HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1869 PCB ELT 05-02 Medicaid
SPONSOR(S): Elder & Long-Term Care Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Elder & Long-Term Care Committee	5 Y, 0 N	Liem	Liem
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1869 permits the Agency for Health Care Administration (AHCA), contingent on federal approval, to expand a Medicaid reform demonstration waiver to integrate state funding for Medicaid services provided to individuals dually eligible for the Medicaid and Medicare programs. The bill specifies standards AHCA and a managed care plan are required to comply with in integrating such services.

The bill imposes additional responsibilities on AHCA and managed care plans under contract to AHCA to serve dually-eligible individuals in addition to other regulatory requirements imposed on these managed care delivery systems.

The bill assists traditional safety net providers in becoming managed care organizations by authorizing loans of up to $500,000 for 6 years through a grant application process. Repayment terms include interest equal to or greater than the federal funds rate.

The bill sunsets in 5 years (July 1, 2010) and allows AHCA to promulgate rules to implement the waiver.

AHCA is required to report provisions of the approved waiver and deviations from this act. AHCA is required to seek legislative authority prior to implementation of the waiver.

The effective date of the bill is July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility - The bill will allows Medicaid recipients greater choice of long-term care service delivery systems.

Limited Government – The bill decreases the role of government in determining the long-term care options available to dually-eligible recipients.

B. EFFECT OF PROPOSED CHANGES:

Background

The Empowered Care Proposal

The Governor has proposed a gradual reform and modernization of Florida's Medicaid program which will phase in a change in the fundamental structure of Medicaid away from a state-run program which finances care for recipients and in which government structures coverages and makes direct payments to providers. Under the Governor's Empowered Care proposal, Medicaid would purchase coverage from insurers and other types of health plans which would offer a basic benefit plan along with additional optional coverages which could vary from one health plan to another. A separate pool of funds would cover recipients' catastrophic care needs. Recipients would have the ability to choose between plans which are certified by Medicaid, and in certain instances would be able to "opt out" of Medicaid entirely and use the funds which the state would have spent on their coverage to purchase health insurance through employers or in the private market. The state's role would thus change from direct reimbursement of care to one in which government selects contractors to provide coverage, and ensures that the services and coverage provided are of high quality.

The proposal contemplates a phased-in process. Initially the new system would operate in limited geographic areas on a pilot basis. In selected areas Medicaid recipients in specific eligibility groups or who are receiving certain services would be excluded from participation and would continue to receive services under the traditional fee-for-service Medicaid program. The initial eligibility groups proposed for inclusion in the new system are those in the TANF and TANF-related eligibility groups, recipients of SSI cash assistance, SOBRA expansion groups. The plan initially excludes individuals in institutions, nursing homes, and ICF-DD, and individuals with Medicare coverage. Thus initially the plan would exclude most individuals over the age of 65.

The Agency for Health Care Administration (AHCA or the agency) has indicated that it plans to expand the reform to the initially excluded populations beginning at least 3 years after implementation of the first phase of the program.

Federal Medicaid Framework

Medicaid was enacted in 1965, in the same legislation that created the Medicare program, the Social Security Amendments of 1965 (P.L. 89-97). The act created Title 19 of the Social Security Act of 1965. The creation of Medicaid and Medicare replaced two earlier programs of Federal grants to States that provided medical care to welfare recipients and the aged.

Medicaid is a means-tested entitlement program. It is jointly financed by Federal and State funds. Federal contributions to each State are based on a State's willingness to finance covered medical services and a matching formula. Each State designs and administers its own program under broad Federal rules. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for Federal oversight of the program.

Federal and State Laws and Regulations
The Medicaid program operates under a complex regulatory framework. This framework includes:

- Title XIX of the Social Security Act
- Code of Federal Regulations 42 CFR 430 - 42 CFR 455
- State Plan – The state plan acts as a contract between the State and the Federal government and contains polices regarding: the administration, eligibility, coverage and reimbursement structure of the Medicaid program.
- Sections 409.905 - 409.9201 of Florida Statute

The Agency for Health Care Administration
The Medicaid program is administered primarily by the Florida Agency for Health Care Administration under Chapter 409, Florida Statutes. However, other state agencies have certain responsibilities. For example, the Department of Children and Families determines eligibility; the Department of Legal Affairs, Medicaid Fraud Control Unit, prosecutes Medicaid fraud; and the Department of Health contracts with and monitors medical providers; and the Department of Elder Affairs has responsibility for implementing several home and community based waiver programs designed to keep Medicaid recipients at home in the community instead of more costly nursing homes.

