# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1875 PCB HCR 05-02 Medicaid Reform
**SPONSOR(S):** Health Care Regulation Committee and Garcia
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR |
|---|---|---|---|
| Orig. Comm.: Health Care Regulation Committee | 10 Y, 0 N | Mitchell | Mitchell |
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |


## SUMMARY ANALYSIS

HB 1875 replaces PCB HCR 05-02 as amended and approved by the Health Care Regulation Committee. The analysis is written to HB 1875.

**Pursue Federal Waiver for Medicaid Reform**
HB 1875 allows the Agency for Health Care Administration to seek an experimental pilot or demonstration waiver, pursuant to Section 1115 of the Social Security Act, to reform Florida Medicaid in urban and rural demonstration sites in Broward, Duval, Baker, Clay and Nassau counties, contingent on federal approval to provide a reasonable growth factor, risk pool funding, intergovernmental transfers and upper-payment-limit and disproportionate share funding. The bill provides for a three year phase-in of the pilot projects that are limited to TANF and SSI populations, drawn from existing Medipass and Fee-for-Service enrollees. The bill provides an option to retain fee-for-service rates. It requires a description of the pilot projects, and requires data reporting, legislative oversight and an evaluation.

**Plan Design:**
- Provider service networks in the pilot areas are to be continued.
- Plans must provide basic benefits of Medicaid mandatory services, plus behavioral health care and pharmacy benefits. They may include other optional and supplemental care.
- The bill requires a certificate of operation from AHCA to operate a managed care plan. Requirements and standards for certification include financial solvency and health care network capacity.
- The bill allows AHCA to require recipients to share cost thru co-payments, deductibles, or enrollment fees.

**AHCA and Plan Accountability:**
- The bill requires plans to report encounter data to AHCA on services, cost, frequency and other information.
- It requires plans to have quality assurance and quality improvement systems.

**Provisions for Financing Partial Risk Sharing by Plans and AHCA**
- The bill allows AHCA to establish catastrophic coverage for conditions that exceed a plan's risk capacity. Coverage for an individual does not release plans from providing other services.
- The bill allows the agency to adjust a plan's capitation rate based on recipients' diagnoses and needs.

**Further Legislation Required Prior to Implementation**
- The bill requires that upon waiver approval by the Centers for Medicare & Medicaid Services, the agency must report provisions of the waiver to the Legislature for approval to implement the pilot.
- The bill sunsets the Act on July 1, 2010.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. HOUSE PRINCIPLES ANALYSIS:

**Limited Government** – The bill allows for increased competition in the provision of Medicaid Managed Care, and allows Medicaid recipients to choose health care services from the private insure market.

**Ensure Lower Taxes** – The bill provides for capitation of Medicaid Managed Care Plans to reduce the rate of increase in Medicaid costs.

**Promote personal responsibility** -- The bill allows Medicaid recipients to assume responsibility for their health care through cost sharing such as co-payments and deductibles.

### B. EFFECT OF PROPOSED CHANGES:

The proposed committee bill allows the Agency for Health Care Administration to seek an experimental pilot or demonstration waiver, pursuant to Section 1115 of the Social Security Act, to reform Florida Medicaid in urban and rural demonstration sites in Broward, Duval, Baker, Clay, and Nassau counties.

AHCA pursuit of the waiver is contingent on federal approval to provide a reasonable growth factor, risk pool funding, intergovernmental transfers and upper-payment-limit and disproportionate share funding.

The bill provides for a three year phase-in of the pilot projects that are limited to TANF and SSI populations, drawn from existing Medipass and Fee-for-Service enrollees.

The bill provides an option to retain fee-for-service rates.

It requires a description of the pilot projects, and requires data reporting, legislative oversight and an evaluation.

The bill provides for flexibility in plan design and requirements for accountability by the plans and the agency.

**Flexibility in plan design:**

- The bill requires AHCA to develop a capitated system of care that promotes choice and competition. Plans must provide basic benefits to include mandatory services (409.905), behavioral health care (409.906(8)), and pharmacy benefits (409.906(20)), and other optional and supplemental care. It makes behavioral health care and pharmaceuticals part of a managed care plan (not a carve-out), and allows AHCA to set standards.

- The bill provides for managed care plans to include a wide range of existing forms of benefit coverage and provider service networks, subject to receiving a certificate of operation from AHCA.

- The bill establishes requirements for certification, including, but not limited to, financial solvency and health care network service capacity.

- The bill allows AHCA to require recipients to share in cost thru co-payments, deductibles, or enrollment fees.

