HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1411 Medicaid Managed Care Programs
SPONSOR(S): Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1508

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Healthcare Council		Quinn-Gato/ Massengale	Gormley
2) Policy & Budget Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1411 amends the current law related to the Medicaid Program by creating new, additional criteria for AHCA to consider when assigning Medicaid recipients to managed care plans pursuant to the mandatory assignment process and by modifying current reimbursement rates to hospitals by HMOs. In doing so, the bill requires AHCA to establish managed care network adequacy standards, in addition to quality of care standards, revises existing criteria, and creates new criteria upon which standards shall be based when making such assignments. Further, the bill creates monitoring and evaluation requirements for quality of care and network adequacy standards.

With regard to hospital reimbursement, the bill amends current law relating to AHCA's authority to enter into contracts with traditional providers of health care to low-income persons to provide technical assistance for development of prepaid health plans. The bill changes current law by providing that the authority to enter such contracts is subject to a specific appropriation and by removing any limitations on this provided for in chapter 216. Additionally, the bill authorizes AHCA to extend Medicaid eligibility for Medicaid recipients enrolled in "contracted managed care plans" for the duration of the enrollment period or 6 months, whichever is earlier, provided AHCA certifies that such an offer will not increase state expenditures. This modification would extend such requirements to exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Service network, and pediatric emergency department diversion programs in addition to HMOs. The bill defines the term "Medicaid rate" or "Medicaid reimbursement rate" as used in ss. 409.9122, 409.912(19), 409.9128(5)(d), and 641.513(6)(d), F.S., to mean that such rate shall be the equivalent to the amount paid directly to a hospital by AHCA for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis.

Further, the bill requires AHCA to include exemption payments and low-income pool payments in its calculation of the hospital inpatient component of a Medicaid HMOs' capitation rate for HMOs and all other managed care providers, and removes a provision that provided for an additional adjustment in calculating capitation payments to prepaid health plans.

Finally, the bill modifies the requirements for managed care plans' provision of emergency services and care by clarifying that managed care plans cannot deny "or withhold" payment for emergency services provided by hospitals without compliance with the notification requirements in s. 409.9128, F.S.

The additional cost of the extension of eligibility proposed in this legislation by the inclusion of those enrolled in other managed care plans could have a negative fiscal impact of $110,268,653 ($49.1 million state general revenue). AHCA reports, however, that it is unlikely the additional cost could be certified as required by law and this provision would not be implemented.

The effective date of the bill is July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

The bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

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. 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. For FY 2008-09, the Florida Medicaid Program is projected to cover over 2.25 million people[1] at an estimated cost of $15.8 billion.[2]

Medicaid Managed Care Programs In Non-Medicaid Reform Areas

The state of Florida operates its Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[3] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver further requires Florida Medicaid recipients to be given a choice of managed care providers. In non-reform areas, the Medicaid managed care program includes two major categories of providers: MediPass and managed care plans.[4]

MediPass

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and

[1] http://edr.state.fl.us/conferences/medicaid/medcases.pdf; viewed April 14, 2008.
[2] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf; viewed April 14, 2008.
[3] All Medicaid recipients in non-reform areas must be enrolled in MediPass or a managed care plan except those recipients who: (1) are only eligible for limited Medicaid under such programs as the Family Planning Waiver, Medically Needy or Qualified Medicaid Beneficiary; (2) reside in an ICF/DD, nursing facility, state mental hospital, or state operated residential program; (3) are dually eligible for both Medicare and Medicaid Programs; (4) are under 20 years old and enrolled in Children's Medical Services or attend a prescribed pediatric extended care center; (5) are under 17 years of age and are in a Sub-Acute Inpatient Psychiatric Program; (6) receive hospice services; and (7) are enrolled in a Medicare or private HMO or have other health insurance such as TRICARE. *See* s. 409.9122, F.S. and the 2007-2008 Medicaid Summary of Services at p. 18, located on April 14, 2008 at http://ahca.myflorida.com/Medicaid/pdffiles/SS_07_070701_SOS.pdf .
[4] In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized the Agency for Health Care Administration (AHCA) to seek and implement a federal waiver for a managed care pilot program. AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011. The pilot program administers all health care services through managed care organizations, reimbursed using actuarially based, risk-adjusted, capitated rates, which are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history.

referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $3 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

Managed Care Plans

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Enrollment in MediPass or Managed Care Plans By Medicaid Recipients

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of being determined eligible. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass.[5]

Medicaid Managed Care Payment and Reimbursement

The Florida Medicaid Program is also responsible for reimbursing Medicaid providers in accordance with Florida and federal law according to methodologies set forth in AHCA's rules and policy manuals and handbooks incorporated by reference therein, which may include fee schedules, reimbursement methods based upon cost reporting, negotiated fees, competitive bidding, and other effective mechanisms selected by AHCA for efficiency in purchasing goods and services for Medicaid recipients.[6] Reimbursement is subject to specific appropriation.[7]

Currently, the Florida Medicaid Program pays for services in three ways: fee-for-service reimbursement to health care providers with direct contract relationships with the Medicaid program (MediPass); capitated fee payment to certain managed care organizations (HMOs) which create provider networks by contract with health care providers and which bear full risk for the care of Medicaid recipients who enroll in the managed care organization; and fee-for-service reimbursement to certain managed care organizations (Provider Service Networks) which create provider networks by contract with health care providers and which must share any savings with the Medicaid program or pay Medicaid for lack of savings.

Medicaid uses a capitated payment model for HMOs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s. The HMOs are the provider type that account for the largest number of enrollees.

[5] Senate Bill Analysis and Fiscal Impact Statement for SB 1508 (2008).
[6] s. 409.908, F.S.
[7] *Id.*

Rates for HMOs are set using basic risk adjustment factors (age, sex, geographic location and eligibility group), but are not established by assessing recipients' clinical risk. Within certain limits, Medicaid enrollees can choose to receive care in either a managed care or fee-for-service setting.[8] However, recipients who do not make a choice are automatically enrolled in either managed care plans or fee-for-service Medicaid disproportionately to reach a ratio of 65 percent and 35 percent, respectively.[9]

AHCA is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[10] The methodology is established in rule[11] which is summarized as follows:

- The capitation payment is the fixed amount paid monthly by AHCA to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.
- AHCA uses 2 years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee for service program for the same service the HMO is responsible for delivering.
- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may affect fee-for service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates).
- After the adjustment for policy issues, AHCA applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 8 percent and varies by rate cell depending on the geographic region and eligibility category.
- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by the Centers for Medicare and Medicaid Services, AHCA will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

When capitation rates are calculated, AHCA includes all the costs for services that must be provided to HMO enrollees including hospitalization, physician visits, pharmacy, and others into a single per member per month payment to the health plan. No specific fund amounts are earmarked for any particular service provided through the Medicaid HMOs. It is at the discretion of the HMO how these funds are allocated within their network to provide services, as long as the needs of their enrollees are met.

Medicaid Managed Care Plan Network Adequacy Standards

AHCA currently reviews managed care plan provider networks on an ongoing, routine basis, including when an expansion is requested, when changes in the provider network status occur (primarily upon notice of providers leaving the network), on an ad hoc basis upon receipt of complaints or issues regarding plan network providers and the annual contract required on-site review. For each managed care plan, an enrollment capacity is determined by AHCA based on the number and types of health care providers contained within the plan's network. Managed care plans do not receive mandatory assignment if their enrollment capacity has been reached. The agency's determination process of enrollment capacity includes review and approval of managed care plan network capacity.

