNs)<sup>12</sup>, Managed Provider Networks (MPNs), MediPass disease management, prepaid mental health plans, and prepaid dental health plans.

The Florida Medicaid Program pays for services in three ways: (1) fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; (2) per-member, per-month payments to certain managed care organizations which bear full risk for recipient care; and (3) fee-for-service reimbursement to PSNs which must meet and share savings targets or reimburse the Medicaid program for failure to meet the target.

Medicaid uses a per-member, per-month, or capitated, payment model for Health Maintenance Organizations (HMOs), capitated PSNs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.

Rates for HMOs are set for specific demographic cohorts based on age, sex, geographic location and eligibility group. While these factors are linked with utilization patterns to some extent, they do not capture or reflect any detailed understanding of a person's clinical risk. The Medicaid reform pilot (see below) initiated a process for adjusting rates to reflect clinical risk. The adjustments were phased in over a three-year period with a 10 percent risk corridor to limit any dramatic changes in payment levels.

Medicaid uses fee-for-service reimbursement for PSNs, including MPNs. PSNs are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings

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<sup>9</sup> Agency for Health Care Administration, Overview of National Reform Legislation, March 23, 2010.

<sup>10</sup> Agency for Health Care Administration, Impact of Patient Protection and Affordable Health Care Act, PPACA (P.L. 111-148) and changes made by the corrections measure through the Health Care and Education Reconciliation Act (H.R. 4872) approved by the House and Senate on March 25, 2010, March 31, 2010, on file with the Select Policy Council on Strategic & Economic Planning.

<sup>11</sup> MediPass is the Florida Medicaid primary care case management program. Services to MediPass members are reimbursed on a fee-for-service basis, and MediPass primary care providers (PCPs) are paid a \$2.00 per member per month case management fee. PCPs are responsible for providing primary care and authorizing the specialty care provided to their enrollees. PCPs do not bear risk for their patients but do have requirements in place for case management, care coordination, and preventive care.

<sup>12</sup> s. 409.912(4)(d), F.S.

goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

Federal regulations require Medicaid beneficiaries to have a choice of managed care providers. This requirement may be satisfied with a choice of HMOs, or a choice between an HMO and MediPass, or a choice among MediPass providers. Upon enrollment in Medicaid, recipients have 30 days to exercise their choice of providers. Choice counseling is available during this period through a toll-free help line in non-reform counties. Those who select a managed care plan are enrolled for a 12-month period. After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next nine months. For those who do not make a choice, current law requires AHCA in non-reform counties to assign recipients “until an enrollment of 35 percent in MediPass and 65 percent in managed care plans” is achieved. The law further requires enrollment procedures to maintain this same proportionate distribution over time. After these considerations, assignment procedures may consider past choices of the participants.

### Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized AHCA to seek and implement a federal waiver for a managed care pilot program. AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011. The five-year waiver expires June 30, 2011, unless renewed by AHCA.<sup>13</sup>

Reform is characterized by:

- A managed, coordinated system of care
- Choices and new options for recipients:
  - Different managed care plans, which can offer additional and varying benefits
  - Different models of managed care - between a traditional HMO model and a new provider-based model
  - Opt-out – Opportunity to use Medicaid dollars to purchase employer-based insurance
  - Enhanced benefits - Opportunities to be rewarded for healthy behaviors
- Financing: actuarially sound, risk-adjusted, capitated premiums based on encounter data, with comprehensive and catastrophic components.
- Low-Income Pool

The five-year waiver expires June 30, 2011, unless renewed by AHCA. In 2010, the Legislature directed AHCA to seek an extension of the waiver from the Centers for Medicare and Medicaid Services. The Agency for Health Care Administration is currently negotiating for the extension.

### *Provider Service Networks*

Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements. PSNs are networks owned and operated by providers to deliver comprehensive health care to their enrolled population. By statute, providers in PSNs must have a controlling interest in the governing body of the PSN, and may make arrangements with physicians or other health care professionals, health institutions, or any combination thereof, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians, by other health professionals, or through the institutions.<sup>14</sup>

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<sup>13</sup> According to AHCA, it must submit the renewal request by June 30, 2010. The federal Centers for Medicare and Medicaid Services must approve or deny the request within six months of receiving it.

<sup>14</sup> S. 409.912(4)(d), F.S.

In Medicaid reform counties, PSNs may be paid one of two ways: PSNs may receive the capitated, risk-adjusted payment used by the HMOs; or, for the first three years and at the PSN's option, PSNs may be reimbursed on a fee-for-service basis which includes the savings reconciliation element required for non-reform areas.<sup>15</sup> In Medicaid reform, current law requires all managed care organizations to bear risk; however, PSNs may choose to be reimbursed on a fee-for-service basis, with a savings settlement mechanism consistent with non-reform requirements. The ability for PSNs to be reimbursed on a fee-for-service basis was originally intended to apply to the first three years of reform; however, the deadline was subsequently extended to 2011.<sup>16</sup>

In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (see "Managed Behavioral Health Care in Florida" above).<sup>17</sup> Instead, when a PSN enrollee requires comprehensive behavioral health care,<sup>18</sup> enrollees are referred by the PSN to a prepaid behavioral health plan for services.

Under Medicaid reform, PSNs participate as managed care organizations in the pilot counties and compete with HMOs for recipient enrollment. PSNs may choose to be reimbursed on a fee-for-service basis or on a risk-adjusted capitated basis for the initial five years of the program, and then must convert to risk-adjusted capitated methodology used by HMOs in reform at the end of the third year of operation.<sup>19</sup>

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,<sup>20</sup> and the fully risk-adjusted payment methodology of reformed Medicaid will create the ability to adequately compensate and incentivize the development of these and other specialty PSNs. The 1115 Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services mandates that the state review and approve specialty plans pursuant to criteria that includes the appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population.

### *Risk-Adjusted Rates*

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially sound, risk-adjusted, capitated rates.

Risk-adjusted rates are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history. The initial risk adjustment methodology relied on claims data for prescription drug use. AHCA is in the process of transitioning to data as the basis for determining rates. In the future, encounter data will provide the clinical history for managed care enrollees. Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs. Similarly, clinical risk adjustment creates opportunity for innovative managed care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

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<sup>15</sup> s. 409.91211(3)(e), F.S.

<sup>16</sup> s. 409.91211(3)(e), F.S.

<sup>17</sup> See s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, available at [http://ahca.myflorida.com/Medicaid/pdf/SS\\_07\\_070701\\_SOS.pdf](http://ahca.myflorida.com/Medicaid/pdf/SS_07_070701_SOS.pdf).

<sup>18</sup> "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.

<sup>19</sup> s. 409.91211(3)(e), F.S.

<sup>20</sup> s. 409.91211(3)(bb)-(dd), F.S.



## *Encounter Data*

Prior to reform, Florida law did not require Medicaid managed care plans to report patient diagnosis and service information, or encounter data, about their recipients. For the first time in Medicaid, reform required at-risk plans to report encounter data, for use in evaluating plan quality and in setting risk-adjusted rates, and set a three-year process for establishing the new system.<sup>21</sup> AHCA created the Medical Encounter Data System (MEDS) to track this information. Both the plans and AHCA encountered difficulties in generating, reporting, and receiving the encounter data. However, all historical encounter data was received by AHCA by the end of 2009, and plans are continuing to submit current data. AHCA is reviewing and validating the data to ensure completeness and accuracy. AHCA used the encounter data as part of the rate-setting process for FY 2010-2011.

