HOUSE OF REPRESENTATIVES STAFF ANALYSIS

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

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	6 Y, 4 N, w/CS	Mitchell	Mitchell
2) Fiscal Council	17 Y, 4 N	Speir	Kelly
3) Health & Families Council	8 Y, 3 N, w/CS	Mitchell	Moore
4)			
5)			

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. It also amends ss. 216.346, 409.911, 409.912, 409.9122, and 641.2261, Florida Statutes and creates ss. 11.72 and 409.91212, Florida Statutes.

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 (AHCA).

B. EFFECT OF PROPOSED CHANGES:

HB 3B with 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 as the Medicaid Low Income Pool Council, establishes objectives, and provides a Sunset date.
- Requires the Council to advise AHCA regarding the Low Income Pool that replaces the UPL funding program for safety-net hospitals.
- Allows current capitated, behavior health programs to continue in non-reform counties and allows for participation by Federally Qualified Health Centers.
- Facilitates the establishment of PSNs by, removing the requirement that contracts for Provider Service Networks (PSNs) be competitively bid, so that 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, utilization, 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 AHCA to convene a technical advisory panel to advise the agency on risk adjustment and rate setting, encounter data, and choice counseling.

- Requires a two year phase in of risk-adjusted rate setting, with a 10% limit on variation in rates, and provides for exceptions for plans serving high risk populations.
- 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.
- Establishes a Joint Legislative Committee on Medicaid Reform Implementation for reviewing readiness criteria 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.
- Mandates the assignment of Medicaid recipients in non-reform counties to a managed care plan when they fail to select a service delivery system.
- 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.
- 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, 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, 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 as the Low Income Pool 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. Provides a Sunset date of June 30, 2006.

Section 3. Amends s. 409.912(4), F.S., to allow current capitated, behavior health programs to continue in non-reform counties, and to 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 requires a technical advisory panel for risk adjustment and rate setting, encounter data, and choice counseling, and provides for phased in implementation and limits on risk-adjusted rate setting. The bill makes technical changes to conform to requirements of the federal waiver, and 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 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 readiness criteria related to expansion of the Medicaid managed pilot program, and to make a recommendation regarding the extent readiness criteria are met.

Section 10. Amends s. 216.346, F.S., to allow contracts between state agencies and state colleges and universities to charge a reasonable overhead.

Section 11. 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:

Medicaid reform will change the way Medicaid services are provided to Medicaid recipients. This may have a direct impact on the fees service providers receive.

D. FISCAL COMMENTS:

Administration Costs

CS/CS/SB 838 appropriated more than $15 million ($7.13 million General Revenue) in recurring funds for Medicaid reform administrative costs. In addition to these funds, the agency expects an additional recurring need of just more than $10 million ($3.75 million General Revenue) for Medicaid reform administrative costs.

Administrative Cost Estimates (in Millions)

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	$15.74			
General Revenue	*$7.13*	*$7.13*			
Trust Funds	*$8.61*	*$8.61*			
*Additional recurring need:	$10.06	$10.06			
General Revenue	*$3.75*	*$3.75*			
Trust Funds	*$6.31*	*$6.31*			

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

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.

The agency estimates that the phasing in risk-adjusted rates will reduce the amount of the agency's projected cost savings.

Assignment of Recipients to Managed Care

The bill changes the assignment of undecided enrollees. The agency estimates that this policy change would result in savings of more than $12.2 million ($4.2 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:

Paragraph (c) on page 40 places a duty on the agency in a subsection that grants powers to the Office of Insurance Regulation.

Subsection (8) on page 40 requires the agency to set rates based upon the "recommendation of the committee" without knowing what committee is being referenced. The language also appears to make the agency's rate setting authority subject to another entity. This may violate the single state agency requirements in federal law (See 42 CFR 431.10).

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.

On December 6, 2005, the Health and Families Council adopted eight amendments to the bill that include the following provisions, incorporated into the Committee Substitute.

- Provides for a Sunset date for the LIP Council, and adds a representative of Family Practice Teaching Hospitals to the council in place of a representative of the Department of Health.
- Adds Federally Qualified Health Centers to providers of school services and as entities that may provide Medicaid prepaid mental health services.
- Includes Minority Physician Networks and Emergency Room diversion programs in the definition of a provider service network.
- Adds utilization and quality to required quality assurance measures to ensure recipient access to care.
- Replaces Office of Insurance Regulation review with requirement that the Secretary of AHCA establish a technical advisory panel with certain representatives to advise the agency on risk-adjusted rate setting, encounter data, and choice counseling.
- Changes implementation of risk adjusted rate setting to phase in over two years instead of three, and allows exceptions to 10% risk adjusted rates to allow for plans that serve high risk populations.
- Includes Children's Medical Services Networks in the term "capitated managed care plan."
- Removes appropriation.

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

This analysis is drafted to the committee substitute.