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/SB 2-B
INTRODUCER:	Health Care Committee and Senators Peaden, Carlton, and Atwater
SUBJECT:	Medicaid Reform Implementation
DATE:	December 6, 2005 REVISED: 12/07/05

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HE	**Fav/CS**
2.	Dull	Coburn	WM	**Fav/8 amendments**
3.				
4.				
5.				
6.				

Please see last section for Summary of Amendments

- [ ] Technical amendments were recommended
- [X] Amendments were recommended
- [X] Significant amendments were recommended

I. Summary:

This bill provides the Agency for Health Care Administration (AHCA) the authority to implement the Medicaid managed care pilot program as specified in CS/CS/SB 838 (ch. 2005-133, L.O.F.) and in accordance with the federally-approved Medicaid waiver application and special terms and conditions received in October 2005. Specifically, the bill:

- Authorizes AHCA to begin implementing the Medicaid capitated managed care pilot program in two demonstration sites (Broward and Duval Counties per CS/CS/SB 838).
- Provides for statewide expansion of the program in accordance with the process in the federally-approved special terms and conditions, which requires legislative approval of expansion into additional sites, with the goal of full statewide implementation by June 30, 2011.
- Requires AHCA to ensure that there is fair representation of the stakeholder groups included in current statute on the Medicaid Disproportionate Share Council; requires the Council to use the low income pool objectives specified in the bill to guide its recommendations regarding the development of the low income pool plan; and repeals the Council on June 30, 2006, unless saved from repeal by the Legislature.
- Creates a Medicaid Low-Income Pool Council and specifies its membership. The Council must be in place by July 1, 2006. The Council will make recommendations to the Legislature regarding the low-income pool, which replaces the Upper Payment Level (UPL) funding

program for safety-net hospitals. The bill establishes objectives to guide the distribution of funds from the low-income pool.

- Excludes managed care pilot program counties from the current requirement for AHCA to provide comprehensive behavioral health care services to Medicaid recipients on a capitated, prepaid basis.
- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than the state solvency requirements for HMOs. Eliminates the requirement that AHCA competitively bid contracts with provider service networks. Requires provider service networks established in a managed care pilot area that are reimbursed on a fee-for-service basis to include a savings-settlement mechanism to share savings with the state.
- Authorizes AHCA to seek options for making direct payments to hospitals and physicians employed by or under contract with the state's medical schools for the costs associated with graduate medical education under Medicaid reform.
- Requires managed care networks in the demonstration sites to include in their networks the Department of Health's Children's Medical Service Network, to the extent possible.
- Establishes detailed standards for managed care plan compliance, including quality assurance and outcome measures and a patient-encounter reporting requirement.
- Establishes detailed requirements to minimize the risk of Medicaid fraud and abuse in all plans operating in the Medicaid managed care pilot program.
- Requires AHCA to assign Medicaid recipients who are currently in a Medicaid managed care plan and who do not make a choice of plans during the reform enrollment process, or at the point of eligibility redetermination, into the most appropriate reform plan operated by the recipient's current managed care plan.
- Requires AHCA to submit proposed changes to the approved special terms and conditions to the Legislature before submitting them to the federal government and requires AHCA to report to the Legislature any changes that are approved by the federal government.
- Requires the Office of Insurance Regulation (OIR) to conduct an annual review of the Medicaid reform rate setting methodology that will be used in the pilot sites. The OIR is required to contract with an independent actuary firm to assist in the review. The review will examine the methodology adopted by the agency, the rates for each eligibility groups, and administration and implementation issues regarding the use of risk-adjusted rates.
- Specifies Legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the reform requirements prevail. AHCA must report to the Legislature any conflicts identified during implementation.
- Requires AHCA to report to the Legislature by April 1, 2006, regarding negotiations with the federal government over the Low Income Pool and to submit to the Legislature quarterly and annual reports regarding implementation of the pilot projects.

The bill is effective upon becoming law.

This bill amends ss. 409.911, 409.912, 409.91211, and 641.2261, Florida Statutes. The bill also creates s. 409.91213, Florida Statutes, and an undesignated section of law.