## *Plan Choice and Opt Out Program*

Upon enrollment in Medicaid, recipients in reform counties have 30 days to voluntarily select a managed care plan. For those who do not make a choice, current law requires AHCA to assign the recipient to a plan “based on the assessed needs of the recipient as determined by the agency.” In making such assignments, the agency must take into account several factors: the plan’s network capacity; a prior relationship between the recipient and the plan or one of the plan’s primary care providers; the recipient’s preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.<sup>22</sup> Recipients in reform counties may receive choice counseling through telephone, face-to-face counseling, mailings and outreach activities.

Evaluation by the University of Florida found the most common bases for recipient plan choice are primary care physicians in the network, and the prescription drugs covered by the plan.<sup>23</sup> Voluntary plan choice (as opposed to automatic assignment by AHCA) has increased.

Making Medicaid premiums available to help recipients purchase private insurance is a key component of Medicaid reform. The reform waiver allows recipients with access to employer-sponsored insurance to use their Medicaid dollars to purchase coverage through the employer. While few recipients currently use the Opt Out program, those who do are highly satisfied.

## *Low Income Pool*

The terms and conditions of the Medicaid reform waiver created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. Based on the waiver, Florida was able to increase these payments to hospitals and other providers by approximately \$250 million. The federal waiver sets a capped annual allotment of \$1 billion for each year of the 5-year demonstration period for the LIP.<sup>24</sup> The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Florida law provides that distribution of the Low-Income Pool funds should:<sup>25</sup>

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;

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<sup>21</sup> In the interim, risk-adjusted rates in reform are achieved using clinical data from recipient pharmacy records.

<sup>22</sup> s. 409.91211(4)(a), F.S.

<sup>23</sup> Florida Medicaid Reform Quarterly Progress Report April 1, 2009 – June 30, 2009, Agency for Health Care Administration, available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml) (last viewed April 8, 2010).

<sup>24</sup> Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration, at 24.

<sup>25</sup> s. 409.91211(c), F.S.

- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

In 2010, \$1 billion in LIP payments were made to hospitals and other providers. The LIP expires in 2011, unless renewed. Per the Legislature's directive in 2010, AHCA is currently negotiating the extension of the reform waiver, including the LIP funding.

### *Reform Objectives*

Reform has five objectives:

1. To increase the number of plans and enhance individual choice, including having different types of plans.
2. To ensure access to services not previously covered and improve access to specialists.
3. To improve enrollee outcomes.
4. To enable individuals to opt out and obtain private coverage.
5. To increase patient satisfaction.

Reform met the first objective. Pre-reform, AHCA contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, and two MPNs, for a total of twelve managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. AHCA currently has contracts with eight HMOs and five PSNs for a total of thirteen health plans in Broward County; and three HMOs and two PSNs for a total of five health plans in Duval County.

Reform met the second objective by allowing customized benefit designs, and making recipient choice the driving factor of plan enrollment. Plans were encouraged to offer new and additional services at no extra cost to the state. Currently, plans offer several services not previously covered:

- Over-the-counter drug benefit from \$20 to \$25 per household, per month;
- Adult preventive dental care;
- Acupuncture;
- Additional adult vision services - up to \$125 per year for upgrades such as scratch resistant lenses;
- Additional hearing services – up to \$500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition therapy.

Reform is also meeting the second objective. The figure below shows the Year One data on the numbers of certain specialists in Duval County pre- and post-reform, compared to national adequacy standards. After factoring in estimates of need for each specialty, AHCA concluded that access to care for the five identified specialties in Duval County either improved under reform or is more than adequate to meet recipient needs based on national benchmarks.

### Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

	Pre-Reform (June 2006)						Post-Reform (June 2007)		Adequacy Benchmarks	
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	Specs per 100K	Health Plan Count	Specs per 100K	Estimate of Need per 100k (Low)	Estimate of Need per 100k (High)
Pain Mgmt	2	4.9	143	351.3	145	<b>178.1</b>	58	<b>84.0</b>	<b>1.2</b>	<b>10.6</b>
Dermatology	3	7.4	3	7.4	6	<b>7.4</b>	9	<b>13.0</b>	<b>0.7</b>	<b>2.9</b>
Neurology	21	51.6	44	108.1	54	<b>66.3</b>	67	<b>97.0</b>	<b>1.2</b>	<b>3.4</b>
Orthopedics	32	78.6	31	76.2	48	<b>58.9</b>	64	<b>92.7</b>	<b>1.5</b>	<b>7.7</b>
General Dentistry	14	34.4	32	78.6	45	<b>55.3</b>	31	<b>44.9</b>	<b>17.5</b>	<b>30.8</b>
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

AHCA conducts quarterly network validation surveys to confirm that plans have active contracts with providers - particularly primary care physicians and specialists. The two most recent (2010) surveys found 97 of the providers listed by plans actually have current contracts with them.<sup>26</sup> These efforts continue to indicate that the plans are maintaining up-to-date provider files.

For Objective 3, AHCA measured enrollee outcomes based on national standards developed by the National Committee for Quality Assurance.<sup>27</sup> The Healthcare Effectiveness Data Information Set (HEDIS) is a tool used to measure health plan performance in patient care and service. The HEDIS allows policy-makers to compare varying plans with a standard measure. Results for reform plans indicate that more reform plans than non-reform plans exceed the national mean in HEDIS measures. The shaded areas in the table below indicate mean-exceeding measures.

Measure	Non-Reform			Reform			National Mean
	2008	2009	Difference	2008	2009	Difference	
Annual Dental Visit	n/a	n/a	n/a	15.2%	28.5%	13.3%	42.5%
Adolescent Well-Care	41.9%	<b>46.0%</b>	4.1%	<b>44.2%</b>	<b>46.5%</b>	2.3%	43.6%
Controlling Blood Pressure	52.7%	51.6%	-1.1%	46.3%	<b>55.9%</b>	9.6%	52.9%
Cervical Cancer Screening	56.6%	53.8%	-2.8%	48.2%	52.2%	4.0%	65.7%
Diabetes – HbA1c Testing	74.7%	75.1%	0.4%	<b>78.9%</b>	<b>80.1%</b>	1.2%	78.0%
Diabetes - HbA1c Poor Control INVERSE	48.5%	51.7%	3.2%	<b>48.3%</b>	<b>46.8%</b>	-1.5%	48.7%
Diabetes - Eye Exam	36.3%	41.9%	5.6%	35.7%	44.0%	8.3%	51.4%
Diabetes - LDL Screening	<b>75.6%</b>	<b>76.3%</b>	0.7%	<b>80.0%</b>	<b>80.2%</b>	0.2%	71.1%
Diabetes - LDL Control	29.5%	29.4%	-0.1%	29.3%	<b>35.9%</b>	6.6%	30.6%
Diabetes – Nephropathy	<b>77.1%</b>	<b>76.1%</b>	-1.0%	<b>79.2%</b>	<b>80.3%</b>	1.1%	74.6%
Follow-Up after Mental Health Hospital – 7 day	30.5%	37.2%	6.6%	20.6%	29.3%	8.7%	39.1%
Follow-Up after Mental Health Hospital – 30 day	47.0%	51.7%	4.8%	35.5%	46.6%	11.1%	57.7%
Prenatal Care	71.7%	69.1%	-2.6%	66.6%	67.4%	0.8%	81.2%
Postpartum Care	58.5%	50.1%	-8.4%	53.0%	51.5%	-1.5%	59.1%
Well-Child First 15 Months – Zero Visits INVERSE	<b>2.8%</b>	<b>3.0%</b>	0.2%	4.9%	<b>1.6%</b>	-3.3%	3.8%
Well-Child First 15 Months – Six Visits	44.0%	51.0%	7.0%	44.4%	49.3%	4.9%	55.6%
Well-Child 3-6 years	<b>71.1%</b>	<b>72.5%</b>	1.5%	<b>71.3%</b>	<b>75.7%</b>	4.4%	66.8%
Adults' Access to Preventive	n/a	69.3%	n/a	n/a	71.8%	n/a	76.8%

<sup>26</sup> Florida Medicaid Reform Year 4 Annual Report July 1, 2009 – June 30, 2010, Agency for Health Care Administration, available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml) (last viewed March 15, 2011).