Medicaid Eligibility
Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions.

Florida's Medicaid program covers all individuals required by federal law and has expanded eligibility to certain populations deemed particularly vulnerable. The average monthly caseload for FY 2004-05 is estimated to be over 2.15 million persons. The following categorical groups are served by Florida Medicaid.

- Individuals in single-parent low-income families who meet the AFDC eligibility standards effective in September 1996 or meet Temporary Assistance to Needy Families (TANF) eligibility guidelines.
- Unemployed parents and children under 18, children under 21 in intact families, or children born after 9/83 living with non-relatives, where family income meets AFDC standards.
- Individuals who meet SSI or TANF eligibility after expenses for medical care are deducted. This category is 100% federally funded and covers the first eight months in the U.S. for individuals who generally meet the TANF and SSI eligibility requirements.
- Elderly or disabled individuals of low income who are determined eligible for supplemental security income (SSI) as determined by the Social Security Administration.
- Elderly and disabled individuals with income above the criteria for supplemental security income but less than 90% of the Federal Poverty Level.
- Medicaid covers certain Medicare-related expenses for elderly and disabled individuals between 90-120% of the Federal Poverty Level.
- Pregnant women under 100% of the Federal Poverty Level and children age 6 and older in families under 100% of the Federal Poverty Level.
- Children age 1 to 6 under 133% of the Federal Poverty Level; pregnant women and infants less than one year old with incomes less than 185% of the Federal Poverty Level.
- Children born after 10/93 who have not reached age 19 and are under 100% of the Federal Poverty Level.

Waivers
Waivers are instruments under which the CMS allows states to try innovative programs that are cost neutral to the federal government. States may request waivers of certain federal rules. In general these rules require services to be provided on a statewide basis, comparable across the state, and must be sufficient in amount, duration, and scope to reasonably achieve its purpose

Waivers allow the reform of Medicaid services for certain populations and benefits. For example, Medicaid's home and community–based services waiver program affords states the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. This waiver program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. There are many types of Medicaid waivers available to states; however, the majority of waivers fall into one of four major categories: 1115, 1915 (b), and 1915 (c)

Section 1115 of the Social Security Act allows states to pursue "an experimental, pilot or demonstration project which, in the judgment of the Secretary of Health and Human Services, is likely to assist in promoting the objectives" of Title XIX

While 1115 waivers allow states some flexibility regarding coverage eligibility, provider choice, provider reimbursement, managed care and other provisions, states must adhere to certain requirements. For example, any waiver initiative must be budget neutral to the federal government, must contain adequate evaluation components, and must maintain service to specific categories of beneficiaries.

Section 1115 waivers are initially approved for 5 years and can be extended for 3 years.

Funding

For program administration costs, the federal government contributes 50 percent for each state. For medical services, the federal government contributes at a variable rate called the federal medical assistance percentage (FMAP). A state's FMAP is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent.

Florida's FMAP is 59 percent, which means that the federal government pays 59 cents of every dollar spent in Florida's Medicaid program. These matching rates provide significant assistance to states in their efforts to provide medical care to low-income individuals; however, if downturns in the economy occur over a long period of time, states may find it difficult to balance their budgets even with this assistance.

Long Term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. This care is often supportive, rather than curative in nature, and is provided in institutions, home-like institutional settings and to persons living in their own residence. Long-term care may be care provided in a nursing home, in a residential setting such as an assisted living facility, in an adult day care center, or may be delivered to a person as home care. Long-term care in nursing homes is more medically oriented and is often provided by licensed and certified personnel to people with severe limitations and severe cognitive disorders. Much of long-term care provided in the home is supportive in nature, such as assistance with the activities of daily living of eating, toileting, and dressing.

Medicaid is permitted under section 1915(c) of the Social Security Act to waive certain federal requirements in order to provide home and community-based services to persons who would require institutionalization without community supports. Services vary by waiver but typical waiver programs include services such as personal care, homemaker, companion, chore, respite care, and adult day health care. Most services are provided directly in a recipient's home. Florida has twelve approved HCBS waivers. Each waiver has specific eligibility criteria such as age, type and level of disability, and service area covered. All waivers provide case management services to assess individual needs and work with recipients to develop a plan for their care, including which services will be provided, by which provider, and at what frequency. Unlike other long term care services, the state can, and does, limit the number of individuals served in each waiver program. There are waiting lists for most waiver programs due to this limit. Most waivers reimburse providers on a fee-for-service basis.

