

# 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.)

BILL: CS/CS/SB 1178

SPONSOR: Appropriations Committee; Health, Aging, and Long-Term Care Committee and Senator Miller

SUBJECT: Minority Health Care

DATE: April 20, 2004                      REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Parham	Wilson	HC	Favorable/CS
2.	Belcher	Belcher	AHS	Favorable/CS
3.	Belcher	Coburn	AP	Fav/CS
4.				
5.				
6.				

**I. Summary:**

This bill requires the Department of Health (DOH) to monitor and report, within existing resources on Florida’s status on the Florida Healthy People 2010 Program goals and objectives. The federal Healthy People 2010 Program goals are to help individuals of all ages increase life expectancy and improve their quality of life; and eliminate health disparities among different segments of the population. The department is required to:

- Report to the Legislature by December 31 of each year on the status of the disparities in health among minorities and nonminorities, using health indicators that are identified in the federal program;
- Work with minority physician networks to develop programs to educate health care professionals about the importance of culture in health status;
- Work with and promote the establishment of public and private partnerships with charitable organizations, hospitals, and minority physician networks to increase the proportion of health care professionals from minority backgrounds; and
- Work with and promote research on methods by which to reduce disparities in health care at colleges and universities that have historically large minority enrollments, including centers of excellence in the state identified by the National Center on Minority Health and Health Disparities, by working with colleges, universities, and community representatives to encourage minority college students to pursue professions in health care.

The bill requires the Agency for Health Care Administration (AHCA) to contract with a minority physician network that provides services to historically underserved minority patients. The network must:

- Provide cost-effective Medicaid services;
- Comply with the requirements to be a MediPass provider; and
- Provide its primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.

The bill requires AHCA to provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules. Any savings shall be split with the minority physician network pursuant to the contract. Medicaid recipients enrolled in MediPass must be assigned to a minority physician network based on specified statutory ratios. AHCA is to conduct actuarially sound audits to ensure cost-effectiveness of services.

The bill amends ss. 409.901 and 409.912, F.S.

The bill creates s. 381.736, F.S.

## **II. Present Situation:**

### **The Federal Healthy People 2010 Initiative**

The Healthy People 2010 initiative is a set of health objectives for the U.S. to achieve over the first decade of the new century. The Healthy People 2010 initiative builds on initiatives pursued over the past two decades. The 1979 Surgeon General's Report, Healthy People, and Healthy People 2000: National Health Promotion and Disease Prevention Objectives both established national health objectives and served as the basis for the development of state and community plans. Like its predecessors, Healthy People 2010 was developed through a broad consultation process, built on the best scientific knowledge, and designed to measure programs over time.

Healthy People 2010 was designed to achieve two overarching goals:

- Help individuals of all ages increase life expectancy and improve their quality of life; and
- Eliminate health disparities among different segments of the population.

The 28 focus areas of Healthy People 2010 (ranging from environmental health to maternal, infant, and child health) were developed by leading federal agencies with the most relevant scientific expertise. The development process was informed by the Healthy People Consortium—an alliance of more than 350 national membership organizations and 250 State health, mental health, substance abuse, and environmental agencies. Additionally, through a series of regional and national meetings and an interactive web site, more than 11,000 public comments on the draft objectives were received. The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 also provided leadership and advice in the development of national health objectives.

A set of health indicators was developed under the initiative to measure the health of the nation over the next ten years. Each of the ten Leading Health Indicators has one or more objectives from Healthy People 2010 associated with it. As a group, the Leading Health Indicators reflect

the major health concerns in the U.S. at the beginning of the 21st century. The Leading Health Indicators were selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as public health issues. The ten Leading Health Indicators include:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

### **National Center on Minority Health and Health Disparities**

In April 2000, the Office of Research on Minority Health (ORMH) within the National Institutes of Health (NIH) convened the conference entitled *Challenges in Health Disparity in the New Millennium: A Call to Action*. The conference commemorated the 10th anniversary of the ORMH. Among the recommendations that emerged from the conference was a call for the creation of an Institute or Center at NIH to conduct minority health and health disparities research.

