SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Ways and Means Committee

BILL:	CS/CS/SB 838
SPONSOR:	Ways and Means Committee, Health Care Committee and Senator Peaden
SUBJECT:	Medicaid Reform
DATE:	April 22, 2005 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Fav/CS**
2.			HA	**Withdrawn**
3.	Dull/Heflin	Coburn	WM	**Fav/CS**
4.			RC	
5.				
6.				

I. Summary:

Committee Substitute for Senate Bill 838 was developed from recommendations submitted to the President of the Senate by the Senate Select Committee on Medicaid Reform. The bill contains both short and long-term Medicaid reform activities, pilot projects, and studies designed to improve efficiency and achieve sustainable growth in Florida's Medicaid program. Specifically, the bill:

- Requires the Agency for Health Care Administration (AHCA) to contract with a vendor to identify and counsel providers whose clinical practice patterns are outside normal practice patterns.
- Authorizes AHCA to use more single source contracting to reduce costs.
- Requires AHCA to determine if purchasing medical equipment is less expensive than rental and authorizes AHCA to facilitate purchases in lieu of long-term rentals.
- Requires that provider service network contracts currently in effect shall be extended for a period of three years and provides a definition for a provider service network.
- Directs AHCA to redesign and implement the capitated, integrated long-term care system (Senior Health Choices) in a pilot area containing Orange, Lake, Osceola, and Seminole Counties.
- Requires AHCA to consider increasing rates for certain services if it reduces costs in other parts of the Medicaid program.
- Requires the Comprehensive Assessment and Review for Long-term Care Services (CARES) staff to identify Medicare patients in nursing homes who are being inappropriately disqualified from coverage under Medicare and assist with appeal of the disqualification.
- Requires AHCA to contract with an entity to develop a real-time utilization tracking system or electronic medical record for Medicaid recipients.

- Requires the expansion of disease management programs through pilot projects.
- Requires AHCA to provide emergency department diversion programs.
- Changes the Medicaid prescription drug cost control program to reduce costs, waste, and fraud, while improving recipient safety.
- Requires AHCA to implement a program of all-inclusive care for certain children enrolled in the Children's Medical Services network.
- Allows mental health crisis care to be provided in a non-hospital setting if it is less costly.
- Authorizes AHCA to continue developing a plan to pilot the Governor's capitated managed care system to replace the fee-for-service system, contingent upon a mechanism that provides a reasonable growth factor for the upper-payment-level funding and other intergovernmental transfers.
- Requires AHCA to post any waiver applications to implement the pilot on its Internet website 30-days before submission to the federal government and to submit the waiver applications to the Select Committees on Medicaid Reform for approval before submission.
- Requires AHCA to develop an implementation plan with all specified elements that will be submitted to the Senate and House Select Committees on Medicaid Reform for consideration and recommendation to the Legislature for implementation approval.
- Requires the Office of Program Policy Analysis and Government Accountability and the Auditor General to conduct an evaluation of the pilot to be provided to the Governor and the Legislature no later than June 30, 2008, to consider statewide expansion.
- Requires that at least 5 percent of Medicaid audits to detect Medicaid funds lost to fraud and abuse be conducted on a random basis.
- Requires Medicaid recipients to be provided explanations of benefits.
- Requires AHCA to study the legal and program barriers to enforcing copayments in the Medicaid program.
- Requires AHCA to develop recommendations to improve third-party liability recoveries.
- Requires AHCA to study ways to give financial incentives to physicians and other providers to reduce inappropriate utilization.
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to confirm the value of nursing home diversion programs.
- Requires AHCA to conduct an analysis of joining a multi-state drug purchasing pool.
- Requires AHCA to study mechanisms for collecting patient-responsibility payments from persons in the diversion programs.
- Requires OPPAGA to conduct a study of Medicaid buy-in programs.
- Appropriates $15,000,000 in non-recurring funds to AHCA for the purpose of developing the administrative infrastructure necessary for the managed care pilot project.
- Appropriates $1,700,000 in recurring funds to AHCA for the purpose of contracting with a vendor to monitor and evaluate the clinical practice patterns of providers and provide information to improve patient care and reduce utilization.
- Appropriates $2,200,000 in recurring funds to AHCA for the purpose of contracting with a vendor to design a web-based database to allow providers to review real-time utilization in order to coordinate care and identify fraud and abuse.
- Appropriates $3,169,447 in recurring funds, $7,869 in non-recurring funds, and three FTEs to AHCA for the purpose of developing a managed care encounter data information system.

This bill amends ss. 409.912, 409.9122, and 409.913, Florida Statutes, and creates s. 409.91211, Florida Statutes, and eleven undesignated sections of law.

II. Present Situation:

Florida's Medicaid Program

Florida's Medicaid program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

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

Some services are mandatory services that must be covered by any state participating in the Medicaid program. Other services are optional. A state may choose to include optional services in its state Medicaid plan, but such services must be offered to all individuals statewide who meet Medicaid eligibility criteria. Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, F.S.