<sup>27</sup> See, National Committee for Quality Assurance, <http://www.ncqa.org/tabid/675/Default.aspx>.

Care – 20-44 Years							
Adults' Access to Preventive Care – 45-64 Years	n/a	82.2%	n/a	n/a	<b>84.7%</b>	n/a	82.4%
Adults' Access to Preventive Care – 65+ Years	n/a	<b>74.7%</b>	n/a	n/a	<b>83.6%</b>	n/a	78.8%
Antidepressant Medication Mgmt – Acute	n/a	<b>45.6%</b>	n/a	n/a	<b>52.0%</b>	n/a	42.8%
Antidepressant Medication Mgmt -- Continuation	n/a	<b>31.2%</b>	n/a	n/a	<b>29.8%</b>	n/a	27.4%
Appropriate Medications for Asthma	n/a	<b>87.0%</b>	n/a	n/a	83.6%	n/a	86.9%
Breast Cancer Screening	n/a	47.5%	n/a	n/a	<b>51.4%</b>	n/a	50.0%
Childhood Immunization Combo 2	n/a	61.8%	n/a	n/a	63.6%	n/a	72.3%
Childhood Immunization Combo 3	n/a	52.0%	n/a	n/a	53.8%	n/a	65.6%
Frequency of Prenatal Care	n/a	51.6%	n/a	n/a	52.6%	n/a	59.3%
Lead Screening	n/a	46.0%	n/a	n/a	54.8%	n/a	61.5%

Similarly, AHCA compared quality outcomes and compared managed care performance in non-reform areas to reform areas.<sup>28</sup>

For Objective 4, AHCA established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. Since 2006, 86 individuals have enrolled in the Opt Out Program. Of those, 65 individuals have disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance. There are currently 26 individuals enrolled in the Opt Out Program. AHCA analysis indicates recipients choose the Opt Out Program because the desired primary care physician was not enrolled with a Medicaid Reform health plan or recipients elected to use the Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.<sup>29</sup>

For Objective 5, AHCA contracted with the University of Florida to measure recipient satisfaction. The most recent report<sup>30</sup> indicates satisfaction was generally high. Most enrollees in Broward and Duval counties indicated:

- It was “not a problem” to get a doctor or a nurse they were happy with;
- They communicate well with their providers;
- They chose their health plan; and
- Their overall satisfaction rating was at the highest level (9 or 10).

Approximately 85 percent of surveyed recipients said it was not difficult to get an appointment with a physician, and about 50 percent said it was easy to get an appointment with a specialist. Ratings by enrollees in rural counties (Baker, Clay and Nassau) were similar to those in Broward and Duval. Generally, there were no statistically significant differences between patient satisfaction pre- and post-reform, with a couple of exceptions in Broward County.

In addition to the five objectives, Medicaid reform was intended to reduce the rate of growth to a more sustainable rate and improve the financial predictability of the program in the long term. In the most recent fiscal evaluation report by the University of Florida, researchers reported that expenditures have

<sup>28</sup> Florida Medicaid Reform Year 4 Annual Report July 1, 2009 – June 30, 2010, Table 42, Agency for Health Care Administration, available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml) (last viewed March 12, 2011).

<sup>29</sup> Florida Medicaid Reform Year 3 Annual Report July 1, 2009 – June 30, 2010, Agency for Health Care Administration, available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml) (last viewed April 8, 2010).

<sup>30</sup> Duncan, Paul, et al. Medicaid Reform Enrollee Satisfaction Year One Follow-On Survey, March 20, 2009, Department of Health Services Research, Management and Policy, University of Florida, available at <http://mre.php.ufl.edu/publications/> (last viewed April 8, 2010).

been reduced by shifting patients from unmanaged, fee-for-service care to managed care.<sup>31</sup> Expenditures in Broward and Duval Counties were lower (on a per-member, per-month basis) in the first two years of reform than they would have been in those counties without reform.

### Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities.<sup>32</sup> A developmental disability is defined in chapter 393, F.S., as “a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.”<sup>33</sup> Children who are at high risk of having a developmental disability and are between the ages of 3 and 5 are also eligible for services.<sup>34</sup>

#### *Services to Persons with Developmental Disabilities*

APD provides an array of home and community based services through contract providers, as well as services in Developmental Disabilities Centers and Forensic program services. APD administers home and community based services through 14 area offices that are responsible for day to day operations.

#### *Four-Tier Medicaid Waiver System*

The 2007 Legislature directed APD to establish a four-tier waiver system to replace the current waiver program. APD currently serves 30,062 people in the Medicaid waiver tier system and has a waitlist of over 19,000<sup>35</sup> people for the program. Each of the tier waivers targets a specific group of people with certain needs. Three of the four tier waivers have caps on annual expenditures per person and one of the tier waivers has no cap and is reserved for individuals with the most intense needs.<sup>36</sup> The purpose of the tier system is to create a predictable spending model for the program and help control over utilization of services which has lead to significant program deficits in recent years.

#### *Individual Budgets (ibudget Florida)*

The 2010 Legislature directed APD in consultation with AHCA to develop and implement individual budgets (also known as ibudget) as the basis for allocating funds to people enrolled in Medicaid waiver programs. The ibudget system uses an algorithm to allocate funds to individuals based on client characteristics and acuity which are reliable predictors of need. The ibudget sets a cap on each person’s spending for a 12 month period. Exceptions to the capped expenditures are available for extraordinary needs. AHCA received approval to implement the ibudget system from federal CMS on March 4, 2011 with an effective date of March 15, 2011. APD estimates that the reallocation of funds to individuals through the ibudget formula could result in an increase in funding for 64 percent of recipients and reduction in funding for 36 percent of recipients.<sup>37</sup>

### Long-term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients through nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution.

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<sup>31</sup> Duncan, Paul, et al. An Analysis of Medicaid Expenditures Before and After Implementation of Florida’s Medicaid Reform Pilot Demonstration, Department of Health Services Research, Management and Policy, University of Florida, June 2009, *available at* <http://mre.phhp.ufl.edu/publications/> (last viewed April 8, 2010)

<sup>32</sup> s. 20.197(3), F.S.

<sup>33</sup> s. 393.063(9), F.S.

<sup>34</sup> “High-risk child” is defined in s. 393.063(19) F.S.

<sup>35</sup> APD Monthly Report to the Governor’s Office of Policy and Budget (OPB), January 2011.

<sup>36</sup> s. 393.0661(3), F.S.