II. Present Situation:

The Governor's Medicaid Reform Proposal

On January 11, 2005, Governor Bush released a Medicaid reform proposal (originally called Empowered Care) for consideration by the Legislature. The proposal is based on data demonstrating that the current Medicaid budget is growing at an unsustainable rate and that a comprehensive overhaul of the system is necessary to improve care and provide predictability in the state Medicaid budget.

The Governor's proposal centers on the concept of moving Medicaid recipients out of the current fee-for-service system into a mostly managed care environment. In this new system, managed care plans (including traditional Medicaid HMOs and new provider service networks) will receive actuarially-sound, risk-adjusted capitation rates to provide all mandatory and optional services to Medicaid recipients.

The risk-adjusted capitation rates will be divided into sets of benefits: comprehensive benefits (those services needed by most recipients most of the time within a specific eligibility category) and catastrophic benefits (services for which the amount or cost exceeds a certain threshold). In addition, Medicaid recipients will be eligible for enhanced benefits accounts by following healthy lifestyle guidelines established by their managed care plan and approved by the agency (funds that can be used for benefits and services not covered by Medicaid). The proposal also includes an "opt-out" provision that allows a person to use the Medicaid capitation premium to purchase employer-sponsored health insurance instead of participating in a Medicaid managed care plan.

The proposal allows managed care plans to vary the amount, duration, and scope of services provided to Medicaid recipients enrolled in their plans within certain parameters deemed actuarially equivalent and sufficient by the state. Specifically, actuarial equivalence assesses the value of a particular managed care plan's proposed benefits compared to a target population's historical Medicaid expenditures to ensure the overall financial value of benefits is appropriate. Sufficiency to meet medical needs means whether the plan's proposed medical services will be provided at sufficient levels to serve a target population. A reform plan must cover the medical service needs of its target population. If a managed care plan fails to meet either the actuarial equivalency or sufficiency standards, the agency will not certify the plan until the benefits and services are adjusted to meet the necessary criteria.

In summary, the four fundamental elements of Florida's Medicaid reform program are as follows:

1) Risk-adjusted premiums that will be developed for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program.

2) Enhanced Benefits Accounts will be established to provide incentives to Medicaid reform enrollees for healthy behaviors. As enrollees earn access to these incentives, funds will be

deposited into individual Enhanced Benefits Accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

3) An Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace.

4) A Low-Income Pool (LIP) will be established and maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems.

Through these fundamental elements, the reform initiative is expected to provide more recipient choice through greater competition among multiple managed care plans while promoting cost savings through better coordinated care, an increase in the use of preventive medicine, and a reduction in Medicaid fraud and abuse.

CS/CS/SB 838 (Medicaid Reform)

In response to the Governor's Medicaid reform proposal, the President of the Senate and the Speaker of the House of Representatives created Select Committees on Medicaid Reform in their respective chambers. The respective Select Committees met separately several times prior to and during the 2005 Regular Session. The Select Committees also held five joint public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. During these meetings, the Select Committees heard testimony from hundreds of individuals including Medicaid recipients, health care providers, HMOs, advocacy groups, and other interested parties on ways to improve the Medicaid program. Committee members also met with stakeholders in one-on-one meetings during the Regular Session.

The Select Committees considered the ideas and suggestions from the various stakeholders and provided reform recommendations to their respective substantive committees that were included in bills in each chamber. The Legislature eventually passed a Medicaid Reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.). The provisions of the final bill offered opportunities to improve the current Medicaid program, while continuing a deliberative review of more comprehensive reform initiatives. As passed into law, CS/CS/SB 838 (2005) includes language:

- Authorizing and supporting the Office of the Governor and AHCA's efforts to develop and submit a waiver application to the federal government to implement the Governor's Medicaid reform proposal, including specific provisions and conditions that must be addressed in the waiver application.
- Requiring that any waiver approved by the federal government must preserve the upper payment limit (UPL) program with a reasonable growth factor (the upper payment limit cannot be used in a capitated managed care system because it is calculated with fee-for-service claims).
- Requiring that any federally-approved waivers and a detailed implementation plan are to be submitted to the Legislature for it to consider whether to approve implementation of the demonstration program.