The federal government, through the Medicare program, pays for the majority of health care required by older people, including short-term nursing home care and recuperative home health care. The federal government also funds long-term community care services through the Older American's Act. States, through their Medicaid programs, finance the majority of nursing home bed days (long-term nursing home care). Medicaid also finances the home and community-based care that serves as an alternative to nursing home placement through the use of Medicaid waivers.

A major impediment for states in planning an efficient long-term care system has been the difficulty of managing the interrelationship of incentives between the Medicare and Medicaid financing systems, and the effect that care of acute illnesses has on the eventual need for long-term care. States often have little control over the admission of a patient into a nursing home since the initial portion of a nursing home stay is usually financed by Medicare or other sources.

Many of these Medicare beneficiaries end up converting to Medicaid. Medicaid conversion in nursing homes occurs when a resident spends all of his or her assets to pay for an extended stay in a nursing home and is without private long-term care insurance. When an individual is eligible for Medicaid at the time of nursing home entry and Medicare coverage is available as well, Medicare is considered the primary payer although Medicaid might also fund part of the costs of the nursing home stay. Medicaid per diem payments begin only after the Medicare benefit is exhausted. Most Medicaid conversions in Florida happen within the first year of a nursing home stay. Medicaid pays for approximately two-thirds of the patient days in nursing homes in Florida.

Community-based Long-term Care

The Department of Elderly Affairs (DOEA) and AHCA provide a system of home and community-based services to elderly individuals through a variety of programs. Though the stated purpose of these programs is to assist elderly individuals to remain in their homes as they become increasingly frail, the programs differ in the characteristics of their target groups and their payment methodologies and rates. Some of these programs are targeted at elderly people who meet nursing home admission criteria and who are in the process of entering a nursing home, while others serve people who have lesser levels of disability and who can be assisted in remaining in their homes with the provision of limited supportive services. There are other programs that provide supportive services to lessen isolation, keep elders healthy, or relieve the burdens and stresses placed on families caring for aged family members.

The "Aging Network"

Florida has a long history of providing care and services to elderly individuals through a system of Area Agencies on Aging and local Community Care for the Elderly Lead Agencies - often referred to as Florida's "Aging Network". Area Agencies on Aging (AAA) are the administrative entities used by DOEA to manage aging services in the state. When DOEA was created, AAAs assumed many of the functions formerly performed by HRS District Aging and Adult Services offices, making the AAAs, in effect, DOEA's district offices. The AAAs perform program oversight for DOEA at the local level; for example, DOEA has contractual agreements with the AAAs to oversee the Medicaid Aged/Disabled Adult Waiver and the Medicaid Assisted Living for the Elderly Waiver. Area Agencies contract for and monitor service delivery under the state's Community Care for the Elderly, Home Care for the Elderly, and the federal Older Americans Act Programs.

Florida has long aligned its federal Older Americans Act Planning and Services Areas (PSA) to correspond with the 11 former Department of Health and Rehabilitative Services service districts, which were in existence prior to the formation of the Department of Children and Family Services (DCF). When DOEA became the state unit on aging in 1992, it continued to use the same boundaries for program purposes. The Older Americans Act requires states to establish an Area Agency on Aging in each PSA. Thus, there are 11 AAAs in Florida.

Lead Agencies

Lead agencies are the local community agencies that provide state-funded aging services directly to individuals. Lead agencies have provided case management services to the state's functionally

impaired elders since 1980, when the Legislature expanded the Community Care for the Elderly Program statewide. The Community Care for the Elderly Act required that each PSA in the state develop at least one community care service system to enable functionally impaired elders to live independently in the community and prevent unnecessary nursing home placement.

The Community Care for the Elderly law requires AAAs to contract with lead agencies to coordinate case management and ensure that "core services" are available to meet the needs of the elders in their communities. The statute provides that core services "must include case management and may include homemaker and chore services, respite care, adult day care, personal care services, home-delivered meals, counseling, information and referral, and emergency home repair services."

Lead agencies may directly provide these services or subcontract with other providers. In essence, the lead agencies were developed specifically for the Community Care for the Elderly Program, although they now function to provide case management and services under other programs (Aging Disabled Medicaid Waiver, Assisted Living Medicaid Waiver, and Home Care for the Elderly).

Although the majority of direct services are provided through contracts with the lead agencies, the AAAs can provide services directly to caregivers in crisis through the Family Caregiver Support Initiative. In addition, the AAAs manage the Elder Helpline.