The Minority Health and Health Disparities Research and Education Act was passed in November 2000, and established the National Center on Minority Health and Health Disparities (NCMHD). While the ORMH's focus was on minority health, the NCMHD's constituency was broadened to include other health disparity populations such as the rural and urban poor who live in medically underserved areas. There were other new developments as well. The NCMHD was authorized to fund grants. The law also required other agencies of the U.S. Department of Health and Human Services (HHS), such as the Agency for Healthcare Research Quality, to support NCMHD's work to eliminate health disparities.

The mission of NCMHD is to promote minority health and to lead, coordinate, support, and assess NIH's effort to reduce and ultimately eliminate health disparities. NCMHD conducts and supports basic, clinical, social, and behavioral research, promotes research infrastructure and training, fosters emerging programs, disseminates information, and reaches out to minority and other communities with health disparities.

#### *Centers of Excellence*

The purpose of the NCMHD Centers of Excellence Program is to support the training of researchers representative of minority and health disparity populations and facilities construction for health disparities research at designated institutions. Public Law 106-525 gives the Director of the National Center on Minority Health and Health Disparities the authority to designate institutions as Centers of Excellence and award funding to assist the institutions in supporting

programs of excellence in biomedical and behavioral research training for individuals who are members of minority health disparity populations or other health disparity populations. Eligibility to compete for these funds is determined by an institution's minority health disparity student population and its demonstrated commitment to and effectiveness in recruiting, retaining, and graduating these students from the institution's educational programs. In 2003, the Florida A&M University and the Florida International University were designated as Centers of Excellence under the NCMHD program.

Florida A&M University, in partnership with the Harvard School of Public Health, also received a \$6 million grant from NIH to help eliminate health disparities in rural and urban communities. The four-year grant will establish the Center for Healthy Options and Innovative Community Empowerment (CHOICE), which will capitalize on the strengths of a well-respected historically black university and an Ivy League school. Through CHOICE, individuals in rural communities in Gadsden County, Florida, and in the urban Boston neighborhood of Roxbury will participate in this research effort to address major causes of excess mortality in minority communities.

### **Institute of Medicine Report on Health Disparities**

In 1999, the U.S. Congress requested that the Institute of Medicine (IOM) perform a study to assess differences in the kinds and quality of healthcare received by U.S. racial and ethnic minorities and non-minorities. Specifically, Congress requested that the IOM:

- Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);
- Evaluate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and
- Provide recommendations regarding interventions to eliminate healthcare disparities.

The IOM study found that:

- Racial and ethnic disparities in health care exist and are associated with worse outcomes in many cases;
- Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life;
- Many sources including health systems, health care providers, patients, and utilization managers may contribute to racial and ethnic disparities in health care;
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research; and
- A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain health care disparities.

The report made numerous recommendations related to legal, regulatory, and policy interventions, health systems development, patient education, cross-cultural education, and data collection and monitoring.

### **U.S. Department of Health and Human Services Department of Minority Health**

The Office of Minority Health responded to the IOM study by contracting for a study to analyze the status and the perceptions of state laws and actual practices of selected health plans, health insurers, and governing entities regarding collection and reporting of racial and ethnic data by health insurers and managed care plans.

The study found that racial and ethnic data are not routinely collected by many health service delivery systems or insurers, most likely stemming in part from their confusion about whether relevant laws and regulations prohibit or allow such data collection. The lack of data on enrollees' race and ethnicity is a major barrier to performance measurement and clinical quality improvement efforts.

### **Health Disparities in Florida**

In September 1998, the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services, contracted with COSMOS Corporation to assess the minority health infrastructure in selected states and territories and to examine the capacity of these jurisdictions to address health disparities by race and ethnicity. The office expressed particular interest in states' efforts to eliminate health disparities in the following health areas: 1) cancer; 2) diabetes; 3) cardiovascular disease; 4) infant mortality; 5) substance abuse; 6) HIV/AIDS; and 7) suicide, homicide, and unintentional injuries. In addition, the office asked that the study include an assessment of four cross-cutting issues: 1) data collection and analysis; 2) cultural competence; 3) access to health care; and 4) health professions development.