- Requiring the first phase of the demonstration to be in Broward and Duval Counties, with an expansion into Baker, Clay, and Nassau Counties after the first year of implementation.
- Directing AHCA, in consultation with the Department of Elder Affairs, to redesign and implement an integrated managed long-term care system for persons over 60 years of age. The integrated system is to be pilot tested in two areas of the state with one pilot allowing voluntary participation and the other mandatory participation. The agency is to recommend the pilot sites.

Other provisions of the law expand AHCA's authority to deter, detect, and recover Medicaid funds lost to fraud and abuse; require AHCA to develop incentives for providers to reduce inappropriate utilization in the current system; require AHCA to develop and expand systems to share medical information in Medicaid; require AHCA to modify and expand its disease management programs; and require AHCA and the Office of Program Policy Analysis and Government Accountability (OPPAGA) to further study other ideas to improve Medicaid. Finally, the bill established a formal process for the Legislature to review any approved waivers prior to the agency moving forward with implementation of any federally approved waivers regarding reform.

The Federally-Approved Waivers and Special Terms and Conditions

The Agency for Health Care Administration complied with the provisions of CS/CS/SB 838 by posting the waiver application on its website 30 days before submitting it to the federal government and received approval of the waiver application on October 19, 2005. The federally-approved waivers are accompanied by special terms and conditions (numbered 11-W-00206/4) which, combined, constitute the guiding agreement between the state and federal government on the implementation of the Governor's Medicaid reform proposal.

The federally approved waivers and special terms and conditions are divided into 19 sections with 120 specific conditions, or items. The contents of each section are described below.

A. **PREFACE** – This section explains that the document comprises the special terms and conditions (STCs) for the Florida Medicaid Reform Section 1115 demonstration waiver and that the parties to this agreement are the Agency for Health Care Administration (Florida) and the U.S. Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. This demonstration is approved for a 5-year period, from July 1, 2006, through June 30, 2011.

B. **PROGRAM DESCRIPTION AND OBJECTIVES** – This section describes the fundamental concepts of the Medicaid reform proposal and the objectives that are to be attained through the demonstration.

C. **GENERAL PROGRAM REQUIREMENTS** – This section contains general program requirements that are included with most waivers including requirements for: compliance with federal laws, including non-discrimination; procedures for amending the approved STCs; extension of the demonstration program; procedures for phasing out the demonstration

if either party elects to discontinue the program; and procedures to address non-compliance with the provisions of the waiver.

D. **GENERAL REPORTING REQUIREMENTS** – This section contains general reporting requirements that are routinely included in similar waivers including requirements for: general financial reports; reporting issues relating to budget neutrality; managed care data reports; quarterly progress reports; and annual progress reports.

E. **DEMONSTRATION IMPLEMENTATION** - This section specifies how the Medicaid reform initiative may be implemented in the state. It provides for implementation, which will be conducted in four phases, consistent with the requirements in CS/CS/SB 838.

Phase I requires that the state will initially implement the demonstration in two counties, Broward and Duval, beginning sometime between July and September 2006. Within a year of implementation in Duval County, the state shall expand the demonstration into Baker, Clay, and Nassau Counties. Further implementation of Phases II through IV will be only as authorized by the Florida Legislature.

Phase II requires an assessment on the availability of plans, variation of plans, voluntary selection rates, consumer satisfaction, and on-site reviews of the plans authorized in Phase I. The preliminary fact-finding and evaluation of Phase I rollout will occur during the second year of operation, and will be complete by June 2008. This information will be available to the Legislature, and, once the agency receives approval, it will initiate implementation in additional geographic areas of the state.

Phase III will occur over the following two state fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis. In addition, by Phase III the State expects that the special care networks for children with chronic conditions will be fully developed beyond the Broward and Duval areas, either on a limited or statewide basis. Enrollment of these children will become mandatory in those areas with such networks.

Phase IV of Medicaid reform implementation will occur once the geographic implementation is complete. This phase consists of expanding reform to additional populations, specifically by mandating the enrollment of those population groups previously enrolled voluntarily (see 6. below for example of these groups). The area-by-area roll out of each population may be different for different population groups, depending upon the availability of fully developed networks. Enrollment may be limited to those areas that were fully implemented by the end of Phase II, thus enabling those with the most experience under reform principles to be the initial sites for population expansion. The transition of these populations will also be on a staggered basis.