Aging Resource Centers

While the states aging system generally provides high quality services to its clients, the network can be a complicated maze for elderly persons and their families. During the 2004 Legislative Session, the Florida Legislature authorized the establishment of a network of Aging Resource Centers (ARCs) throughout Florida. The development of ARCs was intended to make the system easier to navigate and provide a realignment of long-term care responsibilities to focus agencies on performing core functions in their area of expertise and eliminate duplication of effort within the system. ARCs will also be collocated, either physically or virtually, with the entities that provide eligibility determination for services. On February 9, 2005 DOEA announced that it had selected 3 area agencies to begin the transition to Aging Resource Centers : the Area Agency on Aging of Pasco-Pinellas, Inc., in St. Petersburg, Senior Resource Alliance in Orlando, and the Area Agency on Aging of Broward County, Inc., in Fort Lauderdale.

Prepaid Payment Systems

Under the traditional fee-for-services Medicaid program, the state acts as an insurer in that Medicaid pays fee-for-service claims based on provider billings for services rendered. The services covered by Medicaid are delineated in state statutes (ss. 409.905 and 409.906, F.S.). Medicaid imposes a variety of limits on specific services (such as a 45 day limit on inpatient care) and has a system of prior authorization for some high cost services, in which providers must demonstrate that care which is being rendered is medically necessary prior to provision of the service being authorized. Under the fee-for-service system, health care providers enroll directly with the Medicaid program, and submit their claims for reimbursement to a fiscal agent contracted by Medicaid to process and pay claims according to a pre-established fee schedule.

Under a managed care arrangement, the state pays a fixed (generally) monthly fee to an insurer, often a Health Maintenance Organization, which assumes the responsibility of developing the provider network, negotiating fees with its network, and paying provider claims. Generally the managed care plan assumes the risk for providing care needed by enrollees up to limits defined in the plan's contract with the funding source. The monthly fee is generally determined based on an estimate of what the cost of providing the covered benefits would have been on a fee-for service basis. This estimate is inflated forward to account for medical inflation, and the total projected monthly cost is discounted by a fixed percentage. In Florida Medicaid, separate rates are computed which recognize variations in health care utilization and costs based on eligibility group, age, sex and region.

Since a managed care plan is at risk for and has the responsibility for providing the care needed by enrollees, the plan either makes a profit or incurs a loss based on its ability to efficiently and economically manage enrollee health care events and reducing enrollee need for health care services by providing wellness and disease prevention and early intervention in health care problems which, if not addressed, could lead to much more expensive acute care. In addition, managed care plans contain health care delivery costs by effectively negotiating favorable service rates with subcontract providers, use downward substitution (for example: using walk-in clinics rather than hospital emergency rooms; using advanced nurses or physician assistants to provide less complex care), and rigorous prior authorization for delivery of non-routine medical care.

Managed Long-term care

Over the past 20 years, states have been increasingly interested in bringing the financial incentives inherent in managed care to bear on the long-term care population. During the 1990's several states, including Florida, received grants from the Robert Wood Johnson Foundation to assist in the development of managed models of long-term care. These grants resulted in the development of a variety of managed long-term care program models in Florida, Oregon, Texas, Minnesota, New York, Utah, Maryland, and others. Current managed long-term care programs are characterized by plan assumption of risk for a range of medical services and assumption of full or partial risk for nursing home care. In order to prevent or delay expensive nursing home services, managed long-term care plans provide a set of home and community-based services which are authorized by care managers who are responsible for ensuring that participants have access to needed medical and home care services. In addition, managed long-term care plans make use of alternative facility services such as assisted living for participants who are unable to remain in their own homes but who do not have medical complexities requiring 24 hour nursing care. In general, satisfaction of Medicaid managed long-term care participants has been higher than that of recipients in fee-for service systems, in large part due to the presence of a "care manager" who is responsible for assisting the recipient in accessing needed community-based services.

Effects of the Bill:

House Bill 1869 permits the Agency for Health Care Administration (AHCA), contingent on federal approval, may revise or apply for a 1915 Medicaid waiver or apply for a Medicaid reform demonstration waiver to integrate state funding for Medicaid services provided to individuals dually eligible for the Medicaid and Medicare programs. The bill specifies standards AHCA and a managed care plan are required to comply with in integrating such services.

AHCA is required to offer dually eligible recipients a choice of managed care plans, which includes an insurance company or an HMO, or alternatively, other qualified providers, including Community Care for-the-Elderly Lead Agencies and their subcontractors.

