The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL:	CS for SB 12-C
INTRODUCER:	Committee on Health and Human Services Appropriations and Senator Peaden
SUBJECT:	Health Care
DATE:	October 3, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Dull	Peters	HA	**Fav/CS**
2.				
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill provides an exception for clients who have intensive medical or adaptive needs to the monthly 180 hour limit on personal care services provided through the Developmental Disabilities Home and Community-Based Services Waiver and repeals proviso in Specific Appropriation 270 in chapter 2007-72, Laws of Florida, to conform with the changes.

The bill clarifies that the reduced assessment of 1.0 percent on hospital outpatient services contained in section 16 of chapter 2000-256, Laws of Florida, was to be imposed upon each hospital, beginning on or after July 1, 2000.

The bill exempts Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in Area 10, from having to participate in the separate specialty prepaid plan operated by the community-based lead agencies. The bill requires the agency to implement service delivery systems sufficient to meet the medical, developmental, behavioral and emotional needs of these children by July 1, 2008.

The bill removes the current equal assignment process to managed care organizations and MediPass in Medicaid Service Areas 1 and 6 for persons who fail to make a choice. Currently

throughout all areas of the state, except for Areas 1 and 6, new Medicaid recipients who fail to choose between Medipass or a managed care plan are assigned to a managed care plan until an enrollment of 65 percent in managed care and 35 percent in Medipass is achieved.

The bill requires the Agency for Health Care Administration to give priority consideration in Medicaid managed care enrollment to certain managed care plans until the providers reach 15,000 members per month.

This bill substantially amends, the following sections of the Florida Statutes: ss. 393.0661, 395.701, 409.912, 409.91211, and 409.9122, Florida Statutes.

II. Present Situation:

Agency for Persons with Disabilities
The Agency for Persons with Disabilities has the responsibility to provide services to persons with developmental disabilities. A developmental disability is a disorder or syndrome attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and constitutes a substantial handicap expected to continue indefinitely. An individual is eligible for services if he/she has a developmental disability, and is three years of age or older. Children who are between the ages of three and five years of age and are at high risk of having a developmental disability are also eligible for services.

The developmental disabilities Home and Community Based Services (HCBS) waiver program is a Medicaid funded program and the largest source of funding for services. Services provided through the HCBS waiver program enable clients to live in a family setting in their own home or in a licensed residential setting and avoid institutionalization. Clients receiving services through the HCBS waiver are also eligible for all services in the Medicaid state plan. There were approximately 25,000 clients enrolled in FY 2006-2007.

The Family and Supported Living (FSL) waiver makes services available to clients who live with their family or in their own home. Annual expenditures per client are capped at $14,792, and fewer services are available under this waiver. Clients are also eligible for all services in the Medicaid state plan. There were approximately 6,000 clients enrolled in FY 2006-2007.

The 2007 Legislature directed the Agency for Persons with Disabilities in consultation with the Agency for Health Care Administration to establish limitations to supported living coaching, limited support coordination, personal care assistance and residential habilitation services. Additionally, direction was provided to seek federal approval and implement a four-tiered waiver system for clients in the developmental disabilities and family and supported living waiver programs. The criteria and dollar caps are defined below for the four-tiered new waiver system:

- Tier One – No cap on expenditures. Limited to persons with intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.

- Tier Two - $55,000 per client annual cap - Limited to persons who have high cost residential facility and residential habilitation service needs or supported living service needs.
- Tier Three - $35,000 per client annual cap - Limited to persons who require lower cost residential placements, independent or supported living situations and persons who live in their family home.
- Tier Four - $14,792 per client annual cap - Limited to persons already enrolled in the Family and Supported Living waiver which includes independent living, supported living or family home living situations

Medicaid Prepaid Behavioral Health Plans

In March 1996, the Agency for Health Care Administration (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 his/her physical health care services is assigned to a prepaid behavioral health plan for the provision of his/her mental health services, unless he/she is ineligible.[1] 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,

[1] 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.

- Recipients receiving FACT services, and
- Children enrolled in the HomeSafeNet database.

Because of their unique situation, children in the HomeSafeNet database[2] 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.

Managed Care Enrollment

MediPass and managed care plans are currently the two primary healthcare delivery systems in the Medicaid program. MediPass is a primary care case management system that requires a recipient to utilize a primary physician who coordinates all of the recipient's care for a three dollar per month payment from Medicaid. Medicaid managed care plans consist of health maintenance organizations, provider service networks and minority physician networks. Current law provides Medicaid recipients up to thirty days to make a choice to enroll in a managed care plan or MediPass, and upon enrollment into the selected plan, the recipient is given an additional ninety days to opt out. The Agency for Health Care Administration (AHCA) is required to provide information about the plans to Medicaid recipients for purposes of giving them the opportunity to make an informed choice between a managed care plan or MediPass.