**AHCA and Plan Accountability:**

- The bill requires AHCA to develop a data reporting system and requires plans to report encounter data (services, cost, frequency and other information) to AHCA.

- It requires the agency to implement accountability systems.

- It requires plans to have quality assurance systems that meet requirements of 409.912(27), and quality improvement systems to identify causes of system problems and improve the quality and effectiveness of care.

**Provisions for Financial Partial Risk Sharing by Plans and AHCA**

- The bill allows AHCA to establish catastrophic coverage for individuals with costly conditions that exceed a plan's risk capacity.

- The bill allows AHCA to establish a funding methodology and to develop policies and procedures to allow access to the catastrophic coverage.

- Recipients may be included at a cost threshold determined by the agency based on actuarial analysis. Plans are not released from providing benefits or case management, except when it is in the best interest of the recipient to release the plan from its obligations.

- The bill also provides a framework to allow the agency to increase a plan's capitation rate depending on the diagnoses or needs for services of recipients who chose the plan.

**Implementation Provisions**

- The bill requires AHCA to report provisions of the approved waiver and deviations from the Act to the Legislature.

- It requires legislative authority prior to implementation of the waiver.

- The bill provides that the Act Sunsets in 5 years (July 1, 2010) if provisions fail to produce desired reform outcomes.

- It allows AHCA to use existing applicable provisions of law to facilitate implementation of the reform waiver, and authorizes AHCA to promulgate rules to implement the waiver.

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

EFFECTS OF PROPOSED CHANGES IN RELATED MEDICAID REFORM LEGISLATION

**Provisions of other proposed Medicaid reform legislation that is being considered by the Florida House of Representatives include:**

Limiting the waiver to categorical groups that represent the following current eligibility groups:

- Recipients under the Temporary Assistance for Needy Families consistent with section 402 and 1931 of the Social Security Act and Chapters 409, 414, and 445 Florida Statutes.
- Recipients under Supplemental Security Income as defined in Title XVI of the Social Security Act, except for individuals dually eligible for Medicaid and Medicare.
- All children covered pursuant to Title XIX and Title XXI of the Social Security Act.

Other proposed provisions include:

- A framework for choice counseling component that allows a recipient to make an inform choice to either receive health care coverage through Medicaid benefits or through the private insurance market.
- Allowing the agency to establish enhanced benefit coverage and a methodology to fund the enhanced benefit coverage that will allow recipients, who comply with the objectives of a wellness or disease management plan, to purchase additional health-care services or health-care products.
- Requiring the agency to implement several existing provisions of law related to Medicaid fraud and abuse to ensure the integrity of the waiver program.
- Creating a process to convert the service delivery for dually-eligible recipients (eligible for Medicare and Medicaid) to a system of integrated manage care.
- Establishing a mechanism to allow the agency to award up to $500,000 per network, to help networks meet provisions of the Act, by assisting with the development costs to convert to a managed care plan.

BACKGROUND

**Federal Medicaid Framework**
Medicaid was enacted in 1965 along with Medicare program in amendments to the Social Security Act (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 very complex and detailed regulatory framework. This frame work 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.
- State Medicaid Directors Letter.
- Sections 409.905 - 409.9201 of Florida Statute.
- Florida Administrative Code Chapters 59G-1 - Chapters 59G-13.
- Medicaid Handbooks
- Policy Transmittals.

**Florida Medicaid**
Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

Florida's Medicaid expenditures have grown in several distinct surges since its inception in 1970, with the most significant increases over the last 20 years. Florida Medicaid expenditures increased from $795 million in FY 1983-84 to over $12.5 billion in FY 2003-04. Since 1999, Medicaid expenditures have doubled, growing by over 112 percent.

**The Agency for Health Care Administration**
Federal law requires that a state's Medicaid program must be administered by a "single state agency." In Florida, the Agency for Health Care Administration administers the Medicaid program under Chapter 409, Florida Statutes.

The Florida Legislature created the Agency for Health Care Administration as part of the Health Care Reform Act of 1992 (Ch. 92-33, Laws of Florida) to reduce administrative costs and improve the state's efficiency in addressing health care issues. The Governor nominates and the Senate confirms the Secretary of the agency.

Other state agencies have certain responsibilities for administering certain programs and functions. 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 the responsibility for implementing several home and community based waiver programs designed to keep Medicaid recipients at home in the community, instead of in more costly nursing homes.