The bill imposes additional responsibilities on managed care plans under contract to AHCA to serve dually-eligible individuals. The following requirements are in addition to other regulatory requirements imposed on these providers:

- A managed care plan must allow an enrollee to select any provider with whom the plan has a contract.
- Make a good faith effort to develop contracts with current aging network providers.
- Have sufficient subcontracts with nursing home; community-based services to ensure access to and choice for recipients.
- Develop and use a service provider qualification system that describes the quality-of-care standards that providers must meet in order to obtain a sub-contract with the plan, which does not duplicate other state or federal requirements.
- Contract with all qualified nursing homes located in the area that is served by the plan, including Gold Seal.
- Permit individuals who are residents of nursing homes who do not choose to move to another setting, to remain in the facility in which they are receiving care.

- Plan providers are at risk for serving individuals who convert from non-Medicaid funding sources to Medicaid; AHCA must ensure that Medicaid recipients transitioned out of nursing home care and into community alternatives continue to receive Medicaid.
- Have an internal quality assurance and quality improvement system - determined by AHCA to be adequate.
- Have a system to identify elderly participants who have special health care needs such as polypharmacy, mental health and substance abuse problems, falls, chronic pain, nutritional deficits, and cognitive deficits, in order to respond to and meet these needs. (Delete “elderly” in AHCA version to make apply to all participants).
- Use a multidisciplinary team approach to participant management, which ensures that information is shared among providers responsible for delivering care to a participant.
- Ensure medical oversight of care plans and service delivery, regular medical evaluation of care plans, and the availability of medical consultation for care managers and service coordinators.
- Develop, monitor, and enforce quality-of-care requirements.
- Have a in place a care coordination system which contains educational and training standards for care managers and service coordinators.
- Develop a business plan that demonstrates the ability of the contractor to organize and operate a risk-bearing entity as determined by AHCA.
- Furnish evidence of liability insurance coverage or self-insurance that is determined adequate by the Office of Insurance Regulation to respond to claims for injuries arising out of the furnishing of health care.
- Comply with prompt payment requirements applicable to licensed HMOs.
- Provide for periodic review of its facilities as required by the agency, which do not duplicate other state and requirements (AHCA is to provide survey results to the plan).
- Provide enrollees the ability, to the extent possible, to choose nursing home and ALF providers: affiliated with an individual's religious faith or denomination or part of a retirement community in which an enrollee resides and geographically located as close as possible to an enrollees family, friends, and social support system.

The bill imposes several conditions on AHCA as it moves to a managed care model for dually eligible individuals:

- AHCA is to develop additional quality assurance standards specific to the care needs of the elderly in managed care, in consultation with area agencies on aging and the Department of Elderly Affairs; AHCA is to contract with are agencies to perform initial and ongoing measurement of quality of care for the elderly in managed care plans. Area agencies are to collect grievance and complaint information and report on resolution. AHCA and the Department of Elderly Affairs are to coordinate these quality measurement activities in a manner which promotes efficiency and avoids duplication.
- Nursing homes with no MCO contract are required to cooperate with a managed care plan’s efforts to determine if a recipient could be moved to a community setting, and plan required to pay Medicaid rates for members in such nursing homes.
- The bill allows AHCA to develop risk sharing agreements in which plan risk for custodial nursing home care may be limited. The bill allows AHCA to define the parameters of risk sharing, and under risk sharing, AHCA may reimburse either the plan or a nursing home directly.
- The bill creates a quality reserve fund” which requires AHCA to withhold a percentage of the capitation rate, which is to be disbursed to plans which demonstrate high quality of service delivery based on achievement of several indicators such as a low rate of enrollee complaints, successful enrollee outcomes, compliance with quality improvement standards, and other factors determined by the agency as indicators consistent with high quality service delivery.
- The bill requires that managed care plans rebate excess profits earned on long-term care services to dually eligible individuals:
    - Rebates are assessed on portions plan profits which exceed 3 per cent: Portion of profit above 3 percent are to be rebated determined by the agency on a sliding scale.
    - No profits above 15 percent may be retained by the plan.