Florida was one of nine study states. Findings from the study in Florida include:

- Blacks are five times more likely to die of HIV infection;
- Infant mortality rates are at least twice as high for black infants compared to white infants;
- Blacks were almost three times as likely to have diabetes;
- Twenty-one percent of Florida counties had shortages of mental health and primary care professionals and twelve of these counties had percentages of minorities that exceeded the state average; and
- Data on Hispanics and Native Americans was limited in Florida as it was in the other study states.

The study found a lack of state data across the nine states studied on certain racial and ethnic minority populations. If a state fails to collect data on its minority populations' health conditions, there is no accurate way to determine public health priorities for those populations. Also, without collection of health information on minority groups, states have difficulty determining how successful their efforts to eliminate health disparities have been.

## **Florida Department of Health Office of Equal Opportunity and Minority Health**

In 1993, Florida's Minority Health Improvement Act authorized a two-year time-limited Minority Health Commission. The charge of the Commission was to provide recommendations to the Governor and the Legislature regarding the health status of Florida's minority population; increasing access to health care; increasing minority participation in the health professions industry; and establishing a center or an Office of Minority Health. The Commission faced legislative sunset in 1995. Effective November 12, 1998, a new office was created in the Office of the Secretary called the Office of Equal Opportunity and Minority Health.

The mission of the Office of Equal Opportunity and Minority Health within DOH includes ensuring nondiscrimination and equal opportunity in service delivery in accordance with state and federal laws; and eliminating health disparities in ethnic and minority populations. DOH has a variety of programs that directly, and indirectly, impact on minority health outcomes and is working on ways to better address minority health care needs.

### **“Closing the Gap” Grant Program**

On June 8, 2000, Governor Bush signed HB 2339, the Patient Protection Act, into law. The 1999-2000 Legislature appropriated \$5 million to DOH to implement and administer the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program. The program targets six priority health areas - Cardiovascular Disease, Cancer, Diabetes, HIV/AIDS, Adult and Child Immunizations, and Maternal and Infant Mortality - in which racial and ethnic groups experience serious disparities in access to care and health outcomes. The Closing the Gap Act created an initiative that works to eliminate racial and ethnic health disparities in Florida. It provides grants to local counties and organizations with the intent to increase community-based health promotion and disease prevention activities. In fiscal year 2000-2001, Closing the Gap funded 69 projects in 37 counties.

An evaluation of Florida's “Closing the Gap” initiative was conducted for the period January 2001 through June 2002. This evaluation discussed the impact of Closing the Gap activities in the areas of prevention, intervention, and education services for the six health disparities. Since the inception of the Closing the Gap initiative, over 248,154 individuals have been screened, tested, and referred for diagnosis and treatment; participated in weight and diabetes management classes; referred for prenatal care; received immunizations; or referred for HIV counseling and testing. Numerous individuals were identified with abnormal cancer screenings, hypertension, high cholesterol, high blood pressure, diabetes, and in need of weight and diabetes management classes. Individuals served through the project were African-American (64 percent); Hispanic (15 percent); Haitian (4 percent); and Asian (4 percent).

### **Racial and Ethnic Health Disparities Advisory Committee**

Section 381.7353(3), F.S., gives the Secretary of Health authority to appoint an ad hoc advisory committee on Racial and Ethnic Health Disparities. The committee was appointed to:

- Examine areas where public awareness, public education, research, and coordination regarding racial and ethnic health outcome disparities are lacking;

- Consider access and transportation issues which contribute to health status disparities; and
- Make recommendations for closing the gaps in health outcomes and increasing the public's awareness and understanding of health disparities that exist between racial and ethnic populations.

### **The Medicaid Provider Access System**

The Medicaid Provider Access System (MediPass) was designed as a managed care alternative for Florida Medicaid recipients under a federal 1915(b) waiver. MediPass provides health care services to Medicaid eligibles under a primary care case management model. The goals of MediPass are to:

- Assure access to care;
- Provide continuity of services;
- Strengthen the provider/patient relationship;
- Promote educational and preventive aspects of health care;
- Reduce unnecessary service utilization; and
- Control Medicaid expenditures.