F. **ELIGIBILITY** - This section specifies which Medicaid eligibility populations will be included at what point during the demonstration. During the initial phase, participation in Medicaid reform will be mandatory for two eligibility groups currently covered by Florida

Medicaid. The first group is the 1931 eligibles and related group, also referred to as the TANF and TANF-related eligibility group, and the second is the Aged and Disabled group (or SSI population). The above groups are mandatory Medicaid eligibles, with the exception of poverty level children up to age one with family income above 185 percent of FPL but below 200 percent of the federal poverty level (FPL).

During the initial phase, individuals listed below may voluntarily participate in the demonstration. The state anticipates that during subsequent phases, individuals identified as voluntary in the groups below, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in the demonstration. Specifically, children with chronic conditions participating in Children's Medical Services, foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified by the state Legislature.

The following individuals eligible under the TANF and SSI groups listed below will be excluded from mandatory participation during the initial phase:

a. Foster care children will be a mandatory population no later than the end of demonstration year 3.
b. Individuals with developmental disabilities will be a mandatory population no later than the end of demonstration year 3.
c. Children with special health care needs will be a mandatory population no later than the end of demonstration year 3.
d. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD (by year 5).
e. Individuals eligible under a hospice-related eligibility group (by year 5).
f. Pregnant women with incomes above the 1931 poverty level (by year 5).
g. Dual eligible individuals (by year 5).

The state is not obligated under this demonstration to extend eligibility to population groups listed above as voluntary populations, but may do so.

G. **ENROLLMENT** – This section describes the enrollment process that will be used to implement Medicaid reform. Within each geographic demonstration area the state will stagger the transition for enrollment of mandatory participants into the Medicaid reform demonstration. At the time of eligibility determination, individuals who are mandated to participate will receive information about managed care plan choices in their area. They will be informed of their option to select an authorized managed care plan or opt out of Medicaid. Individuals will be given the opportunity to meet with a choice counselor (either state-employed or state-designated) to obtain additional information in making a choice. If they opt out, they can use their Medicaid established premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility determination. If the individual does not select a plan or opt out within the 30-day period, the state will auto-assign the individual into a Medicaid reform plan. Current Medicaid enrollees who are enrolled in a managed care plan

or the MediPass program will be required to enroll in a reform plan at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner.

Once a mandatory enrollee has selected a Medicaid Reform Plan the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a Medicaid reform plan the individual will have 90 days to voluntarily disenroll from that plan and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period except for cause.

H. **CHOICE COUNSELING** – This section describes the process that will be used to provide choice counseling to Medicaid recipients so they will be adequately informed of their options in order to choose a plan that best meets their health care needs. Specifically, the choice counselor will provide information on either selecting a reform plan or opting out of Medicaid. The choice counselor will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the administrator. The choice counselor will assist the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice.

As it does now, the state or the state's designated choice counselor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the state will supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

The state shall contract with an independent choice counselor to provide full and complete information about managed care plan choices and the ability to opt out of Medicaid. As directed by the state Legislature, the state will develop a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

I. **BENEFIT PACKAGES AND MEDICAID REFORM PLANS** – This section specifies that Medicaid reform plans will have the flexibility to provide customized benefit packages for Medicaid reform enrollees. The customized benefit packages must cover all mandatory services specified in the state plan including medically necessary services for pregnant women and EPSDT services for children under age 21. In addition, the plans will cover needed optional services as indicated by historical data. However, the amount, duration and scope of all covered services, mandatory and optional, may vary to reflect the needs of the population. The plans authorized by the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and

emergency services. The state may also capitate all state plan services in a demonstration area.

The state will separate the Medicaid capitation premium into two components – comprehensive care and catastrophic care. The comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees will need and is expected to represent approximately 90 percent of historical medical expenditures. The catastrophic care component is designed to meet the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. For each target population served, the state will establish criteria to allow plans to choose whether or not to assume the catastrophic risk.

All benefit packages must be prior-approved by the state and must be at least actuarially equivalent to the services provided to the target population under the current state plan benefit package. In addition the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.

All health plans will be responsible for providing and coordinating all recipient benefits, regardless of whether those benefits are being funded through the comprehensive or catastrophic premium component and regardless of whether the plan has chosen to bear financial risk for catastrophic care. For those plans that do not accept financial risk, the state becomes the re-insurer, and the health care plan remits claims to the state for services rendered under this component. The move from comprehensive to catastrophic is seamless for the enrollee, and the enrollee does not know which health plans are at risk for the catastrophic component.

The state will also establish an overall annual maximum benefit level in conjunction with the development of the premium components. The maximum benefit limit will be applied to all reform recipients with the exception of children under age 21 and pregnant women. The annual aggregate maximum limit provides a safeguard to enrollees, as the annual limit will renew each year to cover additional services.

J. **EMPLOYER SPONSORED INSURANCE/OPT-OUT PROVISION** – This section describes the opt-out provision which allows a Medicaid recipient to use the capitation premium to acquire employer-sponsored insurance (ESI). If a person elects the opt-out provision, the state shall provide the employee share but no more than the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, then the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage or purchase supplemental health insurance coverage offered by the employer. The state may limit payment for supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage.

K. **ENHANCED BENEFIT ACCOUNTS** – This section describes the establishment and access to the enhanced benefit accounts. Enhanced Benefits Accounts (EBA) will be established to provide incentives to Medicaid reform enrollees for participating in state-

defined activities that promote healthy behaviors. All enrollees in a Medicaid reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn enhanced benefits for the duration of their enrollment. An individual who participates in a state-defined activity that promotes healthy behavior shall have funds deposited into the individual EBA. These funds shall be used for health care related expenditures as defined in Section 1905 of the Social Security Act. Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual may retain access to any earned funds for a maximum of 3 years, so long as, the individual's income is below 200 percent of the federal poverty level (FPL).

L. **RECIPIENT COST SHARING** – This section establishes allowable cost-sharing requirements for specific services. It also states that individuals who select to opt out of Medicaid are subject to any cost sharing requirements in their employer's benefit plan.

M. **DELIVERY SYSTEM** – This section establishes criteria for which plans may participate in the reform demonstration; requires managed care plans to contract with Federally Qualified Health Centers (FQHCs), County Health Departments (CHDs), and Rural Health Centers (RHCs), or to demonstrate that the plan has adequate network capacity if the plan does not contract with these entities in their service area; and requires the state to evaluate its benefit evaluation model to verify actuarial equivalence and sufficiency on an annual basis.

N. **EVALUATION** - This section requires the state to develop an evaluation design that shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population and capitated revenue expenditures for the demonstration waiver. The evaluation design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state shall conduct the evaluation, or select an outside contractor for the evaluation. This design must be submitted to the federal government for approval by February 2006.

O. **LOW INCOME POOL** - This section creates the low income pool (LIP) as a replacement for the hospital upper payment (UPL) program. The LIP will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured, and uninsured populations. The LIP consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act. These health care expenditures may be incurred by the state, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the state and the federal CMS.

Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones." In order to define LIP permissible expenditures the state shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining state-authorized expenditures from the LIP and entities eligible to receive reimbursement. This document must be submitted to the federal government by March 2006.

P. **LOW INCOME POOL MILESTONES** – This section describes the milestones that must be met by the state for each year of the demonstration in order to access the total $1 billion annual allocation of LIP funds. Each year of the demonstration includes specific milestones, including five significant milestones that must be achieved before July 1, 2006, in order to transition from the current hospital UPL program to the new LIP program.

Q. **OTHER DEMONSTRATION MILESTONES** – This section cross references other milestones for the reform waiver in general that are included throughout the federally-approved special terms and conditions.

R. **GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX (MEDICAID)** – This section specifies how the budget neutrality agreement is established and the reporting requirements necessary to verify expenditures under the reform demonstration.

S. **MONITORING BUDGET NEUTRALITY** – This section describes the budget neutrality monitoring process, or how the federal government will determine whether the state is spending equal to or less than what it was expected to spend in its Medicaid program without this reform waiver.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.911, F.S., requiring the Medicaid Disproportionate Share Council to use the objectives established in s. 409.91211(1)(c), F.S., in its recommendations to AHCA regarding the low-income pool plan; requiring AHCA to ensure that there is fair representation of the stakeholder groups included in current statute on the Medicaid Disproportionate Share Council; requiring the Council to report to the Legislature no later than March 1st; repealing the Council on June 30, 2006; creating the Medicaid Low-Income Pool Council by July 1, 2006; providing for membership and duties of the Council; and requiring the Low-Income Pool Council to report to the Legislature no later than February 1 of each year.

Section 2. Amends s. 409.912, F.S., authorizing AHCA to contract with comprehensive behavioral health plans in separate counties within or adjacent to an AHCA area in order to prevent a conflict with the Medicaid reform pilot program; conforming provisions to the solvency requirements in s. 641.2261, F.S., for provider service networks; deleting the competitive-procurement requirement for provider service networks; and updating a reference to the provider service network.

Section 3. Amends s. 409.91211, F.S., to:

- Specify the process for statewide expansion of the Medicaid managed care demonstration program;
- Require that matching funds for the Medicaid UPL/LIP program be provided by local governmental entities;
- Provide for distribution of low income pool funds by the agency;
- Provide legislative intent with respect to the low-income pool plan required under the Medicaid reform waiver;
- Specify the agency's powers, duties, and responsibilities with respect to implementing the Medicaid managed care pilot program;
- Revise the guidelines for allowing a provider service network to receive fee-for-service payments in the demonstration areas;
- Authorize the agency to make direct payments to hospitals and physicians for the costs associated with graduate medical education under Medicaid reform;
- Include the Children's Medical Services Network in the Department of Health within those programs intended by the Legislature to participate in the pilot program to the extent possible;
- Require that the agency implement standards of quality assurance and performance improvement in the demonstration areas of the pilot program;
- Require the agency to establish a patient encounter database to compile data from managed care plans;
- Require the agency to implement procedures to minimize the risk of Medicaid fraud and abuse in all managed care plans in the demonstration areas;
- Clarify that the assignment process for the pilot program is exempt from certain mandatory procedures for Medicaid managed care enrollment specified in s. 409.9122, F.S.;
- Revise the automatic assignment process in the demonstration areas; requiring that the agency report any modifications to the approved waiver and special terms and conditions to the Legislature within specified time periods;
- Authorize the agency to implement the provisions of the waiver approved by the federal Centers for Medicare and Medicaid Services;
- Require OIR to conduct an annual review of the Medicaid reform rate setting methodology that will be used in the pilot sites; require OIR to contract with an independent actuary firm to assist in the review; require OIR to solicit input concerning the agency's rate setting methodology from specified organizations; require OIR to submit its findings and advisory recommendations to the Governor and Legislature no later than February 1 of each year; and
- Provide that, if any conflict exists between the provisions contained in s. 409.91211, F.S., and ch. 409, F.S., concerning the implementation of the pilot program, the provisions contained in s. 409.91211, F.S., control.

Section 4. Creates s. 409.91213, F.S., requiring the agency to submit quarterly and annual progress reports to the Legislature and requiring certain provisions to be included in the quarterly and annual reports.

Section 5. Amends s. 641.2261, F.S., updating a reference to federal solvency requirements for managed care organizations and revising the application of solvency requirements to include Medicaid provider service networks.

Section 6. Creates an undesignated section in law requiring that the agency report to the Legislature the pre-implementation milestones concerning the low income pool which have been approved by the federal government and the status of those milestones remaining to be approved.

Section 7. Provides an effective date of upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill authorizes the implementation of the Medicaid reform pilot program as specified in s. 409.91211, F.S. One of the provisions allows for Medicaid recipients to opt out of the Medicaid program and use their capitated premium to purchase employer-sponsored insurance. This may allow more individuals to be covered through their employers which would increase the size of the private sector risk pools, which could reduce the rate of growth in premiums for those plans. Since it is unknown how many people will choose the opt out provision, the actual fiscal effect on the private insurance market is unknown.

C. Government Sector Impact:

CS/CS/SB 838 required AHCA to submit a Medicaid reform implementation plan to the Legislature, as a whole, for consideration in making a decision on approval of implementation of the waiver. The implementation plan was to include a timeline for implementation of the waiver and budgetary projections for 5 years (FY 2006 07 through FY 2010 2011).

The agency submitted The Florida Medicaid Reform Implementation Plan dated November 28, 2005, that reflects the budget neutrality estimates included in the federally approved reform waiver. Budget neutrality was estimated based on statewide implementation.

The budget neutrality estimates for Medicaid services reflect savings ranging from $190.8 million ($78.6 million general revenue) in FY 2006 2007 to $938.9 million ($386.8 million general revenue) in FY 2010 2011. Additional administrative expenditures of $10 million will be required in FY 2006 2007 per the Agency's estimates.

CS/CS/SB 838 requires the Office of Program Policy Analysis and Government Accountability to submit an evaluation of the pilot programs (Broward and Duval counties), that includes cost savings, to the Legislature no later than June 30, 2008.

Estimates in Millions

	FY 2006-07	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**
***Medicaid Services:**					
Estimated Expenditures Under Current Medicaid Program	$8,005.38	$9,074.63	$10,317.42	$11,763.27	$13,446.86
Estimated Expenditures Under Reform	$7,814.62	$8,747.05	$9,823.41	$11,067.67	$12,507.99
Projected Savings:	$190.76	$327.58	$494.01	$695.59	$938.87
General Revenue	*$78.59*	*$134.96*	*$203.53*	*$286.58*	*$386.81*
Trust Funds	*$112.17*	*$192.62*	*$290.48*	*$409.01*	*$552.05*

*Fiscal estimates based on budget projections as provided in the federal waiver and the agency's implementation plan submitted to the Legislature on November 28, 2005.

Reform Administrative Expenditures:	**FY 2006-07**	**FY 2007-08****	**FY 2008-09****	**FY 2009-10****	**FY 2010-11****
Recurring funds in base budget:	$15.74	$25.80			
General Revenue	*$7.13*	*$10.88*			
Trust Funds	*$8.61*	*$14.92*			
***Additional recurring need:**	$10.06				
General Revenue	*$3.75*				
Trust Funds	*$6.31*				

* Estimated additional recurring administrative expenditures as identified by AHCA.
** Additional administrative costs are indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

Barcode 463656 by Ways and Means:
Provides that specified federally qualified health centers (FQHCs) or entities owned by one or more federally qualified health centers and reimbursed on a prepaid basis are exempt from certain requirements in chapter 641imposed on health maintenance organizations and health care services but must comply with the solvency requirements and meet other financial, quality assurance and patients' rights requirements established by the agency. (WITH TITLE AMENDMENT)

Barcode 482414 by Ways and Means:
Includes minority physician networks and emergency room diversion programs in the definition of a provider service network and requires that they meet any Medicaid reform credentialing requirements or standards required for other managed care plans in the reform areas.

Barcode 874602 by Ways and Means:
Clarifies that the special terms and conditions referenced in the bill are the ones that were federally approved by the Centers for Medicare and Medicaid on October 19, 2005.

Barcode 542240 by Ways and Means:
Ensures that state matching funds provided through intergovernmental transfers and the allocation of these funds under the low income pool are done in a manner consistent with published federal statutes, regulations, and waivers, and the low income pool methodology approved by the federal Centers for Medicare and Medicaid Services.

Barcode 771236 by Ways and Means:
Provides a technical correction that moves the definition of a "capitated managed care plan" to another section of the bill.

Barcode 290676 by Ways and Means:
Adds additional data to be collected to measure a reform plans performance in ensuring access to medically necessary services, including underutilization or inappropriate denial of services.

Barcode 304782 by Ways and Means:
Adds federally qualified health centers to entities allowed to be reimbursed for the provision of medically necessary services to Medicaid recipients in school districts in the reform areas.

Barcode 923506 by Ways and Means:
Requires the agency to convene a technical advisory panel to advise the agency in the areas of risk-adjusted rate setting, benefit design and choice counseling and specifies panel membership.

Requires the agency to establish a 10% financial range (risk corridor) within which the Medicaid reform capitation rates can vary. These risk corridors will only be allowed for the first two years of the demonstration.

Requires the agency to phase-in the risk adjustment factor in the Medicaid reform capitation rates over a three-year period.

Requires that any rates established in the reform areas must be certified by an actuary and approved by the federal government.

Provides for the definition of a "capitated managed care plan" and adds Children's Medical Services Network to the definition. (WITH TITLE AMENDMENT)