<sup>37</sup> Report to the Legislature on the Agency’s Plan for Implementing Individual Budgeting, February 1, 2010.



Home and Community Based services are provided through six Medicaid Waiver programs and one State Plan administered by the Department of Elder Affairs in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers<sup>38</sup> and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care. These waivers and the state program are described below.

Waiver	Population	Enrolled <sup>39</sup>	Services	Area
<b>Adult Day Health Care<sup>40</sup> (2004)</b>	Adults age 75 years or older with functional or cognitive impairments and live with a caregiver	24	Intake and assessment, case management and other direct care services such as transportation, medication management, rehabilitation and services which allow frail elders to remain in their home or community instead of going to a nursing facility.	Palm Beach, Lee
<b>Aged and Disabled Adult (1982)</b>	<ul style="list-style-type: none"> <li>• Frail adults over age 60 or older</li> <li>• Adults with disabilities ages 18-59</li> <li>• Adults over age 20 who age out of Children's Medical Services</li> </ul>	10,142	Adult companion, attendant care, caregiver training, case management, consumable medical supplies and others.	Statewide
<b>Assisted Living for the Frail Elderly (1995)</b>	Frail elders age 65 or older or disabled elders age 60 to 64 who reside in Assisted Living Facilities	2,919	Attendant call system, attendant care, behavior management, case management, companion services, intermittent nursing, medication administration, therapeutic social and recreational activities and other services.	Statewide
<b>Channeling (1985)</b>	Frail elders age 65 or older	1,233	Adult day health care, adult companion, case management, chore services, family training, financial assessment, personal care, respite care, special drug and nutritional assessment, home delivered meals, medical equipment and supplies, therapies and other services	Miami-Dade Broward
<b>Nursing Home Diversion Program (1998)</b>	Frail elders age 65 or older at risk for nursing home placement	21,031	Under this program, applicants can choose to continue living in their own homes or a community setting such as an assisted living facility. Coordinated acute and long-term care services to frail elders in the community, including acute medical services such as dental, community mental health, inpatient hospital, outpatient hospital emergency, physicians and prescribed drugs and long-term care community services such as adult companion, assisted living, case management, chore, family training, home health care, nutritional assessment, personal emergency response system, nursing facility services, therapies and other services.	33 counties; authorized to expand to 27 additional counties
<b>PACE - All-Inclusive Care for the Elderly (2002)</b>	<p>Medicaid and Medicare eligible adults age 54 or older who qualify for nursing home care and live in a PACE service area</p> <p>*State plan service; not a waiver program</p>	550	Managed care program providing a comprehensive range of medical and home and community-based services adult day health care, home care, prescription drugs, nursing home and inpatient care	Miami-Dade, Lee

<sup>38</sup> Area Agencies on Aging (AAAs) are designated private not-for-profit local entities that are responsible for the planning, coordination and distribution of funds for services to elders

<sup>39</sup> 2010-2011 Florida Medicaid Summary of Services; *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 11-03, January 2011, Office of Program Policy Analysis & Governmental Accountability

<sup>40</sup> This waiver includes the Consumer-Directed Care Plus (CDC+) Program. The CDC+ program allows participants to hire workers and vendors of their own choosing to help with daily needs such as housecleaning, cooking, and getting dressed. The program offers consultants to help individuals manage their budgets and make decisions. See, *Summary of Programs & Services*, Department of Elderly Affairs.

## Aging Resource Centers

The 2004 Legislature created the Aging Resource Center<sup>41</sup> initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed the Department of Elder Affairs to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers. The legislation required each area agency to transition to an Aging Resource Center by taking on additional responsibilities, while at the same time maintaining its identity as a local area agency on aging. All 11 area agencies on aging are now functioning as Aging Resource Centers. The Aging Resource Centers are to perform eight primary functions that are intended to improve the elder services system:<sup>42</sup>

- Increase access to elder services;
- Provide more centralized and uniform information and referral;
- Increase screening of elders for services;
- Improve triaging and prioritizing of elders for services;
- Streamline Medicaid eligibility determination;
- Improve long-term care options counseling;
- Enhance fiscal control and management of programs; and
- Increase quality assurance.

## Certificate of Need for Nursing Homes

The certificate of need (CON) is a regulatory review process administered by AHCA which requires specified health care providers to obtain prior authorization before offering certain new or expanded services or making major capital expenditures. A "Certificate of Need" is defined as: "...a written statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice."

Florida's CON program has been in operation since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria. Each state was required to have a CON program in compliance with those standards as a condition for obtaining federal funds for health programs. The federal health planning legislation was repealed in 1986.

Pursuant to s. 408.036, F.S., with certain limited exceptions, nursing homes in Florida are subject to CON. In addition to general criteria applicable to CON issuance, pursuant to s. 408.040, F.S., AHCA may issue a CON or exemption based upon a statement of intent from a nursing home. In doing so, AHCA may consider that a specified percentage of the annual patient days at a facility will be utilized by Medicaid recipients. AHCA's issuance of the CON to such nursing homes is issued as a condition of that utilization level, and any change in utilization level requires the certificate holder to seek a modification of conditions from AHCA. Failure to comply with these conditions can result in administrative fines against the certificate holder.

A moratorium on the approval of additional nursing home beds has been in effect since 2001. In 2006, the Florida Legislature extended the moratorium through July 1, 2011.<sup>43</sup>

## Medicaid Third-Party Recovery

The Medicaid program by law is intended to be the payer of last resort; that is, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Third-party liability refers to the legal obligation of third parties to pay all or part of the expenditures for Medicaid medical assistance for an individual. Third-

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<sup>41</sup> Ch. 2004-386 (8), L.O.F.

<sup>42</sup> s. 430.2053 (5), F.S.

<sup>43</sup> s. 408.0435(1), F.S.

party recovery is the legal entitlement to recover amounts paid for Medicaid medical assistance for an individual as the result of an injury or illness for which a third party is responsible. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered health insurance derived by noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (unless specifically excluded by federal statute). Examples of third-party recoveries are amounts paid or awarded to an individual who was injured in an automobile accident or as the result of medical malpractice.

Federal Medicaid law requires the states to seek reimbursement for medical assistance from third parties to the extent of their legal liabilities.<sup>44</sup> Every state has implemented this law in a slightly different manner, depending upon its Medicaid program and state laws. Federal law provides protections to ensure adequate notice to recipients, prevention of undue hardship, and cost effectiveness under a state's recovery program.

### Florida Medicaid Third-party Liability Act

The Medicaid Third-party Liability Act<sup>45</sup> requires individuals eligible for Medicaid to assign their rights to third-party payments and recoveries to AHCA. Florida Medicaid seeks recovery for services paid on behalf of the beneficiary. In addition, the state is entitled to an automatic lien for the full amount of medical assistance provided to an individual as a result of an accident or illness for which a third-party may be liable.<sup>46</sup>

In 2006, the United States Supreme Court held that a state's Medicaid liens do not attach to amounts recovered in tort by Medicaid recipients for damages other than medical expenses.<sup>47</sup> The State of Arkansas had placed a lien on the proceeds of a settlement that the Medicaid recipient had entered into after she was injured in an automobile accident. The Arkansas Medicaid program had paid \$215,645 in medical expenses as a result of the accident. The settlement was for \$550,000 with \$35,581 stipulated to be for medical expenses.