The managed care plan contracts include requirements that plans provide emergency, urgent and routine care, and appointments within specified time frames and within specific geographic access

[8] *See* s. 409.9122(2)(a), F.S.
[9] *See* s. 409.9122(2)(f),(k), F.S.
[10] s. 409.9124, F.S.
[11] 59G 8.100, F.A.C.

standards based on federal regulations.[12] Plan network capacity is based, in part, on the plan having an adequate number of providers in the network to meet these specific time frames with regard to emergent, urgent and routine care. Each contract provides for sanctions by AHCA, such as ceasing assignments and voluntary enrollments, if the plan has violated its contract with AHCA.[13]

Medicaid Managed Care Quality of Care Standards

Section 409.9122(2), F.S., provides that AHCA shall not enroll or assign eligible recipients to a managed care plan or MediPass, unless the plan or MediPass has complied with specified quality of care standards. For managed care plans, the quality of care standards are based upon, but not limited to:

- Compliance with the accreditation requirements as provided in s. 641.512, F.S.
- Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.
- The percentage of voluntary disenrollments.
- Immunization rates.
- Standards of the National Committee for Quality Assurance and other approved accrediting bodies.
- Recommendations of other authoritative bodies.
- Specific requirements of the Medicaid program, or standards designed to specifically assist the unique needs of Medicaid recipients.
- Compliance with the health quality improvement system as established by AHCA, which incorporates standards and guidelines developed by the Medicaid Bureau of the federal Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.[14]

AHCA requires managed care plans to collect and report data on patient outcome performance measures as defined by the Healthcare Effectiveness Data and Information Set, as well as performance measures on the required disease management programs for specified chronic conditions, and agency defined measures. Managed care plans also participate in annual provider satisfaction surveys that indicate quality of care, recipient access to services and overall satisfaction.[15]

Medicaid Exempt Rates for Hospitals

Medicaid participating hospitals are reimbursed at a daily rate (per-diem) that is calculated using a cost-based reimbursement methodology. To calculate the daily rate, the methodology uses each hospital's prior year costs inflated forward with a health care indexing inflation factor. However, there are factors within the methodology (called ceilings) that limit the growth in the calculated daily rate each year. Due to the ceilings, the final daily rate may not equal a hospital's actual cost of providing services.

To account for this difference, the Legislature has allowed certain hospitals to qualify for "exemptions" from the ceiling limitations. To qualify, a hospital's sum of charity care and Medicaid days as a percentage of adjusted patient days must equal or exceed 11 percent (7.3 percent if designated or are a provisional trauma center), or must be a Specialized Statutory Teaching and Community Hospital Education Program (CHEP) hospital. The exempt amount is equal to the difference between a hospital's actual daily cost and the final calculated daily rate that is limited by the

[12] *See* 42. CFR 438.206(b)(1-5) and (c)(1)
[13] Agency for Health Care Administration 2008 Bill Analysis and Economic Impact Statement.
[14] s. 409.9122(3)(a), F.S. MediPass quality standards include: (1) quality of care standards that are comparable to those required for managed care plans; (2) credentialing standards for MediPass providers; (3) compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements; (4) immunization rates; and (5) specific requirements of the Medicaid Program, or standards designed to specifically assist the unique needs of Medicaid recipients. *See* s. 409.9122(3)(b), F.S.
[15] *See* Florida Medicaid Managed Care Programs Quality Assessment and Improvement Strategies; located on April 14, 2008 at http://ahca.myflorida.com/Medicaid/quality_mc/pdfs/fl_medicaid_quality_assess_improve_strategies.pdf.

ceilings in the methodology. To pay for the exemptions, the state certifies local funds, or Intergovernmental Transfers (IGT's), as the state contribution in order to draw down federal matching funds. [16]

Emergency Care And Services Provided To Medicaid Recipients

Pursuant to s. 409.9128, F.S., if a MediPass or managed care plan enrollee receives hospital emergency care, neither the managed care plan nor the MediPass program can deny payment to the hospital based upon the enrollee's or hospital's failure to notify the managed care plan or MediPass program provider in advance or within a certain period of time after care was given.

Current law, s. 409.9128(5), F.S., provides that emergency care and service providers that are not under contract with a Medicaid managed care plan are reimbursed the lesser of:

- The provider's charges;
- The usual and customary provider charges for similar services in the community where the services were provided;
- The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or
- The Medicaid rate.