The state submitted the original MediPass 1915(b) waiver application to the Health Care Financing Administration in March 1989; it was approved in January 1990. MediPass has evolved into a comprehensive program since its inception. The original MediPass program served a relatively healthy population of recipients eligible for aid under Temporary Assistance for Needy Families. Enrollment into MediPass was expanded to include those recipients receiving Supplemental Security Income (without Medicare) in October 1992. The program became operational throughout the state and enrolled all eligible recipients by June 30, 1996.

The MediPass program is a primary care case management program developed by Florida Medicaid for the purpose of securing access for Medicaid recipients to adequate primary care, decreasing inappropriate utilization, and controlling program costs for individuals receiving services. Medicaid eligible persons either select or are assigned to a Primary Care Provider (PCP). The PCP is currently paid a fee of \$3.00 per month per enrolled person to manage and coordinate the enrollee's care in addition to the customary reimbursement for Medicaid services. The goal of the MediPass program was to incorporate some of the advantages of managed care into Medicaid program administration by providing access to high quality care, ensuring that clients receive appropriate care in the proper setting, and fostering development of strong doctor-patient relationships.

Florida statutes currently mandate individuals in specific Medicaid eligibility categories, Temporary Assistance to Needy Families and Supplemental Security Income without Medicare, to enroll in managed care; individuals dually eligible for Medicaid and Medicare are not included in these eligibility categories. All eligible Medicaid enrollees now participate in either MediPass or in a health maintenance organization (HMO). Enrollees who do not choose either MediPass or an HMO are assigned using a formula designed to balance the number of enrollees between these programs.

### **Minority Physician Network MediPass Pilot Project**

In May 2001, AHCA was authorized by the General Appropriations Act to establish pilot projects for improving the quality of care and the cost effectiveness of the MediPass program. AHCA was authorized to contract with physician-owned and operated organizations with experience managing care for Medicaid and Medicare programs, utilizing at least one predominantly minority, physician network. Three entities applied to operate under the pilot program. Two minority physician networks were awarded contracts: Florida Netpass and PhyTrust. These two minority networks of primary care physicians began operating in South Florida, Medicaid Areas 10 and 11, in 2001. In 2003, the networks expanded to the Tampa and St. Petersburg areas covering Medicaid Areas 5 and 6 under a two-year contract with AHCA. The current contracts expire in 2005. The providers in the network are reimbursed on a fee-for-service basis and receive a \$3.00 case management fee per member per month. AHCA pays the networks a \$12.00 administrative fee. The networks share any cost savings through the program with AHCA (50/50). Presently, the minority physician networks are not required to partner with a public college or university or a tax-exempt charitable organization. An evaluation of the pilot project will be completed by the end of January 2004.

### **III. Effect of Proposed Changes:**

**Section 1.** Creates s. 381.736, F.S., to establish the federal Florida Healthy People 2010 Program.

*Subsection (1)* provides that DOH shall monitor and report, within existing resources, on Florida's status on the Healthy People 2010 Program.

*Subsection (2)* provides that DOH shall report to the Legislature by December 31 of each year regarding the status of the disparities in health among minorities and nonminorities, using health indicators that are identified in the federal program.

*Subsection (3)* requires DOH to work with minority physician networks to develop programs to educate health care professionals about the importance of culture in health status. These programs shall include but not be limited to:

- The education of health care providers about the prevalence of specific health conditions among certain minority groups;
- The training of clinicians to be sensitive to cultural diversity among patients and to recognize that inherent biases can lead to disparate treatments;
- The creation of initiatives that educate private-sector health care and managed care organizations about the importance of cross-cultural training of health care professionals and the effect of such training on the professional-patient relationship; and
- The fostering of increased use of interpreter services in health care settings.

*Subsection (4)* requires DOH to work with and promote the establishment of public and private partnerships with charitable organizations, hospitals, and minority physician networks to increase the proportion of health care professionals from minority backgrounds.



*Subsection (5)* requires DOH to work with and promote research on methods by which to reduce disparities in health care at colleges and universities that have historically large minority enrollments, including centers of excellence in the state identified by the National Center on Minority Health and Health Disparities, by working with colleges, universities, and community representatives to encourage minority students to pursue professions in health care.