Under Arkansas law, the state was entitled to recover the entire \$215,645 out of the proceeds of the settlement even though the remainder of the settlement was for damages other than medical expenses. The Court held that Arkansas law was in conflict with federal law and that the federal law controlled. Accordingly, states are not entitled to recover medical expenses for amounts specifically awarded for other types of damages.

Florida has a statutory distribution formula for apportioning a tort settlement or award to a Medicaid recipient.<sup>48</sup> The formula states that after the payment of costs and attorney's fees, one half of the proceeds shall be paid to the state, up to the amount of the total amount of the medical assistance. The remainder is retained by the recipient. The statutory distribution formula only applies if the award is not allocated among categories of damages.<sup>49</sup> An award specifically for noneconomic damages would not be subject to the statutory formula.

### Effect of Proposed Changes

HB 7109 makes immediate statutory changes to existing Medicaid provisions or provisions related to Medicaid providers; repeals existing provisions on a date certain, as they become outdated based upon the full implementation of managed medical assistance, managed long-term care, or managed long-term care for persons with developmental disabilities pursuant to ss. 409.961 through 409.992, F.S.; and repeals other outdated provisions immediately.

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<sup>44</sup> 42 U.S.C., Section 1396.

<sup>45</sup> Section 409.910, F.S.

<sup>46</sup> Section 409.910(6)(c), F.S.

<sup>47</sup> *Arkansas Dept. of Health and Human Services, et al. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (2006)

<sup>48</sup> Section 409.910(7)(f), F.S.

<sup>49</sup> *Russell v. Agency for Health Care Administration*, 23 So.3d 1266 (Fla. 2d DCA Jan. 6, 2010)



## Immediate Statutory Changes

### *Provider Service Networks*

Pursuant to s. 409.912(4)(d), F.S., any contract previously awarded to a PSN operated by a hospital shall remain in effect for three years after the current contract expiration date. The bill repeals this provision, and provides new guidelines for payments to PSNs. The bill clarifies that prepaid PSNs receive per member per month payments, while non-prepaid PSNs receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall only be available for the first five years of the plan's operation. The bill requires AHCA to annually conduct cost reconciliations to determine the amount of cost savings achieved for fee-for-service PSNs for the dates of services in the period reconciled, and adds specific requirements to the method by which AHCA reconciles PSN spending. The changes include specifying the period of the reconciliation, providing for consideration of incurred but not reported claims, and limiting the time period for completing the reconciliation.

### *General Medicaid and Medicaid Managed Care Provisions*

The bill expands statewide, the opt-out option created in Medicaid reform, but also authorizes recipients to use their Medicaid funds to purchase or other insurance products that may be offered through state programs such as Florida Health Choice Program, or health insurance exchanges in addition to employer sponsored health insurance.

The bill directs AHCA to establish a uniform method for managed care plans to use for accounting for and reporting of medical and nonmedical costs.

The bill gives AHCA specific guidance on the operation and maintenance of the Medicaid Encounter Data System. The plans are directed to submit the data in an electronic format in accordance with guidelines and deadlines established by AHCA. Additionally, AHCA is responsible for analyzing the data. AHCA shall use the data to provide feedback to the plans and take corrective action if necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

The bill authorizes AHCA to exempt certain recipients from mandatory enrollment in managed care on a case-by-case basis when the recipient's situation is unique, time limited and disease or condition-related and enrollment in managed care would interfere with the recipient's on-going care because his or her provider does not participate in the managed care plans in the area. AHCA currently has rulemaking authority to provide such exemptions, but this amendment specifies the circumstances under which such exemptions shall apply. The existing rulemaking provision is immediately repealed in the bill.

The bill directs AHCA to contract with a provider service network (PSN) to serve as a third party administrator for the Medipass program in all counties with less than two prepaid plans.

The bill changes the methodology for the calculation of Medicaid rates for hospitals. The rates will be calculated once per year, instead of twice, and become effective at the start of the state fiscal year. Rates will be effective for one year and no adjustments will be made after September 30. Error discovered after September 30 will be reconciled in the next year. Cost reports must be reconciled within 5 years.

Additionally, AHCA is directed to develop a plan to convert inpatient hospital rates to a prospective payment system that categorizes each case into diagnosis related groups (DRG). The agency should model the plan on existing payment systems such as those used by Medicare. The plan should maintain budget neutrality. The agency shall submit the plan that includes steps to implement and costs, to the Governor, the President of the Senate, and the Speaker of the House of Representative no later than January 1, 2013.

### *Medically Needy*

Persons qualifying for the medically needy program will be included in the mandatory enrollment category Medicaid managed care. The bill directs AHCA to develop a plan for implementing s. 409.975(8)<sup>50</sup> relating to the medically needy program. The plan shall include a preliminary calculation of actuarially sound rates and estimated fiscal impact. Since this population has not previously been enrolled in managed care, the bill directs AHCA to immediately seek federal approval to implement the subsection.

Subject to receiving the needed federal approval, AHCA is directed to immediately contract with a single provider service network to manage and administer the Medically Needy Program. The contract will require care management and care coordination for the medically needy enrollees. Medically needy individuals will be enrolled continuously for a period of six month and must pay their share of costs to the PNS as a premium. Enrollees will be given a 90-day grace period for premium payment before they are disenrolled. The PSN may earn an administrative fee, if the fee is less than any savings achieved by the management and coordination of the care as determined by AHCA through reconciliation. The contract would expire when the medically needy are transitioned into Medicaid managed care.

### *Nursing Homes*

Specifically, the bill provides licensure and regulatory relief to nursing homes to enable them to have the capacity to service Medicaid recipients pursuant to the Medicaid managed long-term care program established in HB 7107. The bill amends s. 408.040, F.S., by suspending the conditions on the issuance of a CON to nursing homes based on Medicaid patient utilization. Finally, the bill extends the current moratorium scheduled to expire July 1, 2012, until after statewide Medicaid managed care is implemented pursuant to ss. 409.961-409.992, F.S. or October 1, 2016, whichever occurs first.

### *Services to Dual Eligibles*

The bill also makes immediate changes applicable to recipients who are dually eligible for both Medicare and Medicaid.

To fully facilitate the process of reimbursing providers for services to dual eligibles, the bill amends s. 409.9122, F.S., by authorizing AHCA to establish a per member per month payment for Medicare Advantage Special Needs members who are also eligible for Medicaid as a mechanism for meeting the state's cost sharing obligation. Additionally, AHCA is authorized to develop a per member per month payment for Medicaid only covered services for which the state is responsible. In conjunction with these payments, the state must develop a mechanism that ensures that such per member per month payments enhance the value to the state and enrolled members by limiting cost sharing, enhancing the scope of Medicare supplemental benefits that are equal to or greater than the Medicaid coverage for select services, and improving care coordination.

Currently s. 409.907, F.S. allows AHCA to enroll entities as Medicare cross-over providers exclusively for the purpose of the payment and processing of claims. Medicare crossover provider agreements require that the provider must:

- Be an eligible Medicare provider, have a current Medicare provider agreement with the Centers for Medicare and Medicaid Services.
- Immediately notify AHCA, in writing, within five days of the provider's suspension or disenrollment as a Medicare provider or be subject to statutory sanctions, including the return of any funds paid to the provider by Medicaid during the period it was suspended or disenrolled from Medicare.
- Maintain recipient records for a minimum of six years and provide them to AHCA or the Attorney General Medicaid Fraud Unit upon request or be subject to sanctions.