**Medicaid Eligibility**
Medicaid is a program targeting individuals with low-income, but not all of the poor are eligible, and not all those covered are poor. 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. Florida Medicaid serves the following categorical groups when they meet specified financial 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.
- 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 and disabled individuals with income above the criteria for supplemental security income but less than 90% of the Federal Poverty Level.
- Certain Medicare-related expenses for elderly and disabled individuals between 90-120% of the Federal Poverty Level (excludes Silver Saver program).
- 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.

**Mandatory Services**
Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans; however, a state's Medicaid program must offer certain mandatory medical benefits to most categorically needy populations if federal matching funds are to be received. As a result, Medicaid, generally, has a more comprehensive benefit package than most commercial health insurance plans and Medicare. Medicaid is unable to disqualify people based on pre-existing medical conditions. Mandatory Medicaid benefits include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.
- Emergency and non-emergency transportation.

**Optional Services**
Florida's Medicaid program provides all of the mandatory medical benefits under its state plan; but, it may also receive federal matching funds to provide certain optional services. The following optional benefits are provided under Florida's Medicaid program:

- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care
- Birth Center Services
- Children's Dental Services
- Children's Hearing Services
- Children's Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department
- Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Emergency Dental for Adults
- Healthy Start Services
- Home & Community-Based Services
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Occupational Therapy
- Optometric Services
- Orthodontia for Children
- Personal Care Services
- Physical Therapy
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case
- Management (MediPass)
- Private Duty Nursing
- Registered Nurse First
- Assistant Services
- Respiratory Therapy
- School-Based Services
- Speech Therapy
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management

**Service Delivery System for Medicaid Services**
Florida law requires that, to the extent possible, Medicaid recipients enroll in a managed care delivery system. Depending on geographic availability, recipients have several managed care arrangements from which to choose. As of January 2004, over 1.4 million (or 67%) of the state's Medicaid recipients were enrolled in one of these managed care options, including 697,694 recipients enrolled in MediPass, 697,453 in Medicaid HMOs, and 18,144 in Provider Service Networks (PSNs). All other recipients are considered fee-for-service. This group includes dual eligible individuals who receive both Medicare and Medicaid, institutionalized and hospice recipients, new recipients, recipients for whom Medicaid is supplemental insurance, and the Medically Needy.

- Medicaid Provider Access System (MediPass). The MediPass system is available statewide and is a primary care case management program. MediPass recipients select or are assigned a primary care physician (PCP) who is responsible for providing primary care and referring patients for specialized services. The state pays PCPs a $3 monthly case management fee for each recipient in addition to fee-for-service reimbursement for each service they provide to recipients. The MediPass program also is currently implementing two pilot projects, Children's Provider Networks (also known as the Pediatric ER Diversion Program) and Minority Physician Networks. These pilot projects target specific utilization and cost concerns related to children and minorities and have the flexibility to develop their own networks and to outsource many administrative functions.

- Medicaid Health Maintenance Organizations (HMOs). Medicaid HMOs, which are available in 41 of the state's 67 counties, provide medical services to Medicaid recipients on a prepaid basis. For each enrolled recipient, the state pays HMOs a monthly fee that is set at 92% of the expected cost to provide services to equivalent groups of fee-for-service recipients. Besides the approved Medicaid services, HMOs are required to provide additional services, including smoking cessation, pregnancy prevention, and domestic violence intervention services.

- Provider Service Networks (PSNs). PSNs are currently available in only two counties, Broward and Miami-Dade. PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups.

**Waivers**

Waivers are instruments under which 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. In addition, the recipient must have freedom of choice.

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), 1915 (b/c), 1915 (c). Florida has numerous waivers.

Section 1115 waivers of the Social Security Act such as that requested in the bill allow 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.

The objectives of the Act are set forth in section 1901, which provides that, in part, funds are appropriated by the federal government for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish,

> (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and
> (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .

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.

**Disproportionate Share Hospital (DSH) Payments**
States may make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. These funds account for a significant proportion of Medicaid funding in many of Florida's "safety-net" facilities.

**Upper Payment Level (UPL) Payments**
This supplemental payment mechanism is a complex funding arrangement between the state and the federal government where states are allowed to make special Medicaid payments to compensate certain hospitals and providers to make up the difference between Medicaid and Medicare fees and their usual and customary charges for certain services.

**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, states may find it difficult to balance their budgets even with this assistance.