Effect of Proposed Changes

House Bill 1411 modifies the way in which AHCA currently administers the Medicaid Program by creating additional quality assurance standards that AHCA must consider when making mandatory assignments of eligible Medicaid beneficiaries, and modifying the way in which reimbursement rates for hospitals providing services to Medicaid recipients are reimbursed by managed care providers.

The bill amends s. 409.9122, F.S., with regard to the mandatory assignment of Medicaid recipients who fail to select a managed care plan or MediPass provider by, in addition to other requirements, requiring that AHCA take into account whether a managed care plan "maintains" sufficient network capacity to meet the need of the members and the managed care plan's performance and compliance with the network adequacy requirements when making mandatory assignment of eligible Medicaid recipients who have failed to select a managed care plan. Moreover, the bill adds additional criterion for AHCA to take into account whether a managed care plan has sufficient capacity to meet the urgent, emergency, acute, and chronic needs of its members and has consistently maintained compliance with the network adequacy requirements over the previous 12-month period when making assignments. Further, the bill requires AHCA to make mandatory assignments based upon the quality of service and performance of managed care plans, and adds the failure to maintain network adequacy requirements to the items that may provide AHCA with objective indication that access to primary care is being compromised, which gives rise to AHCA verifying patient load certifications

The bill provides that AHCA must establish network adequacy standards, in addition to quality-of-care standards, which will be monitored by AHCA quarterly and evaluated annually. These standards are to be established through contract, rule, and statute for urgent, emergency, acute, and chronic care. Additionally, AHCA is authorized to enter into contracts with traditional providers of health care to low-income persons to assist providers with developing prepaid health plans subject to a specific appropriation and any limitations in the General Appropriations Act. This removes a provision clarifying restrictions that exist in chapter 216 also apply to such contracts.

The bill further requires the provision of health care services by managed care plans and MediPass providers in a timely manner, and authorizes AHCA to extend Medicaid eligibility for Medicaid recipients enrolled in "contracted managed care plans" for the duration of the enrollment period or 6 months,

[16] Senate Bill Analysis and Fiscal Impact Statement for SB 1508 (2008).

whichever is earlier, provided AHCA certifies that such an offer will not increase state expenditures. Current law limits this requirement to licensed and accredited HMOs, not all managed care providers, which include exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Service network, and pediatric emergency department diversion programs in addition to HMOs.

The bill modifies the way in which hospitals are reimbursed by HMOs by providing that the terms "Medicaid rate" and "Medicaid reimbursement rate" for purposes of ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), F.S., is "equivalent to the amount paid directly to a hospital by the agency for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis," and requiring AHCA to include in its calculation of the hospital inpatient component of a Medicaid HMOs capitation rate any exemption payments and low-income pool payments, in addition to other special payments, such as upper payment limits, or disproportionate share payments, made to qualifying hospitals through the fee-for-service program. The bill makes identical changes to s. 409.9124, F.S., relating to managed care reimbursement. The bill also removes from s. 409.9124, F.S., a provision for additional adjustments in calculating the capitated payments to prepaid health plans. According to AHCA, the agency would have to seek a federal waiver in order to implement the requirement to include low-income pool payments in the hospital inpatient component of HMO capitated rates.

The bill also precludes managed care plans or MediPass providers from either denying or withholding payment based on an enrollee's or hospital's failure to notify the managed care plan or MediPass provider in advance or within a certain period of time after providing emergency services and care. Finally, the bill amends the current process for reimbursing providers of emergency care or services by managed care plans when the provider is not under contract with the managed care plan, by clarifying that the reimbursement rate is the lesser of the provider's "billed" charges and defining the Medicaid rate as the amount paid directly to a hospital by AHCA for providing inpatient and outpatient services to a Medicaid recipient on a fee-for-service basis.