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<sup>50</sup> This section is created in HB 7107.

The bill adds that the provider service agreement also must require the applicant to attest that it meets the requirements to be a Florida Medicaid provider and to submit fingerprints as required by the agency. AHCA is authorized to establish additional requirements to promote program integrity.

### *Elder Waivers*

The bill repeals the Department of Elder Affairs' statutory authority to administer waivers for elders effective upon October 1, 2012, the deadline for full implementation of long-term care managed care statewide. The bill also requires DOEA to develop a transition plan for recipients receiving services in long-term care Medicaid waivers for elders or disabled adults on the date qualified plans become available in each recipient's region in order to enroll those recipients in qualified plans. Finally, the bill immediately repeals the Alzheimer's Dementia Specific Medicaid Waiver, which expires on April 30, 2010. DOEA is currently in the process of transferring individuals receiving services in this waiver to other waivers.

### *Aging Resource Centers*

The bill repeals outdated provisions in s. 430.2053, F.S., related to Aging Resource Centers (ARCs), repeals other provisions on a date certain and makes future, conforming changes related to the responsibilities the ARCs will have once the Medicaid long-term care managed care is implemented throughout the state. ARCs will assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program, provide choice counseling for the program by integrating choice counseling staff and services – physically or virtually. Pursuant to HB 7107, AHCA may contract directly with the ARCs to provide choice counseling services or with another vendor if an ARC does not choose to provide services. If an ARC does not choose to provide such services, it must enter into a memorandum of understanding with AHCA to coordinate staffing and collaborate with the choice counseling vendor. The MOU must identify the staff responsible for each function and provide staffing levels necessary to carry out the ARC's functions.

ARCs will also assist Medicaid recipients enrolled in Medicaid long-term care managed care with informally resolving grievances with a managed care network and assist recipients in accessing the managed care network's formal grievance process. Once long-term care managed care is implemented in each region, the ARCs are prevented from providing direct services to recipients, other than choice counseling services and other information, referral and screening services.

Once managed long-term care is implemented in each region, DOEA is no longer authorized to make payments for recipients.

### *Agency for Persons with Disabilities*

The bill amends s. 393.0661, F.S., relating to the four-tier waiver system used by APD to provide home and community-based services for persons with developmental disabilities. The bill requires APD to develop a transition plan to move persons receiving services through the four-tier structure to enrollment in a qualified Medicaid plan. The bill provides for expiration of the four-tier system on October 1, 2015.

The 2010 Legislature directed APD in consultation with AHCA to develop and implement individual budgets (also known as ibudget) as the basis for allocating funds to people enrolled in Medicaid waiver programs. AHCA has requested approval from the federal government for the implementation of the ibudget system. Approval is still pending at this time. APD estimates that the reallocation of funds to individuals through the ibudget formula could result in an increase in funding for 64 percent of recipients and reduction in funding for 36 percent of recipients.<sup>51</sup>

### *Department of Elder Affairs*

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<sup>51</sup> Report to the Legislature on the Agency's Plan for Implementing Individual Budgeting, February 1, 2010.

The bill amends s. 430.04, F.S., relating to DOEA Medicaid waiver programs. The bill requires DOEA to develop a transition plan to move persons receiving services through a long-term care waiver program to enrollment in a qualified Medicaid plan as such plans are implemented in each region of the state. The bill provides for expiration of DOEA Medicaid waiver programs on October 1, 2014. The Long-Term Care Community-Based Diversion Pilot and related provisions (Sections 430.701-430.709, F.S.) are repealed effective October 1, 2013.

#### *Limitation on Noneconomic Damages for Medicaid Providers*

The bill amends s. 766.118, F. S., to create a limitation on noneconomic damages<sup>52</sup> for negligence of practitioners<sup>53</sup> providing services and care to Medicaid recipients. The limitation will apply when a Medicaid recipient brings an action for personal injury or wrongful death alleging medical negligence by the practitioner. The amount of noneconomic damages is limited to \$300,000 per person; however, no practitioner individually will be liable for more than \$200,000.

#### Immediate Repeals of Current Law

The following provisions are repealed effective upon the bill becoming law:

- Requires AHCA and DCF work under a collaboration agreement to provide for Medicaid community mental health (s. 409.912(4)(b)2, F.S.)
- Requires implementation of statewide capitated prepaid behavioral health care system (s. 409.912(4)(b)4, F.S.)
- Provides requirements for statewide capitated prepaid behavioral health care system (s. 409.912(4)(b)6, F.S.)
- Requires 3-year contract extension for hospital-operated PSN (s. 409.912(4)(d)2, F.S.)
- Authorizes AHCA to contract for in-home medical services for high-cost conditions (s. 409.912(4)(f), F.S.)
- Authorizes pediatric networks to provide after-hours care for emergency room diversion (s. 409.912(4)(g), F.S.)
- Requires fixed-payment Medicaid program for recipients 60 years of age and older and dual eligibles (s. 409.912(5), F.S.)
- Requires the use of an “appropriate fee schedule” for exclusive provider organization provide who treats a Medicaid recipient in a rural area that lacks an HMO; authorizes AHCA to seek a waiver for the program (s. 409.912(8)(b), F.S.)
- Requires AHCA to develop a cost-benefit analysis business case to test alternative means of providing goods and services in the Medicaid program (s. 409.912(14)(b)-(c), F.S.)
- Requires AHCA report on modifying the level-of-care criteria to eliminate Intermediate II level of care (s. 409.912(15)(g), F.S.)
- Authorizes AHCA to seek waivers for purchasing certain health care services and equipment (s. 409.912(37), F.S.)
- Requires AHCA to conduct a study regarding the availability of electronic identity verification systems (s. 409.912(49), F.S.)
- Provides AHCA rule-making authority for case-by-case exceptions to the mandatory managed care enrollment requirement (s. 409.9122(2)(a), F.S.)
- Requires AHCA to investigate the feasibility of providing Medipass and managed care plan options to certain Medicaid groups (s. 409.9122(7), F.S.)

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<sup>52</sup> Section 766.020(8), F.S., defines “noneconomic damages” as nonfinancial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

<sup>53</sup> Section 766.118, F.S., defines “practitioner” to include any person licensed under chapter 458 (Medical Practice), chapter 459 (Osteopathic Medicine), chapter 460 (Chiropractic Medicine), chapter 461 (Podiatric Medicine), chapter 462 (Naturopathy), chapter 463 (Optometry), chapter 466 (Dentistry), chapter 467 (Midwifery), or chapter 486 (Physical Therapy) or certified under s. 464.012 (Nurse Practitioner).

- Authorizes AHCA to encourage public/private partnerships to develop HMO and prepaid health plans services for Medicaid recipients (s. 409.9122(8), F.S.)

### Repeals on Dates Certain

The following provisions are repealed on October 1, 2013, the date Medicaid long-term care managed care must be implemented in all regions pursuant to HB 7107:

- Exempts certain entities from health care services provisions of Part I of Ch. 641, F.S. Exempted entities provide services to elderly recipients on a prepaid or fix-sum basis from health care services (s. 409.912(4)(h), F.S.)
- Requires AHCA to operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program to screen nursing facility Medicaid recipients for proper placement (s. 409.912(15)(a)-(f), F.S.)
- Requires AHCA to establish a long-term care demonstration project in Miami-Dade County for a predominantly minority, medical underserved and medically complex population (s. 409.912(41), F.S.)