C. SECTION DIRECTORY:

**Section 1. Provides for Medicaid Reform Pilot Projects**

**(1) Waiver Authority**--provides authority for AHCA to seek a federal 1115 waiver for urban or rural demonstration sites in specified counties contingent upon preservation of UPL and DSH.
**(2) Manage Care Pilot Projects**—specifies requirements for three year phase in of the pilot projects.
**(3) Implementation of Pilot Projects**—requires enrollees in the plans to come from Medipass and Fee-for Service populations.
**(4) Definitions**—and specifications of administrator, agency, catastrophic coverage, managed care plan, plan benefits, and provider service networks.
**(5) Plans**—specifying basic plan benefits, including mandatory Medicaid services (s. 409.905, F.S.), behavioral health care (s. 409.906(8), F.S.), and pharmacy benefits (s. 409.906(20), F.S.), and other optional and supplemental care. Makes behavioral health care part of a managed care plan (not a carve-out) and allows AHCA to set standards.
**(6) Certification**—establishing requirements for an entity to obtain a certification of operation from the agency to participate as a managed care plan, including establishing financial, service network capacity and infrastructure requirements, including provisions of ch. 624, F.S., and adequate stop-loss coverage.
**(7) Cost Sharing**—allowing AHCA to require recipients to share in costs thru co-payments, deductibles, or enrollment fees.
**(8) Medipass**--requires continuation of the Medipass program until Medicaid reform works statewide.
**(9) Encounter Data System**—requires AHCA to develop a data reporting system and requires plans to report encounter data (services, cost, frequency and other information) to AHCA. Requires plans to have quality improvement systems to improve care and outcomes.

**(10) Accountability**--requires the agency to adopt performance standards including clinical and functional outcomes of recipients, and plan reporting of clinical outcomes, satisfaction and prompt pay.
**(11) Quality Assurance**—requires plans to have quality assurance systems that meet current statutory Medicaid requirements of s. 409.912(27), F.S.
**(12) Quality Improvements**—requires plans to have systems to improve the quality and effectiveness of care.
**(13) Statutory Compliance**—requires compliance with current prompt-pay and emergency medical service provisions.
**(14) Catastrophic Coverage**--allows AHCA to establish catastrophic coverage and a funding methodology. Recipients may be included at a cost threshold determined by the agency based on actuarial analysis. Plans are not released from providing benefits or case management.
**(15) Rate Setting and Risk Adjustment**--provides a framework to allow the agency to increase a plan's capitation rate depending on the diagnoses or service needs of recipients.
**(16) Applicability of Other Law**—allows AHCA to use other statutory provisions not referenced in the act to implement the waiver.
**(17) Rulemaking**—provides rule making authority.
**(18) Implementation**—requires AHCA to return to the Legislature after receiving a waiver to seek legislative authority to implement the Medicaid reform pilot.
**(19) Review and Repeal**—Sunsets the act in 5 years (July 1, 2010) unless reviewed and reenacted by the Legislature.

**Section 2. Amends s. 409.912(4)(d)** to grandfather in existing hospital provider service networks.

**Section 3. Effective Date**

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

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

- FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Not yet determined. A section 1115 waiver initiative must be budget neutral to the federal government. As a result, the waiver's cost must be comparable to or less than current Medicaid expenditure in the waiver demonstration sites.

- FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Not yet determined.

- DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Not yet determined.

- FISCAL COMMENTS:

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not yet determined

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill allows the Agency to promulgate rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill as currently drafted mixes provisions appropriate for a state-wide waiver request with provisions narrowly specifying a limited phased in pilot project. As presently constructed there are internal inconsistencies in requirements that should be addressed.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

The House Health Care Regulation Committee unanimously approved PCB HCR 05-02 with 13 amendments on March 30, 2005. The current analysis is drafted to the bill as amended.

The amendments include a strike-all to include technical corrections and substantive clarifications agreed to in a committee workshop of the PCB on March 28, 2005 that included discussion with representatives of the Agency for Health Care Administration.

Other amendments to the PCB:

- Limit the waiver to pilots in Broward, Duval, Baker, Clay and Nassau counties for TANF and SSI populations.
- Require the waiver to include a wide range of existing types of provider networks and benefit coverage.
- Provide requirements for the phase in of the pilots with existing payment mechanisms.
- Specify that plans are to include optional and supplementary services.
- Require plans to meet financial solvency requirements of ch. 624, F.S.
- Require continuation of Medipass until reform is demonstrated to be successful statewide.
- Require reports on compliance with current prompt-pay provisions.
- Require minimum medical loss ratios determined by an actuarial study.
- Amends s. 409.912(4)(d), F.S. to include grandfathering in of existing hospital provider service networks.