Florida's Medicaid Expenditure and Enrollment Growth

Florida's Medicaid program provides health care coverage and services to over 2.2 million Floridians at a cost of over $14 billion in fiscal year 2004-05.[1] Medicaid plays a significant role in Florida's health care system, financing a broad range of services, including 43 percent of all births in the state, 52 percent of people receiving health care services related to HIV/AIDS, and 66 percent of all nursing home days.[2] Currently, approximately 11.6 percent of Floridians are entitled to receive full Medicaid services, with another 0.9 percent receiving a subset of Medicaid services.[3]

The most significant share of Medicaid costs is borne by the federal government under the Federal Medical Assistance Percentage (FMAP) program. In fiscal year 2004-05, Florida's FMAP is 59.1 percent, which means that for every dollar the state spends on Medicaid services, it is reimbursed 59 cents by the federal government.

[1] Agency for Health Care Administration, Bureau of Program Analysis, June 2004.
[2] *Florida Medicaid: A Status Report*. January 9, 2003.
[3] Florida's Social Services Estimating Conference. Medicaid caseloads estimates. February 25, 2005.

In recent years, health care costs have been rising for both public and private health care coverage. This increase in health care costs, in general, is due to a number of factors, most prominently prescription drug and hospital costs. Analysts expect that the country has entered a period of decelerating cost trends following a steep acceleration during1996-2001. Nevertheless, the cost trend remains high by historical standards and continues to outpace U.S. economic growth by a sizable margin.[4]

Similar to overall health care trends, Medicaid budgets in every state have been subject to these and other pressures – increasing health care costs and rising enrollment at a time when states' tax revenues needed to support the program were declining. In fact, during the recent recession, Medicaid and the State Children's Health Insurance Program (SCHIP) picked up 4.1 million children and their parents nationally.[5]

In Florida, Medicaid enrollment started to increase steadily in 1999, in large part due to the economic downturn. The average monthly Medicaid caseload increased from 1.8 million in 2000, to 2.2 million today. Increases in "high risk" eligibility categories most affected by the economic downturn were sharpest. For example, children whose family incomes fall below the poverty line increased from 312,080 in 2000-01 to 453,206 in 2003-04, a 45 percent increase.[6] In addition, Florida's low-income elderly population is growing at eight times the national average,[7]and Medicaid enrollment among this population has increased remarkably as well. This group is the most expensive to serve because of their high health care needs. In fiscal year 2005-06, elderly and disabled groups in Florida's Medicaid program are expected to increase by 5 percent over the current fiscal year, while women and children are projected to rise by 4.9 percent.

With the improvement in the economic climate in Florida, state revenue collections have started to grow which may ease pressures on the state budget. In particular, Florida saw its quarterly tax collection rise by 8.6 percent from the first quarter of 2003 to the first quarter of 2004, a much larger increase than the national average of 5.5 percent.[8]

In addition, nationally, Medicaid cost growth is slowing down. Costs are expected to rise by just four percent in 2005, as compared to an expected increase of eight percent in 2004. In Florida, growth in aggregate Medicaid expenditures has averaged 12.5 annually over the last five years, with this trend moving downward each year (14.1 percent in FY 2003-04, 9.9 percent in FY 2004-05, and an estimated 7.7 percent in FY 2005-06).[9] Over the past five years, analysis shows that Medicaid enrollment increases account for, on average, 62 percent of Florida's Medicaid

[4] Strunk, Bradley C. and Paul B. Ginsburg. "Tracking Health Care Costs: Trends Turn Downward in 2003," *Health Affairs* – Web Exclusive, June 9, 2004.
[5] Ku, Leighton. *CDC Data Show Medicaid and SCHIP Played a Critical Countercyclical Role in Strengthening Health Insurance Coverage During the Economic Downturn*. (Washington, DC: Center on Budget and Policy Priorities, October 8, 2003).
[6] Florida Social Services Estimating Conference "Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05," February 6, 2004.
[7] Alker, Joan and Lisa Portelli. *What Could a Waiver to Restructure Medicaid Mean for Florida?* (Orlando: Winter Park Health Foundation, April 2004).
[8] Jenny, Nicholas W. *State Tax Revenue Recovery Gathering Steam*. (Albany, NY: Rockefeller Institute of Government, June 2004).
[9] Florida Social Services Estimating Conference. Medicaid Services Expenditures. February 25, 2005.

cost increases. The remaining 38 percent of expenditure increases can be attributed to increases in health care costs and other factors.[10]

Nationally, 42 percent of Medicaid spending is for Medicare recipients who also qualify for Medicaid, the "dually-eligible." In Florida this figure is slightly higher at 43.5 percent.[11] Medicaid fills in the gaps for the Medicare program by providing prescription drugs, long-term care services, as well as paying Medicare premiums and other cost-sharing for very low-income seniors. This area of the Medicaid budget has been growing rapidly and will continue to do so as the population ages, in part because dually-eligible individuals tend to be sicker and have higher health care costs than other Medicaid recipients. While the largest share of Medicaid spending for dual-eligibles goes for long-term care services, the second largest component is prescription drug spending.

States can expect some budget relief as a result of the new Medicare prescription drug benefit which will become effective on January 1, 2006. At that point, all prescription drug costs for the dual eligibles will be transitioned to Medicare. However, the fiscal impact of this law on Florida's budget is unknown, as the state will experience higher administrative costs and will be required to make what amounts to a maintenance-of-effort payment for the prescription drug costs of the dual-eligible population (known as the "clawback" provision) while at the same time relinquishing responsibility for the dually-eligible recipients.

Governor's Medicaid Reform Proposal

On March 30, 2004, AHCA issued a letter seeking public comment on Governor Bush's intention to seek "waiver authority from the federal Centers for Medicare and Medicaid Services to modernize the [Medicaid] program and test a new model that leads to a sustainable and affordable program in the decades ahead."

Over the following months, the agency held several stakeholder meetings to discuss possible changes in the areas of Medicaid long-term care, prescription drugs, health care services for children, behavioral health, disease management, and program financing. At the same time, legislative staff was coordinating with the Governor's Office of Policy and Budget to develop a framework for Medicaid reform.

On January 11, 2005, Governor Bush released an outline of a plan to restructure the Florida Medicaid program. Entitled "Empowered Care," the framework outlined a Medicaid program operated within a system of capitated, managed care plans. The Governor's proposal is premised on the concept that fostering competition among private insurance carriers and provider service networks that would assume the risks of providing services will save the state money without compromising the quality and scope of services for Medicaid recipients.

[10] Georgetown Health Policy Institute analysis based on enrollment data from the Florida Social Services Estimating Conference. "Basic Medicaid Caseloads, Historical and Forecasted: Average Monthly Caseloads by Fiscal Year FY 1995-96 to FY 2004-05," February 6, 2004.; Medicaid expenditure data from AHCA Bureau of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04.

[11] Data provided by AHCA Bureau of Program Analysis (Tony Swinson, Senior Management Analyst Supervisor), 6/28/04. Expenditures for Dual Eligibles for FY 2001-02.

Under the Governor's proposal, Medicaid recipients would receive a set, risk-adjusted capitation rate that would allow the recipient to select among specific capitated managed care plans. According to the proposal, there would be a three-tiered benefit system: comprehensive care, enhanced benefits, and catastrophic care. These tiers would not be defined by the types of benefits but rather by the amount of capitation that is allotted to each person in each category.

Managed care plans and other types of provider networks would compete for recipients by offering them different choices for the comprehensive care services. Recipients could then use their fixed capitation rate to decide which plan to purchase. Once recipients reach a minimum dollar threshold and require more healthcare services they would move into the catastrophic coverage category.

Finally, Medicaid recipients who "exercise personal responsibility" and participate in "established healthy practices" will be eligible for "enhanced benefits." This would be money in a flexible spending account that can be used to purchase additional services, or possibly buy into the private health insurance market.

One of the most significant aspects of the Governor's proposal is that it would allow the private insurers and other provider networks to have broad flexibility to determine what benefits would be provided to recipients from those mandatory and optional Medicaid benefits currently required under Florida and federal law.

Senate Select Committee on Medicaid Reform

In anticipation of the challenges concerning the future of Florida's Medicaid Program and in response to the release of the Governor's reform proposal, the Senate President created the Senate Select Committee on Medicaid Reform on January 19, 2005. The charge of the Select Committee is to:

- Evaluate the Governor's Medicaid reform plan recommendations;
- Gather public testimony from Medicaid recipients and service providers; and
- Provide short and long-term policy recommendations to the Senate President for changes to Florida's Medicaid program.

The Senate Select Committee on Medicaid Reform met five times in Tallahassee and conducted five public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. These public hearings were conducted in conjunction with the House Select Committee on Medicaid Reform. The purpose of the public hearings was to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. The Committees solicited ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled residents.

During the public hearings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, providers, health maintenance organization (HMO) representatives, advocacy groups, and other interested parties on ways to improve the Medicaid program. In addition, the Select Committee's chair, vice chair, and staff met with stakeholder

and advocacy groups in Tallahassee to gain additional information and alternative proposals for reform.

Medicaid Reform Options

The Select Committee developed a list of almost 30 short and long-term Medicaid reform options based on public hearing testimony, stakeholder meetings with the Chairs of the Select Committee, materials submitted via email or in written form to the Select Committee for consideration, and research conducted by Senate staff. The Select Committee reviewed, amended, and approved the final set of recommendations for legislation in session on March 28, 2005, and submitted them to the President of the Senate for consideration. These recommendations include introducing legislation to do the following:

1. **Authorize the continued development of a plan to implement the Governor's reform proposal** – The Legislature should authorize the Executive Office of the Governor and the Agency for Health Care Administration to develop a detailed plan to pilot the Governor's Medicaid reform proposal. All aspects of the reform proposal would have to receive approval by the Legislature before implementation can start.

   The plan should specify the eligibility groups and geographic areas of the pilot. The plan should specify how the established Medicaid system within the selected area will have sufficient community providers to meet the needs of the eligibility group. The plan should specify how Medicaid fee-for-service expenditures for these recipients would be aggregated into lump sum allocations to be divided into risk-adjusted, capitation rates and be separated into a comprehensive, enhanced, and catastrophic benefit for each individual. The plan should detail the Medicaid waivers that will be necessary to implement the pilot as well as a specific implementation timeline.

   The agency should be authorized to continue discussions with the federal government concerning obtaining Medicaid waivers necessary to implement the pilot project. AHCA should also be authorized to submit any waivers necessary for implementation to the U.S. Centers for Medicare and Medicaid Services for approval. The agency would be required to report to the Legislature on a regular basis on the progress of these discussions.

   As required by s. 409.912 (11), F.S., the agency must provide notice and an opportunity for public comment before submitting the waiver(s) to the Legislature for implementation approval. In order to consider authorizing the pilot, the agency should provide the Legislature actuarial and benefit design analyses indicating the anticipated effect on benefits offered in these capitated plans over a five-year period of time based on three assumptions:

   - Growth in capitation rates limited to the growth rate in general revenue.
   - Growth in capitation rates limited to the average growth rate over the last three years in per recipient Medicaid expenditures.
   - Growth in capitation rates limited to the growth rate of aggregate Medicaid expenditures between FY 2003-04 and FY 2004-05.

2. **Reduce costs, waste, inefficiencies, and fraud in the Medicaid prescription drug program** – The Legislature should consider:

   - Decreasing the cost of each drug to the lowest price possible;
   - Changing the current rule that prevents medical practitioners from dispensing pharmaceuticals from their offices if they are within 10 miles of a licensed Medicaid pharmacy;
   - Collecting data on high prescription drug users and target behavioral changes through cooperation between physicians and pharmacists;
   - Improving the state's ability to ensure proper utilization and safety in the Medicaid prescription drug program;
   - Determining if there are ways to reduce the waste associated with destroying unused prescription drugs in institutional settings;
   - Examining the cost saving potential of multi-state purchasing pools;
   - Reducing aggregate expenditures for dispensing fees by allowing persons on Medicaid to receive up to 6 months of maintenance medications for chronic conditions; and
   - Developing ways to identify persons that have multiple prescriptions that may be contraindicated or redundant to improve the health care and safety of these individuals.

3. **Improve the Medicaid fraud and abuse program** – The Legislature should seek legislation that continues to develop ways to aggressively pursue efforts that deter, detect, and recover Medicaid funds lost to fraud and abuse. Medicaid fraud and abuse strategies to consider include:

   - Identification of inappropriate use and distribution of prescription drugs;
   - Identification of inappropriate distribution and pricing of durable medical equipment in the Medicaid waiver programs; and
   - Providing Medicaid recipients with explanations of benefits (EOBs) which identify services received in the name of the recipient and the provider that billed Medicaid. This would allow the recipient to verify if a service was actually provided and could include a contact number to report suspected fraud and abuse that may be represented on the EOB.

4. **Allow AHCA and the Department of Elder Affairs to proceed with implementing pilot projects for Senior Health Choices, the integrated long-term care, capitated payment plan** – The 2004 Legislature directed AHCA and DOEA to develop a plan to move Medicaid long-term care into an integrated, capitated system. The agency provided a workplan to the Legislative Budget Commission in January that included the implementation of two pilot projects to test the plan. The LBC deferred action on the proposal.

   The two main issues with the plan are it only allows health plans licensed under ch. 641, F.S. (HMOs) to participate (some felt that other types of prepaid health plans should be allowed to participate) and it requires mandatory assignment of Medicaid recipients into the managed care plans in the pilot areas.

   The Legislature should direct the agency to redesign the integrated system to allow other types of health plans to participate in the pilot, although the agency would be required to

determine if the quality of the plan and its fiscal solvency were appropriate to accept the risk under the capitated payment. The agency would also be directed to change the assignment from mandatory to voluntary, at least for purposes of the pilot projects.

5. **Assess inappropriate Medicare denials in nursing home care** – Many residents of nursing homes begin their stay with Medicare coverage following a hospitalization. Some suggest it is common practice for providers to prematurely determine that a patient is no longer making reasonable progress in rehab, so they are moved onto Medicaid long-term care coverage. The recipient may appeal this decision, but because payment source in this instance is often not a patient concern, the issue is rarely pursued.

6. **Require the Agency in consultation with the Department of Elder Affairs** to find ways to identify patients who should continue to be covered under Medicare to the greatest extent possible.

7. **Explore ways to collect patient responsibility payments for the nursing home diversion program participants** – Some recipients in the nursing home diversion program who receive care at home may owe a patient responsibility payment, depending on their monthly income. It has been reported that the agency has no system in place to identify and collect those payments if required.

   The Legislature should require AHCA to explain if there is no mechanism for collecting the patient responsibility in these programs, how much could be collected by pursuing these co-pays and would the system development costs be offset.

8. **Continue the Certificate-of-Need (CON) nursing home bed moratorium** – In 2001, the Legislature enacted a 5-year moratorium on new nursing home beds in Florida. The moratorium expires July 1, 2006. The intent was to try and steer the elderly and disabled into options other than permanent placement in nursing homes. This proposal recommends continuing the nursing home CON moratorium, but allows limited expansion in rural planning areas where overall occupancy is 95 percent or greater.

9. **Increase funding of Home and Community Based Services programs and study the programs' effectiveness** – The belief is that additional funding for these waiver services will help keep persons from entering nursing homes. Since nursing home care is one of the most expensive services in Medicaid, the thought is that this will save money through cost avoidance and help people get better care in community settings.

   To confirm the value of these programs, the Legislature should require a study of the diversion programs by an independent party to see if they actually keep Medicaid recipients from entering nursing homes or if they are essentially an expansion of services. OPPAGA should be asked to conduct the study or to develop and manage an ITN for such a study. The study would look at whether the right people are being served under the waiver and if diversion is actually occurring.

10. **Study financial incentives to physicians and other providers to reduce inappropriate utilization and to provider networks to invest in the infrastructure necessary to promote these practices** – The idea is to have the agency study ways through financial or other methods to have physicians and provider networks change their practice patterns using evidence-based medicine protocols to reduce inappropriate utilization. This could be accomplished through pay-for-performance arrangements with providers or other financial incentives for facilities to invest in infrastructure.

11. **Lock-in MediPass beneficiaries to their primary care physician**- 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. However, in practice, many recipients go directly to other providers that accept Medicaid, bypassing the PCP. As a result, there is little coordination of care for fee-for-service enrollees. The Legislature should require that enrollees are locked into their primary care physician in the MediPass program. The PCP would have to serve as a strict gatekeeper, who must approve all treatment received by the patient. No care would be reimbursed (including hospitalization and prescription drugs) without the PCP's approval. The agency should ensure that any provider serving as a PCP has the qualifications necessary to refer patients to specialists as appropriate.

12. **Expand disease management services** – Based on the evidence that shows about 15% of the Medicaid population accounts for 75% of expenditures, groups recommend expanding disease management programs for persons with chronic illnesses in the Medicaid program.

    The Medicaid program currently provides disease management for diabetes, human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), asthma, hypertension, and congestive heart failure (CHF). Other conditions that could be addressed include hemophilia, end-stage renal disease/chronic kidney disease (ESRD/CKD), cancer, sickle cell anemia, chronic fatigue syndrome, and chronic pain.

    Legislation to expand disease management programs to other conditions should be based on the results of pilot projects in which physicians partner with their local pharmacists to coordinate a patient's care.

13. **Establish a provider monitoring system** - The agency should contract with a vendor that can monitor provider utilization across provider types and beneficiaries. The vendor should be able to identify trends in utilization and those providers that are outside of normal practice patterns centered on evidence-based medicine guidelines. Once a provider is identified, the agency should require the provider to re-examine utilization patterns and alter them as appropriate.

14. **Expand the hand-held (PDA) information systems used to track Medicaid prescriptions to other services, such as physician visits and hospitalizations** – AHCA currently has a program in which 3,000 PDAs are provided to physicians with high prescription patterns. The PDAs are used to access the patient prescription records to see if there are multiple prescriptions from multiple doctors on a real-time basis. The idea is to expand this integrated

information system to other services. The PDA program has been very effective in managing inappropriate utilization.

15. **Expand emergency department diversion programs for Medicaid recipients** – This recommendation recognizes that many individuals inappropriately utilize emergency departments for routine and non-emergency care. Inappropriate emergency department utilization can be some of the most costly forms of care. This proposal would build on current emergency department diversion programs in statute for the private sector, and would expand the effort under the Medicaid program.

16. **Allow mental health crisis care to be provided in a non-hospital setting if it is less costly and does not encourage fraud or abuse** – Medicaid rules currently require people in need of emergency mental health care to receive that care in a hospital setting. Allowing these persons to be treated in a state-licensed crisis stabilization facility could provide the same services at 25% of the cost of emergency stabilization in a hospital setting.

17. **Study ways to enforce copayment requirements and examine if other cost sharing measures should be required** – Federal and state law allow the use of copayments in Medicaid. Section 409.9081, F.S., requires copayments for hospital outpatient services, physician services, emergency department services, and prescription drugs. However, both federal and state law allow Medicaid recipients to declare that they cannot afford the copayment and the fee is not enforced.

    The Legislature should require the agency to study the legal and program barriers to enforcing copayments in the Medicaid program, what mechanism can be developed to verify if a person is actually impoverished to the point of being unable to pay the copayment, and how much would be collected if copayments were enforced.

18. **Require AHCA to concentrate more effort on ensuring Medicaid is the payor of last resort** – This proposal was provided by several groups. Specifically, some groups advocated looking at Medicaid recipients eligible for Veteran's benefits to offset Medicaid costs.

19. **Require the agency to permit exceptions to certain Medicaid rules for purchasing services** -There are times when it may be more efficient to allow Medicaid recipients to purchase certain durable medical equipment, rather than rent the equipment. The Legislature should require AHCA to develop a system to make buy-rent decisions for this equipment. Policies and procedures would also have to be developed to ensure this flexibility does not encourage fraud and abuse.

20. **Encourage greater use of single source providers** - For most ancillary services, the agency should use more competitive bidding to secure single-source providers, which is already allowed under state law. In exchange for greater volume, they should be required to serve the needs of the state's Medicaid population at a reduced cost.

21. **Explore Medicaid Buy-In programs** – Medicaid buy in programs allow individuals near the poverty threshold to qualify for Medicaid to pay a premium to gain eligibility in the program. The idea is to allow people to buy into Medicaid without quitting their jobs or losing assets.

The Legislature should require OPPAGA to conduct a study to determine how Medicaid buy-in programs work in other states and whether there is a way to create a buy-in program without necessarily expanding the current Medicaid system. The study should also include whether the Medically Needy program can be transformed into a Medicaid buy in program.

22. **Require the agency to consider times when expanded coverage/increased rates for certain services should be allowed if it reduces costs in other parts of the Medicaid budget** - This proposal is based on the idea that the Legislature should consider increased funding of certain services if it can be demonstrated that it would result in decreased expenditures in other parts of the Medicaid budget, resulting in a net decrease in costs and better quality of care. Some of the examples of these policies include:

    - Paying for partial dentures in addition to full dentures. Current Medicaid policy does not cover dentures if there are teeth that are still in good health. As a result, some dentists extract these teeth so that the person can receive a full set of dentures. The thought is that payment for half plates could offset other costs like the extractions and other health conditions related to poor periodontal health.

    - Increased reimbursement for outpatient dialysis. Providers argue that the current reimbursement rate discourages free-standing dialysis centers from providing needed services. As a result, many Medicaid recipients must enter the hospital for dialysis at significantly higher costs. Current policy also does not allow these free-standing clinics to provide transfusions or infusion of certain medications. Again, this requires that the Medicaid patient go to the hospital for these services at greater cost.

    The Legislature should direct AHCA to develop a system to determine which services could reduce costs by increasing funding for other services. Once identified, the reimbursement policies should be reexamined to determine which rates should be increased to achieve these costs savings.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.912, F.S., to do the following:

- Requires AHCA to contract with a vendor to identify trends in utilization and those providers whose practice is outside of normal practice patterns centered on evidence-based medicine guidelines and to provide information and counseling to such providers.
- Authorizes AHCA to use more single source contracting to reduce costs.
- Requires AHCA to determine when allowing Medicaid recipients to purchase durable medical equipment or goods is less expensive than long-term rental and to facilitate purchases in lieu of long-term rentals.
- Requires that current provider service network contracts must be extended for a period of three years following the current contract-expiration date and provides a definition of a provider service network.
- Directs AHCA to redesign and implement, by December 1, 2005, the capitated, integrated long-term care system (Senior Health Choices) proposed to the Legislative Budget

Commission in January. The redesign would include allowing other types of health plans to participate in the pilot, although AHCA would be required to determine if the quality of the plan and its fiscal solvency were appropriate to accept the risk under the capitated payment. The redesign would also make enrollment in the pilot project voluntary. The program would start with a pilot project in Orange, Osceola, Lake, and Seminole Counties. The bill specifies that entities eligible to participate as networks under the system include managed care organizations licensed under ch. 641, F.S., nursing home diversion program providers, other qualified providers as defined in s. 430.703 (7), F.S., community care for the elderly lead agencies, and other state-certified community service networks.

- Requires AHCA to develop a mechanism for health care vendors to provide data to justify expanding coverage or increasing rates for certain services if it reduces costs in other parts of the Medicaid program.
- Requires the Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff to find ways to identify patients in nursing homes whose care is being paid for by Medicare and assist them in maintaining Medicare coverage to the greatest extent possible.
- Requires AHCA to contract, by September 30, 2005, with an entity to develop a real-time utilization tracking system or electronic medical record for Medicaid recipients to reduce inappropriate utilization, reduce fraud and abuse, and improve patient safety.
- Requires the expansion of disease management programs, by January 1, 2006, through pilot projects in which physicians partner with their local pharmacists to coordinate a patient's care.
- Requires AHCA to coordinate with private emergency department diversion programs to serve Medicaid recipients.
- Creates a most cost-effective Medicaid preferred drug list.
  - Requires prior authorization for all additional prescriptions over an eight-drug limit.
  - Removes the exemptions for inclusion of mental health and anti-retroviral drugs on the preferred drug list.
  - Allows the dispensing of a 180-day supply of maintenance drugs.
  - Requires AHCA to reimburse dispensing practitioners regardless of their proximity to a Medicaid pharmacy.
  - Requires AHCA to implement a Medicaid prescription drug management program.
  - Allows AHCA to require age-related prior authorization for certain prescribed drugs.
  - Requires AHCA to implement a step-therapy, prior authorization approval process for medications excluded from the preferred drug list.
  - Requires the agency to determine if there are additional ways to ensure more prescription drugs dispensed in institutional settings are reused if safe and effective.
- Requires AHCA to implement a program of all-inclusive care for children with serious illnesses who are enrolled in the Children's Medical Services network.
- Allows mental health crisis care to be provided in a non-hospital setting if it is less costly.