The following provisions are repealed on October 1, 2014, the date Medicaid managed medical assistance must be implemented in all regions pursuant to HB 7107:

- Creates the Medicaid Low-Income Pool Council (s. 409.911(10), F.S.)
- Directs AHCA to work with DCF for access to mental health and substance abuse services (s. 409.912(1), F.S.)
- Authorizes AHCA to contract for Medicaid services with HMOs (s. 409.912(3), F.S.)
- Authorizes AHCA to contract for Medicaid prepaid health care services with entities owned and operated by a county, county health department or county-owned hospital (s. 409.912(4)(a), F.S.)
- Provides requirements for Medicaid behavioral health care services; authorizes fee-for-service payment for providers (s. 409.912(4)(b), F.S.)
- Exempts federally qualified health centers that are reimbursed on a prepaid basis from parts I and III of Ch. 641, F.S. (s. 409.912(4)(c), F.S.)
- Authorizes entities to provide comprehensive behavioral health care services to Medicaid recipients through an administrative services organization agreement (s. 409.912(4)(e), F.S.)
- Authorizes the Children's Medical Service Network, as defined in s. 391.021, F.S. (s. 409.912(4)(i), F.S.)
- Authorizes AHCA to contract with public and private entities for Medicaid services; authorizes contractors to subcontract with other entities under certain conditions; provides contracting conditions (s. 409.912(6), F.S.)
- Authorizes AHCA to contract with health insurers for Medicaid recipient coverage on a prepaid or fixed-sum basis (s. 409.912(7), F.S.)
- Authorizes AHCA to use fee-for-service for purchasing of chiropractic services through a statewide not-for-profit chiropractic preferred provider organization (s. 409.912(9), F.S.)
- Prohibits AHCA from contracting with entities whose officers, etc., committed certain crimes (s. 409.912(10), F.S.)
- Requires AHCA to identify Medicaid services misuse through the establishment of a post payment utilization control program (s. 409.912(12), F.S.)
- Requires AHCA to develop coordinated systems of care for Medicaid recipients (s. 409.912(13), F.S.)
- Requires AHCA to identify and monitor Medicaid providers with respect to medical necessary services and treatment (s. 409.912(14)(a), F.S.)
- Requires AHCA to identify utilization and price patterns that are not cost-effective; authorizes AHCA to implement alternative methods to improve cost-effectiveness (s. 409.912(16), F.S.)
- Requires prepaid or fixed-sum contractors to meet surplus insurer requirements in Ch. 641, F.S. (409.912(17), F.S.)

- Authorizes AHCA to require prepaid or fixed-sum contractors to establish a restricted insolvency protection bank account (s. 409.912(18), F.S.)
- Requires prepaid or fixed-sum contractors to reimburse hospitals or physicians outside a contractor's geographic area at specific levels (s. 409.912(19), F.S.)
- Provides for the enrollee assignment process for Miami-Dade County Medicaid managed prepaid plans (s. 409.9122(13), F.S.)
- Requires AHCA to approve assignment or transfer of prepaid Medicaid contracts for post-merger or acquisition contractors under certain conditions (s. 409.912(20), F.S.)
- Prohibits certain Medicaid contractor business practices, including discrimination and false marketing (s. 409.912(21), F.S.)
- Authorizes AHCA to fine contractors for violations of Medicaid provisions (s. 409.912(22), F.S.)
- Prohibits Medicaid recipient solicitation via marketing material by HMOs and Ch. 641, F.S.-exempt individuals (s. 409.91223), F.S.)
- Authorizes HMOs and Ch. 641, F.S.-exempt individuals and entities to provide additional benefits under certain circumstances (s. 409.912(24), F.S.)
- Requires AHCA to use the statewide HMO complaint hotline for Medicaid and prepaid health plan complaints (409.912(25), F.S.)
- Requires AHCA to publish the complaint hotline phone numbers (s. 409.912(26), F.S.)
- Requires Medicaid contractors to achieve a 60% Early and Periodic Screening, Diagnosis and Treatment Service rate (s. 409.912(28), F.S.)
- Requires AHCA to enroll and disenroll eligible Medicaid recipients in MediPass or managed care plans; authorizes the AHCA to contract for enrollment services (s. 409.912(29), F.S.)
- Requires certain formatting for Medicaid provider information (s. 409.912(30), F.S.)
- Requires AHCA to establish an enhanced managed care quality oversight function; provides for required function components (s. 409.912(31), F.S.)
- Requires contracted managed care plan entities to perform background checks on persons with certain ownership interests; requires contractors to submit specified background results to AHCA (s. 409.912(32), F.S.)
- Requires AHCA to promulgate rules regarding Medicaid managed care plan enrollee requests to enter hospice (s. 409.912(33), F.S.)
- Requires Medicaid contractors to provide emergency services to recipients in compliance with emergency services provisions in Ch. 641, relating to health care services (s. 409.912(34), F.S.)
- Requires Medicaid providers to provide specific services to pregnant women and mothers with infants (s. 409.912(35), F.S.)
- Requires Medicaid prepaid health plan services entities to coordinate with assisted living facilities for Medicaid recipient residents (s. 409.912(36), F.S.)
- Requires AHCA to enter into agreements with not-for-profit organizations to provide vision screening for Medicaid recipients (s. 409.912(38), F.S.)
- Requires AHCA to establish a Medicaid recipient utilization management program for occupational, physical, respiratory, and speech therapies; authorizes the AHCA to seek a waiver for the program (s. 409.912(42), F.S.)
- Authorizes AHCA to contract for dental services on a prepaid or fix-sum basis (s. 409.912(43), F.S.)
- Requires Medicaid contracts to be cost effective; requires AHCA to conduct actuarially sound adjustments and publish findings; authorizes AHCA to make contract renewal decisions based on cost-effectiveness (s. 409.912(44), F.S.)
- Requires AHCA to implement a "lock-in" program for Medicaid recipients who have used services at a rate or amount not medically necessary (s. 409.912(45), F.S.)
- Requires AHCA to contract with minority physician networks to provide services to "historically underserved" minority patients; provides conditions for AHCA contracts; authorizes the AHCA to seek a waiver for implementation (s. 409.912(49), F.S.)
- Provides for Medipass intent language (s. 409.9122(1), F.S.)
- Requires AHCA to enroll all Medicaid recipients in Medipass or managed care plan, with certain recipients excepted; requires school districts to be reimbursed for "school based services" as defined in s. 1011.71, F.S. for Medicaid-eligible children; requires easily understandable

information about Medipass and managed care plans; provides for mandatory assignment under certain circumstances; requires AHCA to seek a waiver for the program (s. 409.9122(2), F.S.)

- Requires AHCA to establish quality-of-care standards for Medicaid managed care plans and Medipass program (s. 409.9122(3), F.S.)
- Authorizes an OBGYN to serve as a primary care provider under the designation of a Medipass primary care case manager; requires AHCA to establish a Medipass complaint and grievance process (s. 409.9122(4), F.S.)
- Requires AHCA to encourage dual eligibles to enroll in a Medicare HMO or prepaid health plan; if there is a demonstrated cost-effectiveness, requires AHCA to offer Medipass to dual eligibles (s. 409.9122(5), F.S.)
- Authorizes up to 10 chiropractor and up to 4 podiatrist visits to Medipass recipients without prior authorization (s. 409.9122(6), F.S.)
- Requires AHCA to develop an information program for Medicaid recipients advising them of choices and rights under managed care programs; requires AHCA to develop compliance programs for managed care plans and Medipass providers (s. 409.9122(9), F.S.)
- Requires AHCA to consult with Medicaid consumers regarding patient satisfaction and quality indicators (s. 409.9122(10), F.S.)
- Authorizes AHCA to extend eligibility for HMO enrollment period for Medicaid recipients (s. 409.9122(11), F.S.)
- Caps the per physician patient load at 3,000 active Medicaid patients (s. 409.9122(12), F.S.)