**Section 2.** Amends s. 409.901, F.S., by adding subsection (23), to define, for the purposes of this section, a *minority physician network* as a network of primary care physicians with experience managing Medicaid or Medicare recipients that is predominantly minority-owned, as defined in s. 288.703, which has a collaborative partnership with a public college or university and a tax-exempt charitable corporation.

**Section 3.** Amends s. 409.912, F.S., relating to cost-effective purchasing of health care by the Florida Medicaid Program, by adding subsection (45), to require AHCA to contract with an established minority physician network that provides services to historically underserved minority patients. The network must:

- Provide cost-effective Medicaid services;
- Comply with the requirements of the MediPass program; and
- Provide its primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals.
- Be composed of providers enrolled in the MediPass program.

This section also requires AHCA to:

- Provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules;
- Reimburse the minority physician network as a fee-for-service provider or as a capitated rate provider for Medicaid services; and
- Pay a case-management fee for primary care.

Any savings shall be shared with the minority physician network pursuant to the contract.

Medicaid recipients enrolled in MediPass shall be assigned to a minority physician network pursuant to the assignment ratios provided in s. 409.9122, F.S.

The term “cost-effective” is defined and means that a network’s per member, per month costs to the state, including fee-for-service costs, administrative costs, and case-management fees, must not be greater than the state’s costs associated with contracts for Medicaid services. AHCA is required to conduct actuarially sound audits to ensure cost-effectiveness and is required to publish the results on the website and submit results annually to the Governor and Legislature no later than December 31. Contracts that are not cost-effective cannot be renewed.

Provides authority for AHCA to apply for federal waivers.

**Section 4.** Provides that the act shall take effect July 1, 2004.

**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 Article VII, Section 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 Article III, Subsection 19(f) of the Florida Constitution.

**V. Economic Impact and Fiscal Note:**

**A. Tax/Fee Issues:**

None.

**B. Private Sector Impact:**

The expansion of the Healthy People 2010 initiative at the state level could help communities with health disparities.

Minority physician networks are allowed to have collaborative partnerships with public colleges and universities or tax-exempt charitable corporations.

**C. Government Sector Impact:**

**Agency for Health Care Administration**

The bill provides that the savings to MediPass achieved from using the minority physician network will be shared with the minority physician network pursuant to the contract. Presently, the portion of the savings achieved by the minority physician networks that is eligible for distribution outside of the Medicaid program is shared with the minority physician networks to offset their operational expenses. At this point, according to AHCA, it is not possible to estimate the savings to the program that will occur in FY 2004-2005 and FY 2005-2006, due to the unavailability of baseline data used to determine the upper payment limits.

## **Department of Health**

DOH is only responsible for developing a working relationship with the minority physician networks. These networks will provide information and support to DOH on health disparity issues. There should be no fiscal impact on DOH.

### **VI. Technical Deficiencies:**

If the intent of the bill was to define minority physician network specifically for the MediPass program, language will have to be added. As currently written, the definition only applies to the definitions section of the bill.

### **VII. Related Issues:**

#### **Healthy People 2010**

Healthy People 2010 is a comprehensive, nation-wide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the U.S. The bill is designed to achieve the two main goals stated in Healthy People 2010: increase quality and years of healthy life and eliminate health disparities. The Healthy People 2010 Objectives reflect a broad agenda and not an agency-specific program. Many of the Healthy People 2010 objectives cannot be tracked because data is not systematically available or collected in Florida.

DOH is currently addressing some of the Healthy People 2010 objectives, and has developed several data collection systems to report on life expectancies, health quality, and health disparities. Although DOH is working on a number of indicators from the Healthy People 2010 blueprint, if the intent of this bill is to develop, implement, and report annually to the Legislature regarding all Florida Healthy People 2010 objectives, it will require that DOH be provided with additional resources and time to build reporting systems to capture the data and coordinate with other departments and public and private agencies responsible for objectives outside DOH's control.

#### **Minority Physician Networks**

Section 2 of the bill defines a minority physician network as a network of primary care physicians that is predominantly minority-owned, as defined in s. 288.703, F.S., which may have collaborative partnership with a public college or university and a tax-exempt charitable corporation. A collaborative partnership is not clearly defined. A collaborative partnership could be difficult to prove or disprove.

### **VIII. Amendments:**

None.