Section 2. Creates s. 409.91211, F.S., authorizing AHCA to continuing developing a plan to pilot the Governor's proposal for a capitated managed care system to replace the current fee-for-service Medicaid system. This authorization is contingent on the attainment of a waiver that preserves the upper-payment-limit funding mechanism, including a reasonable growth factor, and other intergovernmental transfers. The waiver may also allow a portion of the upper-

payment-limit funding to be set aside in a risk pool for use in the pilot sites. If the federal government does not approve a waiver with a reasonable growth factor for the upper-payment-level funding mechanism, then the bill requires AHCA to provide the Legislature with estimates of the loss of revenue from the intergovernmental transfers and its effect on hospital funding in the state. The bill also provides Legislative intent regarding the capitated managed care program.

The bill requires that the pilots include mandatory and optional services specified in ss. 409.905 and 409.906, F.S., and to further develop the proposal in order to be considered by the Legislature for implementation, the bill requires AHCA to do the following:

- Define and recommend medical and financial eligibility standards for the managed care plans.
- Recommend eligibility groups and include two geographic areas for the pilot projects. The bill designates one pilot program in Broward County and one pilot program in Baker, Clay, Duval, and Nassau Counties. It allows the pilot in the Duval County area to be phased in over a 2-year period.
- Determine and recommend how to maximize state and federal funds and keep the upper payment limit and disproportionate share programs.
- Determine and recommend actuarially sound, risk adjusted capitation rates for Medicaid recipients that can be separated into comprehensive care, enhanced services, and catastrophic care.
- Determine and recommend a method to phase in financial risk for approved provider service networks over a 3-year period.
- Determine and recommend provisions related to stop-loss requirements.
- Determine and recommend a method for the Social Services Estimating Conference to determine and validate the rate of growth of the per-member costs of providing Medicaid services under the pilot.
- Determine a method to ensure the pilot program enrollment process is adequate to facilitate client choice and provide enough recipients to make a valid assessment.
- Determine and recommend standards and credentialing requirements for plans including those related to fiscal solvency, quality of care, and adequacy of access to health care providers.
- Develop and recommend a system to help Medicaid recipients select a managed care plan that meets their needs.
- Develop a mechanism to prevent managed care plans from inappropriate recruiting practices.
- Develop and recommend a system to monitor plan performance and the provision of services.
- Recommend grievance procedures for managed care plan enrollees and providers.
- Develop and recommend provider credentialing for participation in the managed care plans.
- Develop and recommend provider agreements in the plans.
- Require all providers to be duly licensed in the state.
- Develop and recommend agreements with other state and local governmental programs to coordinate care.
- Develop and recommend a system to detect and deter fraud and abuse by health plans, providers, and recipients, including underutilization and inappropriate denial of care.

- Develop and provide prospective actuarial and benefit design analyses for a five-year period after implementation to estimate effects on benefits based on certain assumptions regarding the rate of growth in Medicaid appropriations.
- Develop a system whereby capitated health plans in the program must reimburse emergency service providers.
- Develop a system whereby school districts shall be reimbursed under the capitated system for Medicaid services provided by the school district.
- Develop and recommend a system to transition and enroll Medicaid recipients into the new capitated system.
- Develop and recommend a service delivery alternative for children with chronic medical conditions under the new system.
- Require mandatory enrollment in a capitated managed care network.
- Allow for disenrollment and selection of another plan within a certain timeframe.
- Lock a recipient in a health plan for 12 months unless the recipient can demonstrate cause to justify a disenrollment.
- Pursue waivers to implement the program; post any waiver applications on its website for 30-days before submitting to the federal government; and obtain approval from the Select Committees on Medicaid Reform of the waiver applications before submission to the federal government.
- Allow the development of rules to implement the pilot upon approval of the federal waivers by the Legislature.

The bill requires the Select Committees to recommend to the Legislature whether the pilot program may be implemented.

Section 3. Requires AHCA to develop an implementation plan with all the elements listed in section 2 to be submitted to the Senate and House Select Committees on Medicaid Reform and the Legislature, or the Legislative Budget Commission if the Legislature is not in session, to gain approval for implementation.

Section 4. Requires an evaluation by OPPAGA, in consultation with the Auditor General, of the two managed care pilot projects during the first 24 months of operation. The evaluation must contain cost savings estimates and quality measures, as well as explanations of any legal or administrative barriers to implementing the pilot projects. The evaluation must be included in a report to the Governor and the Legislature no later than June 30, 2008, to consider statewide expansion. No additional counties beyond those specified in s. 409.91211, F.S., may be included in the managed care pilot program without Legislative authority.

Section 5. Amends s. 409.9122, F.S., changing a reference from the Health Care Financing Administration to the Centers for Medicare and Medicaid Services.

Section 6. Amends s. 409.913, F.S., requiring that at least 5 percent of Medicaid audits to detect Medicaid funds lost to fraud and abuse be conducted on a random basis, and requiring Medicaid recipients to be provided EOBs which identify services received in the name of the recipient and the provider that billed Medicaid.

Section 7. Requires AHCA to study the legal and program barriers to enforcing copayments in the Medicaid program, what mechanism can be developed to verify if a person is actually impoverished to the point of being unable to pay the copayment, and how much would be collected if copayments were enforced.

Section 8. Requires AHCA to develop recommendations to improve third-party liability payments ensuring Medicaid is the payer of last resort.

Section 9. Requires AHCA to study ways to give financial incentives or pay-for-performance systems to physicians and other providers to reduce inappropriate utilization and to provide provider networks to invest in the infrastructure necessary to promote these practices.

Section 10. Requires OPPAGA to confirm the value of nursing home diversion programs. The study will determine if diversion programs actually keep Medicaid recipients from entering nursing homes or if they are essentially an expansion of services.

Section 11. Requires AHCA to conduct an analysis of potential cost savings of joining a multi-state prescription drug purchasing pool.

Section 12. Requires AHCA to explain if there is no mechanism for collecting the patient responsibility payments of persons in the diversion programs, how much could be collected by pursuing these copayments.

Section 13. Requires OPPAGA to conduct a study of Medicaid buy-in programs to determine if they can be implemented in Florida without expanding the Medicaid budget. The study should also determine whether the Medically Needy program could operate as a Medicaid buy-in program.

Section 14. Appropriates $850,000 in recurring general revenue funds and $850,000 in recurring funds from the Administrative Trust Fund to AHCA to contract with a vendor to monitor and evaluate the clinical practice patterns of providers and provide information to improve patient care and reduce utilization.

Section 15. Appropriates $1,100,000 in recurring general revenue funds and $1,100,000 in recurring funds from the Administrative Trust Fund to AHCA for contracting with a vendor to design a web-based database to allow providers to review real-time utilization in order to coordinate care and identify fraud and abuse of Medicaid services.

Section 16. Appropriates $7,500,000 in non-recurring general revenue funds and $7,500,000 in non-recurring funds from the Administrative Trust Fund to AHCA for developing infrastructure and administrative resources necessary to develop the capitated managed care pilot program.

Section 17. Appropriates $845,223 in recurring and $3,935 in non-recurring general revenue, $2,324,224 in recurring and $3,934 in non-recurring funds from the Administrative Trust Fund, and authorizes three new FTEs for AHCA to develop a managed care encounter data information system.

Section 18. Provides an effective date of July 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Depending on how the managed care pilot projects are approved and implemented, the provisions of this bill may change the current cost sharing responsibilities for the Medicaid program, which may impact municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The managed care networks that are created under the pilot projects will be private entities acting on behalf of the state, which could make certain records and meetings subject to the public records or open meetings requirements of Art. I, s. 24(a) and (b) of the Florida Constitution. These entities will also need to develop systems to protect confidential health information as required under state and federal privacy requirements.

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.

D. Other Constitutional Issues:

The bill requires AHCA to submit the waiver application to the Select Committees on Medicaid Reform for their approval before submitting to the federal government. The Select Committees do not have the authority to act in this manner. They may make recommendations to the Legislature, but cannot approve the waiver before submission to the federal government.

The provision of mandatory services to certain eligibility categories in Medicaid is an entitlement under federal law and the United States Constitution. Without changes to federal law addressing the entitlement nature of the Medicaid program, the pilot projects created by this bill may be unconstitutional, even with approved waivers of federal laws and regulations.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The effect on the private sector is indeterminate at this time.

C. Government Sector Impact:

The committee Substitute for Senate Bill 838 includes the following fiscal changes:

SUMMARY OF FISCAL IMPACT

	FY 2005-06			FY 2006-07
	Total	Recurring	Non-Recurring	Total
Section 1 **Vendor Contract for Utilization Trends**				
General Revenue	$850,000	$850,000		$850,000
Trust Funds	$850,000	$850,000		$850,000
Total	$1,700,000	$1,700,000		$1,700,000
Comprehensive Assessment and Review for Long Term Care Services (CARES)*				
31 FTE's				
General Revenue	$437,439	$398,457	$38,982	$398,457
Trust Funds	$1,312,318	$1,195,370	$116,948	$1,195,370
Total	$1,749,757	$1,593,827	$155,930	$1,593,827
Real Time Utilization Tracking System				
General Revenue	$1,100,000	$1,100,000		$1,100,000
Trust Funds	$1,100,000	$1,100,000		$1,100,000
Total	$2,200,000	$2,200,000		$2,200,000
Prescribed Drug Program Revisions *				
General Revenue	($90,000,000)	($90,000,000)		($90,000,000)
Trust Funds	($201,970,803)	($201,970,803)		($201,970,803)
Total	($291,970,803)	($291,970,803)		($291,970,803)
Section 14 **Medicaid Reform - Administrative Infrastructure Activities Funding**				
General Revenue	$7,500,000		$7,500,000	
Trust Funds	$7,500,000		$7,500,000	
Total	$15,000,000		$15,000,000	
Section 15 **Medical Encounter Data System***				
3- FTE's				
General Revenue	$849,158	$845,223	$3,935	$844,640
Trust Funds	$2,328,158	$2,324,224	$3,934	$2,323,640
Total	$3,177,316	$3,169,447	$7,869	$3,168,280

***Included in Senate Budget Recommendations (SB 2600)**

Subsequent to this analysis, the agency has indicated that additional funding may be needed for implementation of the provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None..

VIII. Summary of Amendments:

None.