The Florida Senate

PROFESSIONAL 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: Health Policy Committee

BILL:	CS/SB 934
INTRODUCER:	Health Policy Committee and Senator Dawson and Others
SUBJECT:	Medicaid Services for Children
DATE:	March 21, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Fav/CS**
2.			HA	
3.			RC	
4.				
5.				
6.				

I. Summary:

The bill exempts Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in an area in which Medicaid reform has been implemented from having to participate in the separate specialty prepaid plans operated by the community-based lead agencies as otherwise required in s. 409.912(4)(b)8., F.S.

The bill also amends the Medicaid reform statute to authorize the Agency for Health Care Administration (agency or AHCA) to implement service delivery mechanisms within a provider service network, in addition to capitated managed care plans, to provide Medicaid services to Medicaid-eligible children who are open for child welfare services in the HomeSafeNet system. These services must be coordinated with community-based care providers and be sufficient to meet the medical, developmental, behavioral health, and emotional needs of these children. Covered behavioral health services must include all services currently included in the specialty prepaid behavioral health plan operated by community-based lead agencies. These service delivery mechanisms must be implemented by July 1, 2008, in order for these children to remain exempt from the statewide specialty prepaid plan.

The effect of the bill is to allow children whose cases are open for child welfare services in the HomeSafeNet system and who reside in a Medicaid reform county to receive services through a Medicaid reform plan as long as the covered behavioral health services include all services currently included in the specialty prepaid plan as operated under s. 490.912(4)(b)8, F.S.

This bill amends ss. 409.912 and 409.91211, F.S.

II. Present Situation:

The Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or ch 216, F.S.

For FY 2006-07, the Florida Medicaid Program is estimated to cover 2.1 million people[3] at a cost of $14.6 billion.[4]

Medicaid Reform

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

The Governor's proposal centered 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 Legislature 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.

Beginning in July 2006, the reform was piloted in two areas of state (Broward and Duval Counties). During the initial phase, participation in Medicaid reform is 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 Temporary Assistance for Needy Families (TANF) and

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid Program are found in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 20, 2007)
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 20, 2007)

TANF-related eligibility group, and the second is the Aged and Disabled group [or Supplemental Security Income (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 federal poverty level (FPL), but below 200 percent of the FPL.

During the initial phase of Medicaid reform, certain individuals were excluded from mandatory participation during the initial phase, although they may voluntarily participate in the demonstration pursuant to s. 409.91211, F.S., and the federally-approved waivers implementing the reform pilot. The concern was that these groups need specialized service delivery systems and moving them to a reform plan prematurely could cause disruption of care. The groups excluded from mandatory participation during the initial phase include:

- Foster care children, who will be a mandatory population no later than the end of demonstration year 3.
- Individuals with developmental disabilities, who will be a mandatory population no later than the end of demonstration year 3.
- Children with special health care needs, who will be a mandatory population no later than the end of demonstration year 3.
- 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).
- Individuals eligible under a hospice-related eligibility group (by year 5).
- Pregnant women with incomes above the 1931 poverty level (by year 5).
- Dual eligible individuals (by year 5).

The state anticipates that during subsequent phases, individuals identified as voluntary in the groups above, 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 the Children's Medical Services Network, 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.

Medicaid Prepaid Behavioral Health Plans

In March 1996, the AHCA implemented a Prepaid Mental Health Plan (PMHP) demonstration, under the authority of a 1915B waiver from the Federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services). The program was piloted for many years in two areas of the state before being expanded statewide in 2004.

A prepaid behavioral health plan is a managed care organization that contracts with the AHCA to provide comprehensive mental health services to its members though a capitated payment system. The AHCA pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient Psychiatric Hospital Services,
    - 45 days for adult recipients

    - 365 days for children
- Outpatient Psychiatric Hospital Services,
- Psychiatric Physician Services,
- Community Mental Health Services, and
- Mental Health Targeted Case Management.

Any Medicaid recipient who elects to enroll in MediPass for the provision of their physical health care services is assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible.[5] Ineligible persons include:

- Recipients who have both Medicaid and Medicare (dual eligibles),
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison,
- Medicaid-eligible recipients receiving services through hospice,
- Recipients in the Medically Needy Program,
- Newly enrolled recipients who have not yet chosen a health plan,
- SOBRA-eligible pregnant women and presumptively eligible pregnant women,
- Individuals with private major medical coverage,
- Members of a Medicaid HMO,
- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database.

Because of their unique situation, children in the HomeSafeNet database[6] are excluded from participating in the prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health services) operated by community-based lead agencies as of July 1, 2005.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.912(4), F.S., to exempt Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in an area in which Medicaid reform has been implemented from having to participate in the separate specialty prepaid plan operated by the community-based lead agencies as otherwise required under this subsection.

Section 2. Amends s. 409.91211, F.S., to require the AHCA to implement service delivery mechanisms within a provider service network, in addition to capitated managed care plans, to provide mandatory and optional Medicaid services as specified in ss. 409.905 and 409.906, F.S., to Medicaid-eligible children who are open for child welfare services in the HomeSafeNet system. These services must be coordinated with community-based care providers as specified in s. 409.1675, F.S., and be sufficient to meet the medical, developmental, behavioral health, and emotional needs of these children. Covered behavioral health services must include all services

[5] Persons enrolled in a Medicaid HMO receive their behavioral health services through the HMO if the plan offers benefits equivalent to those in the prepaid behavioral health plans.
[6] HomeSafeNet is the child welfare and client management information system used by the Department of Children and Family Services to track children at risk for abuse or are in the foster care system because of abuse or neglect.

currently included in the specialty prepaid behavioral health plan as implemented pursuant to s. 490.912(4)(b)8, F.S. These service delivery mechanisms must be implemented by July 1, 2008, in order for these children to remain exempt from the statewide specialty prepaid plan pursuant to s. 490.912(4)(b)8, F.S.

Section 3. Provides that the bill takes effect July 1, 2007.

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:

None.

C. Government Sector Impact:

There does not appear to be a fiscal effect on the Medicaid program. The bill does not change the types or amounts of benefits that must be provided to Medicaid-eligible children. The AHCA did not provide a fiscal analysis by the time of publication.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.