The following provisions are repealed on October 1, 2016, the date Medicaid long-term care managed care for persons with developmental disabilities must be implemented in all regions pursuant to HB 7107:

- Authorizes AHCA to enter into agreements with other state agencies and the federal government to implement and operate Medicaid (s. 409.912(2), F.S.)
- Authorizes AHCA to apply for Medicaid waivers (s. 409.912(11), F.S.)
- Requires AHCA to establish a quality improvement system, subject to Medicaid Bureau of Health Care Financing Administration standards and guidelines (s. 409.912(27), F.S.)

#### *Miscellaneous Other Changes*

The bill amends cross references in several sections of law – sections 409.91195, 409.91196 and 641.386, F.S. - in order to conform to the changes in the bill.

The bill divides existing provisions of Chapter 409 into three statutory parts. Part I of Chapter 409, will be titled “Social and Economic Assistance,” and encompass ss. 409.016 – 409.803, F.S. Part II of Chapter 409, will be titled “Kidcare,” and encompasses ss. 409.810 – 409.821, F.S. Finally, Part III of Chapter 409, will be titled “Medicaid,” and encompasses ss. 409.901 – 409.9025, F.S.

The bill rennumbers sections 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86 and 402.87, F.S., respectively.

Finally, except as otherwise provided in the bill, the bill is effective upon HB 7107 or similar legislation passing during this session or an extension thereof and becoming law.

#### B. SECTION DIRECTORY:

- Section 1:** Amends s. 393.0661, F.S., relating to home and community-based service delivery systems.
- Section 2:** Amends s. 393.0662, F.S., relating to individual budgets for delivery of home and community-based services.
- Section 3:** Amends s. 408.040, F.S., relating to conditions and monitoring.

- Section 4:** Amends s. 408.0435, F.S., relating to the moratorium on nursing home certificates of need.
- Section 5:** Designates ss. 409.16 through 409.803, F.S., as part I of chapter 409, F.S., entitled "Social and Economic Assistance".
- Section 6:** Designates ss. 409.810 through 409.821, F.S., as part II of chapter 409, F.S., entitled "KidCare".
- Section 7:** Designates ss. 409.901 through 409.9205, F.S., as part III of chapter 409, F.S., entitled "Medicaid."
- Section 8:** Amends s. 409.905, F.S., relating to mandatory Medicaid services.
- Section 9:** Amends s. 409.907, F.S., relating to Medicaid provider agreements.
- Section 10:** Amends s. 409.911, F.S., relating to the disproportionate share program.
- Section 11:** Amends s. 409.91195, F.S., relating to the Medicaid pharmaceutical and therapeutics committee.
- Section 12:** Amends s. 409.91196, F.S., relating to supplemental rebate agreements; public records and public meetings exemption.
- Section 13:** Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
- Section 14:** Repeals s. 409.91207, F.S., relating to the medical home pilot project.
- Section 15:** Amends 409.91211, F.S., relating to Medicaid managed care pilot program.
- Section 16:** Repeals s. 409.91211, F.S., relating to the Medicaid managed care pilot program.
- Section 17:** Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment; programs and procedures.
- Section 18:** Amends s. 430.04, F.S., relating to duties and responsibilities of the Department of Elderly Affairs.
- Section 19:** Amends s. 430.2053, F.S., relating to aging resource centers.
- Section 20:** Repeals ss. 430.701, 430.702, 430.703, 430.7031, 430.704 430.705 430.706, 430.707, 430.708, and 430.709, F.S., effective October 1, 2013.
- Section 21:** Renumbers ss. 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S. as 402.81, 402.82, 402.83, 402.84, 402.85, 402.86, and 402.87, F.S., respectively.
- Section 22:** Amends s. 443.111, F.S., relating to payment of benefits
- Section 23:** Amends s. 641.386, F.S., relating to agent licensing and appointment required; exceptions.
- Section 24:** Amends s. 766.118, F.S., relating to determination of noneconomic damages.
- Section 25:** Directs AHCA to develop an implementation plan for s. 409.975(8), F.S.
- Section 26:** Provides an effective date of, except as provided in the bill, the act shall take effect if HB 7107 or similar legislation is adopted in the same legislative session.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

None. See Fiscal Comments.

#### 2. Expenditures:

None.

### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

#### 1. Revenues:



None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill creates some additional reporting requirements for all qualified plans statewide related to encounter data and expenditures and costs. The bill will reduce barriers and create efficiencies for Medicare providers serving dual eligibles.

D. FISCAL COMMENTS:

Testimony in the Appropriations Committee asserted that the limitation on noneconomic damages may result in a loss of Medicaid third-party liability recoveries. Such assertion is speculative and not consistent with current state and federal law. As discussed above, Florida can only recover amounts awarded in tort for medical expenses paid by Medicaid. Any amount specifically awarded to a Medicaid recipient for noneconomic damages would not be subject to a lien or other recovery action by the state.

As Florida recovers funds through third-party liability casualty claims, the state is obligated to return the federal share of any recoveries. AHCA reports that from 2000 through March 25, 2011, it had opened approximately 152,393 casualty cases. Of those cases, only 8,871, or 6 percent, were in the category of medical malpractice.<sup>54</sup>

From November 2008 through March 25, 2011, AHCA has closed through collection 335 medical malpractice cases. Of those 335 cases, 29 were settled using the statutory formula for distribution of proceeds. Of those 29 cases, 21 of the recipients remained on Medicaid after the settlement. These recipients may have established special needs trusts with their medical malpractice recoveries, the contents of which are not counted in Medicaid eligibility determinations pursuant to federal law.<sup>55</sup> AHCA is currently unable to determine why the other 8 recipients lost Medicaid eligibility.<sup>56</sup>

### III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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<sup>54</sup> Correspondence from the Agency for Health Care Administration dated March 25, 2011, on file with the Health and Human Services Committee.

<sup>55</sup> 42 U.S.C. 1396p(d)(4).

<sup>56</sup> *Supra*, note XX.

#### **IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES**

On March 24, 2011, the Appropriations Committee adopted a strike-all amendment. The amendment:

- Delays until 2014 the repeal of s. 409.912(42), F.S. which requires AHCA to establish a Medicaid recipient utilization management program for occupational, physical, respiratory, and speech therapies.
- Amends s. 409.9122, F.S., to direct AHCA immediately to contract with a PSN to coordinate and manage services and care for the Medically Needy.
- Delays until 2014 the repeal s. 409.04(15), F.S. relating to waivers for home and community based services which are administered by the Department of Elderly Affairs.
- Amends s. 766.118, F.S. to create a limitation on noneconomic damages for the negligence of practitioners providing services and care to Medicaid recipients.
- Amends s. 409.907(5)(d), F.S., to require that additional provisions be included in Medicare crossover provider agreements.

The bill was reported favorably as a Committee Substitute. This analysis reflects the Committee Substitute.