Section 409.9122(2)(f), F.S., requires AHCA to assign recipients who fail to choose a plan in the initial thirty day choice period into a managed care plan or MediPass until the enrollment percentage reaches 35 percent MediPass and 65 percent managed care. This provision is applied to the entire state except for Medicaid Service Areas 1 and 6 where recipients must be assigned equally to MediPass and a managed care plan.[3]

Public Medical Assistance Act

The Public Medical Assistance Act was created by the Florida Legislature in 1984. The act is codified in sections 395.701, 395.7015, and 395.7016 of the Florida Statutes. Originally, the act imposed assessments upon all hospitals in the state in an amount of 1.5 percent of annual net operating revenue. During the 2000 legislative session the assessments were amended to the amounts equal to 1.5 percent of the annual net operating revenue for inpatient services and 1.0 percent of the annual net operating revenue for outpatient services. (Chapter 2000-256, L.O.F)

Lawsuit

Upon passage of Chapter 2000-256, L.O.F., the AHCA implemented this reduction on July 1, 2000 and applied the lower assessment rate on outpatient services based on the date the hospital earned its revenue. Beginning in September 2002, approximately 90 hospitals challenged the implementation date of this change in law and sought refunds of approximately $37 million for the overpaid assessments. The hospitals argued that the lower percentage amounts applied to assessments that were paid after July 1, 2000. On September 14, 2007, the District Court of

[2] 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.

[3] AHCA Area 1 contains the following counties: Escambia, Okaloosa, Santa Rosa, and Walton.
AHCA Area 6 contains the following counties: Hardee, Highlands, Hillsborough, Manatee, and Polk.

Appeals in the First District Court of the State of Florida issued an opinion ruling in favor of the hospitals thereby requiring the agency to refund the overpaid assessments[4].

III. Effect of Proposed Changes:

Section 1 amends s. 393.0661, F.S., to allow for the authorization of additional hours of personal care assistance services above the current 180 hour per month limit for persons with intensive medical or adaptive needs and if such hours are essential for avoiding institutionalization, or for persons who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harming themselves or others.

Section 2 repeals the following proviso in Specific Appropriation 270 in chapter 2007-72, Laws of Florida: "Personal care assistance services shall be limited to no more than 180 hours per calendar month and shall not include rate modifiers. Additional hours may be authorized only if a substantial change in circumstances occurs for the individual."

Section 3 amends s. 395.701, F.S., to clarify that the reduced assessment of 1.0 percent on hospital outpatient services that was contained in section 16 of chapter 2000-256, Laws of Florida, was to be imposed upon each hospital beginning on or after July 1, 2000.

Section 4 amends s. 409.912, F.S., requiring Medicaid-eligible children who reside in AHCA area 10, with cases open for child welfare services in the HomeSafeNet system, to be exempt from the specialty prepaid plan upon the development of a service delivery mechanism specified in s. 409.91211(3)(dd), F.S.

Section 5 amends s. 409.9122, F.S., requiring AHCA to give priority consideration in Medicaid managed care enrollment to certain managed care plans until the providers reach 15,000 members per month; and prohibit enrollment assignment to a managed care plan that has an enrollment of 25,000 or more members statewide.

Section 6 amends s. 409.9122, F.S., to eliminate the equal assignment process between MediPass and managed care plans for Medicaid recipients in AHCA areas 1 and 6 who fail to choose a plan within the initial thirty day choice period;

Section 7 amends s. 409.91211, F.S., to require the AHCA to implement service delivery mechanisms within capitated managed care plans for services to Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet System by July 1, 2008, in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8, F.S.

Section 8 provides that the act shall take effect upon becoming a law except as otherwise provided in the act.

[4] District Court of Appeal, First District, State of Florida; Case Numbers: 1D06-3857, 1D06-3872, 1D06-3877, 1D06-3890

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Prepaid health plan providers in AHCA areas 1 and 6 may experience an increase in revenue through the increase in enrollment as a result of eliminating the equal assignment process.

C. Government Sector Impact:

The following is a summary of the fiscal impact from the provisions in this bill:

- Projected savings as a result of eliminating the equal assignment process in Medicaid Areas 1 and 6.

	Average Monthly Caseload Increase	Total Projected Savings	General Revenue	Trust Funds
March 1, 2008 - June 30, 2008	2,180	($469,323)	($201,062)	($268,261)
FY 2008-09	25,288	($5,969,157)	($2,557,233)	($3,411,924)
FY 2009-10	31,392	($7,409,988)	($3,174,497)	($4,235,491)

- Clarification of the intent of the effective date of the reduced assessment under the Public Medical Assistance Act (s. 395.701, F.S.), could relieve the Agency for Health Care Administration's obligation to refund the $37 million in overpaid assessments.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

- Provides an exception for clients who have intensive medical or adaptive needs to the monthly 180 hour limit on personal care services provided through the Developmental Disabilities Home and Community-Based Services Waiver; and repeals proviso in Specific Appropriation 270 in chapter 2007-72, Laws of Florida, to conform with the changes.
- Clarifies that the reduced assessment of 1.0 percent on hospital outpatient services contained in section 16 of chapter 2000-256, Laws of Florida, was to be imposed upon each hospital, beginning on or after July 1, 2000.
- Exempts Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in Area 10, from having to participate in the separate specialty prepaid plan operated by the community-based lead agencies and requires the Agency for Health Care Administration to implement service delivery systems sufficient to meet the medical, developmental, behavioral and emotional needs of these children by July 1, 2008.
- Removes the current equal assignment process to managed care organizations and MediPass in Medicaid Service Areas 1 and 6 for persons who fail to make a choice.
- Requires the Agency for Health Care Administration to give priority consideration in Medicaid managed care enrollment to certain managed care plans until the providers reach 15,000 members per month.

B. Amendments:

None.