    - Rebates shall be paid to the agency.
- The bill allows AHCA to limit the number of non nursing home individuals enrolled in the plan at 300% SSI income level described in s. 409.904(3), F.S.
- In the demonstration areas, area agencies are to serve as the aging resource center, and are designated as entry point for eligibility determination, and are designated as choice counselors to assist participants in choosing a plan
- AHCA is, in cooperation with Florida Health Care, Florida Association of Homes for the Aging and the Department of Elderly Affairs is directed to create a task force to develop a system of monitoring and enforcing quality of care requirements and managing and responding to grievances and complaints.
- AHCA is given authority to impose "Liquidated Damages" in the event of non-performance of the plan of its obligations under its contract with the agency or of the requirements of the act. Liquidated damages are calculated by the agency as reasonable estimates of the agency's financial loss and are not to be used to penalize the plan. If the agency imposes liquidated damages, AHCA may collect by reducing amount of monthly premium due plan and are forfeited and will not be paid to plan upon compliance unless a determination is made after appeal that the damages should not have been imposed.
- AHCA is to grant a modification of certificate of need conditions related to Medicaid utilization to nursing homes which have experienced decreased Medicaid patient days due to a transition to managed care.
- AHCA is required to ensure that, to the extent possible, Medicare and Medicaid services are integrated, and when possible, individuals served in the managed care system who are eligible for Medicare shall be enrolled in a Medicare managed health care plan operated by the same entity that is placed at risk for Medicaid services.

The bill expresses legislative intent that AHCA begin discussions with the federal government regarding the inclusion of Medicare in an integrated long-term care system.

The bill requires AHCA to develop a loan program to assist local Community Care for the Elderly agencies and other essential community providers to become managed care organizations. The loan program is subject to appropriations, and allows AHCA to advance up to $500,000, per network. The terms of repayment may not extend beyond 6 years, and AHCA is to develop a grant program to implement.

C. SECTION DIRECTORY:

Section 1. Provides authorization for AHCA, subject to federal approval, to integrate state-funded services for individuals dually-eligible for Medicaid and Medicare into its Medicaid reform waiver program, and includes additional quality requirements on both AHCA and managed care plans; provides for funding development costs of community long-term care providers; authorizes loans of up to $500,000 for 6 years through a grant application process provides for rulemaking; requires that AHCA report regarding the approved waiver; provides for sunset of this act in 5 years (July 1, 2010).

Section 7. Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

   The fiscal impact of this bill is unknown at this time. The bill allows a loan program to assist local provider networks to transition their business model to a managed care delivery system, and requires repayment of these funds with interest.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will increase revenues to entities which become providers under the reformed system, and may reduce revenues to local provider agencies that do not choose to participate.

D. FISCAL COMMENTS:

The fiscal impact of the bill is indeterminate at this time. It is likely that the effect of moving Medicaid services for dually-eligible individuals to a managed care system will ensure that state-funded care is delivered more efficiently, and that there will be a slowing in the rate of increase of long-term care costs.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The mandates provision is not implicated by this bill.

2. Other:

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority for the Agency for Health Care Administration.

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 30, 2005 the Elder and Long-term Care Committee adopted a series of amendments to the Proposed Committee bill which had the following effect:

- The agency was given additional authority to revise or apply for a waiver of s. 1915 of the Social Security Act in addition to the authority to expand an 1115 demonstration waiver, to accomplish the purposes of the bill
- The choices of providers available to recipients was expanded to include either an insurance company or an HMO, as well as other qualified providers.

- The agency is required to select managed care plans through a competitive procurement process, and to limit the program to 3 providers in each of the 11 AHCA service areas.
- In developing and implementing quality of care measures, managed care plan providers are to avoid duplication of survey and certification activities with those pf the agency.
- All managed care plans are to comply with the prompt payment requirements applicable to HMO per s. 641.3155, F.S.
- AHCA, DOEA and area agencies on aging are to develop quality assurance standards specific to the needs of the elderly, and area agencies on aging are to measure the quality of services provided under managed care arrangements.
- AHCA is to create a task force to develop a system of monitoring and enforcing quality of care requirements and responding to enrollee grievances and complaints.

  AHCA is to permit modification of nursing home certificate of need conditions related to Medicaid participation to nursing homes that have experienced decreased Medicaid utilization due to implementation of a managed care delivery system.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

B. EFFECT OF PROPOSED CHANGES:

C. SECTION DIRECTORY:

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

E. FISCAL IMPACT ON STATE GOVERNMENT:

3. Revenues:

4. Expenditures:

F. FISCAL IMPACT ON LOCAL GOVERNMENTS:

3. Revenues:

4. Expenditures:

G. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

H. FISCAL COMMENTS:

III. COMMENTS

D. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

2. Other:

E. RULE-MAKING AUTHORITY:

F. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES