

**HOUSE OF REPRESENTATIVES STAFF ANALYSIS**

**BILL #:** HB 3B CS Medicaid  
**SPONSOR(S):** Benson  
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 2B

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REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	6 Y, 4 N, w/CS	Mitchell	Mitchell
2) Fiscal Council			
3) Health & Families Council			
4)			
5)			

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**SUMMARY ANALYSIS**

In the 2005 Regular Session the Legislature passed CS/CS/SB 838 (Ch. 2005-133, L.O.F.), which establishes s. 409.91211, F.S., to give the Agency for Health Care Administration (AHCA) guidance and authority to seek a federal waiver to reform Medicaid, and specified the agency could not implement the waiver until it received authority from the Legislature. On October 3, 2005, AHCA submitted the waiver to the federal Centers for Medicare and Medicaid Services (CMS) for approval, following a year of negotiation with CMS. On October 19, 2005, the federal Centers for Medicare and Medicaid Services (CMS) approved Florida's Medicaid Reform waiver application with special terms and conditions.

HB 3B with CS amends s. 409.91211, F.S., to give AHCA authority to implement Medicaid reform as required by CS/CS/SB 838, and in accordance with CMS special terms and conditions.

The bill provides an appropriation of \$250,000, for the Office of Insurance Regulation to carry out an annual review of the risk-adjusted rate methodology.

The effective date of the bill is upon becoming law.

## FULL ANALYSIS

### I. SUBSTANTIVE ANALYSIS

#### A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government. The bill requires outsourcing of the administration of health care service delivery to managed care plans approved by the Agency for Health Care Administration.

#### B. EFFECT OF PROPOSED CHANGES:

HB 3B/CS amends s. 409.91211, F.S., to give AHCA authority to implement the reform plan as established in the waiver application and federal terms and conditions for the waiver.

The bill:

- Requires Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.
- Modifies the name, composition, and mission of the existing Medicaid Disproportionate Share Council.
- Establishes Low Income Pool Council objectives for the distribution of LIP funds. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals.
- Allows current capitated, behavior health programs to continue in non-reform counties.
- Facilitates the establishment of PSNs by, removing the requirement that contracts for Provider Service Networks (PSNs) be competitively bid, so hospitals and other provider networks can be established to participate in Medicaid reform.
- Authorizes AHCA to begin implementing the Medicaid managed care pilot program in two sites, Broward and Duval Counties.
- Authorizes AHCA to seek options to make direct payments to state medical school hospitals and physicians.
- Requires PSNs to continue sharing savings with the state as PSNs transition to managed care reform plans.
- Allows the Department of Health's, Children's Medical Services Network, to become a reform plan.
- Establishes detailed measures that require quality assurance, patient satisfaction, and performance standard reporting by managed care reform plans.
- Establishes detailed standards for managed care plan compliance, including patient encounter reporting requirements.
- 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 a plan at the point of eligibility redetermination into the most appropriate reform plan operated by the recipient's current managed care organization.
- Requires AHCA to notify the Legislature before proposing any changes to the terms and conditions of the waiver.
- Requires the Office of Insurance Regulation to advise AHCA and report to the Legislature on the proposed risk-adjusted rate methodology developed for Medicaid reform plans; a four year

phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; and federal approval of risk adjusted rates.

- Requires rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.
- Establishes a Joint Legislative Committee on Medicaid Reform Implementation for reviewing policy issues related to expansion.
- Establishes detailed requirements for readiness that must be met before expansion into other counties can be considered beginning in year two. At least two plans in the expansion area must meet readiness criteria.
- Removes the requirement of automatic assignment of Medicaid recipients in non-reform counties who do not make a choice of plans.
- Requires AHCA to report to the Legislature by April 1, 2006, on Low Income Pool methodology and other issues related to the special terms and conditions.
- Requires AHCA to submit all CMS required quarterly and annual progress reports to the Legislature.
- Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.
- Provides an appropriation of \$250,000 for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.
- Provides an effective date of upon becoming law, so that AHCA can implement Medicaid Reform.

## THE CURRENT SITUATION

Medicaid is the \$15 billion state and federal program that provides health care to more than 2.1 million vulnerable, disabled, and elderly Floridians. According to AHCA, if Florida's Medicaid program continues to grow at its present rate, it would consume more than half of the state's budget by 2015.

### Governor Bush's Proposal for Medicaid Reform

In 2004, Governor Bush proposed a major reform of Florida's Medicaid system, and the Agency for Health Care Administration (AHCA) began meeting with the federal Centers for Medicare and Medicaid Services (CMS) to develop concepts for the reform. The reform is referred to as a "waiver" because it seeks federal permission to waive certain federal requirements that govern the regular Medicaid program. The goals of the reform are to establish a new Medicaid system that achieves:

Patient Choice: Participants in reformed Medicaid plans will be able to choose among a variety of benefit packages. With the help of independent choice counselors they will choose the plan that best meets their needs. They will be able to earn credits for approved health-related expenses such as co-pays, over-the-counter medications, or eyeglasses, by meeting approved healthy lifestyle changes such as meeting all well baby checkups, losing weight, and smoking cessation.

Medicaid Marketplace Innovation: Provider groups will be able to design benefit plans that attract participants because of their benefit package, innovative care, convenient networks, and optional services. Competition among managed care plans will reduce fraud in Medicaid. Currently, Medicaid pays claims first and identifies fraud later. Under proposed reforms, capitated health plans have a financial incentive to aggressively guard against fraud.

Better Care: Health plans can customize their benefit design to meet the needs of the target populations in the geographic areas they serve. The state will evaluate the benefits to ensure

they are actuarially equivalent to historical fee-for-service benefits and are sufficient to meet the needs of the targeted populations. Rates will be risk adjusted to create incentives for more prevention and identification of chronic illnesses.

Budget Predictability: According to the Agency for Health Care Administration, by moving to a managed and capitated system, the state expects to minimize budget fluctuations driven primarily by the current fee-for-service system and improve predictions of budget growth.

### **2004-2005 Legislative Action on Medicaid Reform**

In the Fall of 2004, both the House and Senate established Select Committees on Medicaid Reform. The Select Committees conducted five public hearings in cities around the state, including Tampa, Ft. Lauderdale, Orlando, Panama City, and Jacksonville. 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.

### **CS/CS/SB 838 Authorization and Requirements to Pursue a Federal Waiver**

In 2005, the Legislature passed CS/CS/SB 838, which creates s. 409.91211, F.S., to authorize AHCA to continue developing a plan to pilot the Governor's proposal for a capitated managed care system to replace the current fee-for-service Medicaid system. Requirements of SB 838 include:

Continued federal funding of supplemental payment mechanisms. The law specifies that the authorization was contingent on the attainment of:

- Federal approval to preserve the Upper Payment Limit (UPL) funding for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites.
- Provisions to preserve the state's ability to use Intergovernmental Transfers (IGT) as state match for federal funds.
- Provisions to protect the Disproportionate Share Hospital (DSH) program.

Components for the reform plan. The law requires AHCA to develop and recommend provisions for implementation of Medicaid reform pilot areas that include:

- Eligibility groups and two geographic areas for the pilot projects. The bill designates one pilot program in Broward County and one pilot program in Duval and surrounding Baker, Clay, and Nassau Counties. It allows the pilot in the Duval County area to be phased in over a 2-year period.
- Requirements that health care plans in Medicaid reform pilot areas include mandatory and optional Medicaid services listed in ss. 409.905 and 409.906, F.S.
- Standards and credentialing requirements for plans, including those related to fiscal solvency, quality of care, and adequacy of access to health care providers.
- Actuarially sound, risk adjusted capitation rates for coverage of Medicaid recipients separated into comprehensive and catastrophic care premium components, and a method to phase in financial risk for approved provider service networks over a 3-year period, with stop-loss requirements.
- A system to help Medicaid recipients select a managed care plan that meets their needs. Requirements for mandatory enrollment in a capitated managed care network and locking a recipient into a health plan for 12 months, unless the recipient can demonstrate cause to justify a disenrollment, and provisions for disenrollment and selection of another plan within a certain timeframe.

- A system to monitor plan performance and the provision of services, and to detect and deter fraud and abuse by health plans, providers, and recipients, including underutilization and inappropriate denial of care.

Approval of an implementation plan. Section 409.91211, F.S, requires AHCA to develop an implementation plan to be submitted to the Legislature for approval before implementation of the reform, or if the Legislature is not in session, for approval by the Legislative Budget Commission.

Evaluation of the pilots. The Legislature also requires an independent evaluation of Medicaid reform for consideration of expansion beyond the pilot areas. The Office of Program Policy Analysis and Government Accountability (OPPAGA), in consultation with the Auditor General, will evaluate 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, for consideration of statewide expansion.

Legislature approval of 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.

### **Federal Approval of the Waiver**

The Agency for Health Care Administration (AHCA) published the waiver application for public review on August 31, 2005, and formally submitted the waiver application to the federal government for approval on October 3, 2005.

The federal Centers for Medicaid and Medicare Services (CMS) approved the waiver for reform of Florida Medicaid on October 19, 2005. The waiver covers a 5-year period, from July 1, 2006, through June 30, 2011. Fundamental elements of the reform plan include:

Beneficiary Choice from among benefit packages. With the support of choice counselors, individuals will have the flexibility to choose from a variety of benefit packages and pick the plan that best meets their needs.

Plan Variety. In addition to traditional managed care organizations, new plans will be created from existing provider networks and organizations that wish to participate. Such entities include provider service networks, federally qualified health centers, federally qualified rural health clinics, county health departments, the Division of Children's Medical Services Network within the Department of Health; and other federally, state, or locally funded entities that serve the geographic areas within the pilot program.

Risk-Adjusted Premiums 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.

A Low-Income Pool (LIP) to 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.

An Employer-Sponsored Insurance (ESI) option to allow individuals to use their premiums to "opt out" of Medicaid and purchase insurance through their workplace.

Enhanced Benefits Accounts to provide incentives to Medicaid Reform enrollees for healthy behaviors that they can use to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins, etc.

## Federal Terms and Conditions

In approving the waiver, CMS attached special terms and conditions (11-W-00206/4) that set forth in detail the nature, character, and extent of federal involvement in the reform, and Florida's obligations to CMS during the life of the waiver. The terms and conditions address 120 issues in 16 areas of the reform. They require detailed accountability. The terms and conditions require compliance with current Medicaid law, regulation, and policy. They spell out limits on the scope of change in some areas, and provide for broad flexibility in others. The areas addressed by the terms and conditions include:

- General Program and Reporting Requirements.
- Implementation of Florida Medicaid Reform.
- Eligibility, Enrollment, and Choice Counseling.
- Benefit Packages and Medicaid Reform Plans.
- Employer-Sponsored Insurance.
- The Enhanced Benefits Accounts Program.
- The Low Income Pool.
- Evaluation and Monitoring of Budget Neutrality.

The primary condition of the Medicaid waiver is "budget neutrality." A federal rule requires that the costs of Medicaid services provided to recipients under the waiver must not exceed the projected costs for Medicaid services without the waiver. If expenditures exceed the budget neutrality projections, then the state will have to fund these expenditures without federal matching funds.

The terms and conditions require federal approval of amendments to the waiver before Florida can add dual eligible, hospice, and medically needy groups to the reform; and before any program or budget changes can be made to: eligibility, enrollment, benefits, employer-sponsored insurance, implementation, the Low Income Pool, Federal Financial Participation (FFP), sources of the non-Federal share, and budget neutrality.

### C. SECTION DIRECTORY:

**Section 1.** Amends s. 641.2261(2), F.S., to require Medicaid provider service networks to comply with certain federal solvency requirements, rather than state solvency requirements for HMOs.

**Section 2.** Amends s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council. The revised Council will make recommendations to the Legislature regarding the Low Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver.

**Section 3.** Amends s. 409.912, F.S., to allow current capitated, behavior health programs to continue in non-reform counties, and remove the requirement that contracts for Provider Service Networks (PSNs) be competitively bid.

**Section 4.** Amends s. 409.91211, F.S., to authorize AHCA to begin implementing the Medicaid managed care pilot program in two pilot sites (Broward and Duval Counties per CS/CS/SB 838, 2005). The bill specifies additional requirements related to PSN cost sharing, quality assurance, encounter data, fraud and abuse, and continuity of care; it limits implementation of risk-adjusted rate setting; and it makes technical changes to conform to requirements of the federal waiver.

**Section 5.** Creates s. 409.91212, F.S., to allow Medicaid reform to expand to other counties after the beginning of year two, if detailed criteria for readiness are met.

**Section 6.** Amends s. 409.9122, F.S., to remove the requirement of automatic assignment into Medipass of Medicaid recipients in non-reform counties who do not make a choice of plans.

**Section 7.** Requires AHCA to report to the Legislature by April 1, 2006, on the Low Income Pool methodology and other issues related to the federal terms and conditions requirements of the waiver.

**Section 8.** Requires AHCA to submit all CMS required quarterly and annual reports to the Legislature.

**Section 9.** Creates s. 11.72, F.S., to establish a Joint Legislative Committee on Medicaid Reform Implementation to review policy issues related to expansion of the Medicaid managed pilot program and make recommendations regarding the extent readiness criteria are met.

**Section 10.** Specifies legislative intent that, if any conflict exists between the statutory provisions relating to reform and other Medicaid statutes, the requirements of reform prevail. AHCA must report to the Legislature any conflicts it identifies.

**Section 11.** Amends s. 216.346, F.S., to allow contracts between state agencies and state colleges and universities to charge a reasonable overhead.

**Section 12.** Provides an appropriation of \$250,000, for the Office of Insurance Regulation to carry out the annual review of the risk-adjusted rate methodology.

**Section 13.** Provides an effective date of upon becoming law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

### A. FISCAL IMPACT ON STATE GOVERNMENT:

#### 1. Revenues:

See Comments below.

#### 2. Expenditures:

See Comments below.

### B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

#### 1. Revenues:

None.

#### 2. Expenditures:

None.

### C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

### D. FISCAL COMMENTS:

#### Administration Costs

The Agency for Health Care Administration has requested \$15 million (\$7.5 million General Revenue) of nonrecurring funds for the administration of Medicaid reform in its Fiscal Year 2006-2007 Legislative Budget Request. The request is for the following funds.

Choice Counseling	
General Revenue Fund	\$3,250,000
Administrative Trust Fund	\$3,250,000
Plan Evaluation/Satisfaction Survey	
General Revenue Fund	\$250,000
Administrative Trust Fund	\$250,000
Premium Development	
General Revenue Fund	\$1,000,000
Administrative Trust Fund	\$1,000,000
Enhanced Benefit Accounts	
General Revenue Fund	\$1,500,000
Administrative Trust Fund	\$1,500,000
Management of Employer Sponsored Insurance	
General Revenue Fund	\$1,000,000
Administrative Trust Fund	\$1,000,000
Infrastructure & System Modification	
General Revenue Fund	\$500,000
Administrative Trust Fund	\$500,000

For subsequent years, the agency states that the projects will increase in cost as the capitated managed care pilot program expands into Baker, Clay, and Nassau counties.

Medicaid Reform Benefit Costs

The agency's Florida Medicaid Reform Implementation Plan dated November 28, 2005, compares the costs of Medicaid benefits without Medicaid reform to the costs of Medicaid benefits with Medicaid reform. The comparison is below.

Benefit Costs	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Without reform	\$8,005,381,618	\$9,074,633,163	\$10,317,423,381	\$11,763,265,977	\$13,446,859,984
With reform	\$7,814,617,174	\$8,747,049,308	\$9,823,408,828	\$11,067,673,309	\$12,507,991,943
Difference	\$190,764,444	\$327,583,855	\$494,014,553	\$695,592,668	\$938,868,041

The \$190.7 million in savings shown above for Fiscal Year 2006-2007 is for statewide expenditures. According to the agency, the fiscal impact of moving recipients into Medicaid reform plans in only Duval and Broward counties is indeterminate at this time.

Provisions of HB 3B/CS restrict the implementation of risk-adjusted rate setting that will reduce the amount of the agency's projected cost savings.

Rate Review

This bill authorizes one full-time equivalent position and appropriates \$250,000 from the General Revenue Fund for Fiscal Year 2006-2007 for the annual review of the Medicaid managed care pilot program's risk-adjusted rate setting methodology.



## Assignment of Recipients to Managed Care

The bill changes the assignment of undecided enrollees. Although an estimate of the fiscal impact of this policy decision is not available at this time, an estimate provided by the agency at an impact conference during the 2005 session showed that moving all non-institutionalized SSI-eligible beneficiaries into a health maintenance organization would result in savings of more than \$71 million (\$13.2 million General Revenue).

### **III. COMMENTS**

#### **A. CONSTITUTIONAL ISSUES:**

##### **1. Applicability of Municipality/County Mandates Provision:**

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

##### **2. Other:**

None.

#### **B. RULE-MAKING AUTHORITY:**

None.

#### **C. DRAFTING ISSUES OR OTHER COMMENTS:**

None.

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

On December 5, 2005, the Health Care Regulation Committee adopted two amendments sponsored by Representative Garcia. The Committee Substitute differs from the original bill as filed. The Committee Substitute adds language to require: the Office of Insurance Regulation to advise AHCA, not oversee, the proposed risk-adjusted rate system; a four year phase in of the risk-adjusted rates; limits on variation in rates based on risk, with hold harmless on plan payments; federal approval of risk adjusted rates; and rule making for risk-adjusted rate-setting and for choice counseling of beneficiaries.

The bill, as amended, was reported favorably as a committee substitute.

This analysis is drafted to the committee substitute.