The effective date of the bill is July 1, 2008.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.9122, F.S.; relating to mandatory Medicaid managed care enrollment; programs and procedures.

Section 2. Amends s. 409.9124, F.S.; relating to managed care reimbursement.

Section 3. Amends s. 409.9128, F.S.; relating to requirements for providing emergency services and care.

Section 4. Providing for an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals providing care to Medicaid recipients will likely see an increase in reimbursement payments if the bill passes.

D. FISCAL COMMENTS:

The bill directs AHCA to calculate the hospital inpatient component of a Medicaid health maintenance organization's capitation rate and include any special payments, including, but not limited to, upper payment limit, exemption payments, low income pool (LIP), or disproportionate share hospital (DSH) payments made to qualifying hospitals through the fee-for-service program. The current capitated rate development process includes rates based on legislative directions provided in the General Appropriations Act for each state fiscal year. The rate development is established in rule and statute (s. 409.9124, F.S). As of July 1, 2005, the hospital inpatient component of the managed care plan capitation rate includes the cost of exempting certain hospitals from reimbursement ceilings. Supplemental payments for DSH and LIP are paid separately from the per diems and are not currently included in the calculation of capitation rates.

AHCA notes that preliminary communications with the federal Centers for Medicare and Medicaid Services indicate that the inclusion of LIP payments in the HMO capitation methodology and payments would not be allowed. Per Special Terms and Conditions (STC) #91 of Florida's Medicaid Reform 1115 Waiver, the LIP program is designed to "ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations." According to STC #101, "Providers with access to the LIP and services funded from the LIP shall be known as the provider access system." The LIP is a $1.0 billion per year program, which operates pursuant to the Reform Waiver and as funded and authorized by the Legislature. Low income pool payments are made in quarterly payments, not through the claims based fee-for-service system. AHCA has also indicated that DSH payments would be viewed in a similar manner by the Centers for Medicare and Medicaid Services.

It is important to note that the state share of funding for the LIP and DSH payments come from IGTs or local government contributions. If LIP or DSH payments were included in capitation payments to HMOs, the IGT revenue that currently provides a large portion of the state share of LIP and DSH funding would likely not be available for capitated managed care payments. Including these payments in the HMO capitiation payments would require significant additional state general revenue funding if IGTs were not available to fund the increased costs for the capitation payments. The relationship between IGT funding and payments is not direct when services are provided through capitated managed care plans.

In addition, the bill allows AHCA to extend eligibility for Medicaid recipients enrolled in contracted managed care plans, not just contracted licensed health maintenance organizations, for the duration of the enrollment period or for 6 months, whichever is earlier, provided the agency will certify that such an offer will not increase state expenditures. While current law allows for the extension of eligibility for those enrolled in health maintenance organizations, the agency cannot certify that an extension to contracted managed care plans could be offered without a significant increase in state expenditures, and therefore the policy has not been adopted. The additional cost of the extension of eligibility proposed in this legislation by the inclusion of those enrolled in other managed care plans would be $110,268,653 ($49.1 million state funds). The AHCA reports that since it is unlikely the additional cost could be certified as required by law, this provision would not be implemented.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to AHCA, the proposed changes to s. 409.9122(8)(b), which delete the reference to chapter 216, may imply the sole authority to contract traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid health plans would be obtained through the General Appropriations Act. Moreover, by requiring a specific appropriation for managed care contracts could limit contracting to a specific budget line item rather than funding available to AHCA overall.

D. STATEMENT OF THE SPONSOR

Under Federal and State law, hospitals are required to evaluate and stabilize all patients presenting with emergency medical conditions without regard to payment or insurance status. When an HMO Medicaid subscriber presents in “an out of network” emergency room or when transferred to an “out of network” hospital for services unavailable in the transferring hospital, the payment level for services has developed into one of the most contentious issues in Florida health care. For emergency services and care Florida statutes provide that Medicaid HMO’s are to pay hospitals the “Medicaid rate”. However, the term Medicaid rate is not defined and this is where the problems lies.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES