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 Policy Committee

BILL:	SB 1570
INTRODUCER:	Senator Lynn
SUBJECT:	Medicaid Managed Care Pilot Program
DATE:	March 16, 2008 REVISED: 03/19/08

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Fav/4 amendments**
2.			HR	
3.			CF	
4.			HA	
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill substantially modifies the Medicaid reform managed care pilot program. The bill excludes persons with developmental disabilities, children found to be dependent pursuant to s. 39.01(14), F.S., persons with severe and persistent mental illness, and recipients who meet the institutional or "ICP" level of care required for Medicaid nursing home care or enrollment in a Medicaid home-based or community-based waiver from mandatory enrollment in the pilot program until the service delivery systems required in this bill have been developed and evaluated for a period of at least 1 year, and until the Legislature expressly authorizes their mandatory enrollment. The Agency for Health Care Administration (AHCA) must develop policies and procedures for identifying and notifying these individuals of the ability to not participate in the Medicaid reform pilot. The bill requires the AHCA to adopt rules to establish policies for case-by-case exclusion of individuals from mandatory enrollment if they are not included in the identified populations described above.

The bill requires additional types of information and data to be provided to a Medicaid recipient for the purpose of selecting a Medicaid reform plan, primarily associated with the plans' prescription drug benefits, as well as, the cost and utilization of all services provided by the plans.

The bill requires specialty service delivery systems to be developed within the Medicaid reform pilot for persons meeting Medicaid nursing home level-of-care requirements and for persons with severe and persistent mental illness sufficient to meet the medical, developmental, and emotional needs of these persons.

The bill directs the AHCA to require Medicaid reform plans, through their contracts and by rule, to continue to provide any current service being received by the recipient while any prior authorization process is being conducted.

The bill requires the AHCA to develop improvement benchmarks in the areas of health plan and system readiness, timely claims processing, implementation of a consolidated complaint-tracking system that has analytical capabilities for producing trending reports, and receipt and validations of encounter data, including paid and denied claims. The bill specifies that before the program may be expanded beyond the pilot project counties, the improvement benchmarks must be met and encounter data sufficient to conduct assessments of cost effectiveness and quality, and access to care must be available. The bill also requires future audits or evaluations of cost-effectiveness to examine indicators of cost-shifting, including, but not limited to, increases in emergency room admissions, incarceration rates, use of indigent drug program funds, outsourcing, and administrative costs.

The bill requires the AHCA to perform monthly audits of reports of reform plan provider networks by comparing them with enrollee handbooks for discrepancies and contacting a statistically significant sample of providers to ensure accuracy.

The bill requires Medicaid reform plans to allow an SSI-related recipient to select a specialist within the provider network to serve as his or her primary physician due to a recipient's particular health condition, if the specialist is willing to serve as the recipient's primary care physician.

This bill substantially amends s. 409.91211, F.S.

II. Present 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. The 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

[1] These mandatory services are codified in s. 409.905, F.S.

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 chapter 216, Florida Statutes.

For FY 2008-09, the Florida Medicaid Program is projected to cover 2.25 million people[3] at an estimated cost of $15.8 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 (PSNs), 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.), and the Medicaid reform pilot program is codified in s. 409.91211, F.S. The provisions of the law established a pilot program to be implemented in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties are required to select among a number of managed care plans and recipients are no longer eligible to select the MediPass program as a managed care option. Reform plans offer comprehensive, catastrophic and enhanced benefits which are allowed to vary within certain parameters from plan to plan. Medicaid recipients receive choice counseling to help them select among the plans.

Certain groups were excluded from mandatory participation in the reform pilot until specialty networks were developed to meet their needs. Specifically, the law prevented children with special health care needs, persons with developmental disabilities, and Medicaid-eligible children in foster care from being automatically enrolled into the managed care plans until the AHCA could approve plans to meet their special needs.[5] To date, only specialty plans serving children with special health care needs have been approved to provide services under the reform initiative.

The law requires the Medicaid reform pilot to be evaluated by the Office of Program Policy Analysis and Government Accountability (OPPAGA). Their report is to be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than June 30, 2008. Medicaid reform may not be expanded beyond the initial pilot counties without the express permission of the Legislature.

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[2] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 16, 2008).
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 16, 2008)
[5] Ss. 409.91211(3)(bb), 409.91211(3)(cc), and 409.91211(3)(dd), F.S.

Medicaid Reform Implementation

The Medicaid reform pilot project was implemented in Broward and Duval Counties in September 2006. Expansion into Baker, Clay, and Nassau Counties began in September 2007. There are currently ten HMOs and five PSNs serving eligible Medicaid recipients in Broward County, four HMOs and three PSNs serving eligible Medicaid recipients in Duval County, and one HMO and one PSN serving eligible Medicaid recipients in Baker, Clay, and Nassau Counties. As of January 2008, there were 195,230 persons enrolled in Medicaid reform plans in these five counties.

During the course of implementation, certain issues did arise causing problems for Medicaid recipients and providers. In September 2007, the Office of the Inspector General at the AHCA released a program review of the Medicaid reform pilot project.[6] While generally reporting that the AHCA staff made substantial progress in implementing the reform pilot with limited resources, the Office of Inspector General found there were programmatic and administrative issues which it recommended should be addressed before any additional expansion of the reform pilot. The following is list of some of the report's recommendations:

- Staff should be commended for their dedication and persistence in implementing the Medicaid Reform Pilot Project with few additional resources and within an extremely short timeframe.
- The agency should develop standardized policies and procedures describing how plans will be approved in the future. The policies should address such areas as plan approval steps, on-site visits, systems readiness testing, claims processing, encounter data readiness and provider network adequacy.
- Prior to further expansion, the agency should develop benchmarks for resolution of issues encountered to date in the areas of plan and systems readiness, timely claims processing, implementation of the consolidated complaint tracking system, and receipt and evaluation of valid encounter data. The agency should seek broad input from bureaus and area offices, in developing the benchmarks. Further expansion of Medicaid Reform should be delayed until such time as those improvement benchmarks are met and encounter data sufficient to conduct at least preliminary assessments of cost effectiveness is available.
- In future audits or evaluations of cost-effectiveness the agency should examine indicators of possible cost-shifting (e.g., increases in emergency room admissions, incarceration rates, use of indigent drug program funds) as well as outsourcing and administrative costs.
- The agency should continue efforts to adopt a consolidated, real-time complaint/issue tracking system with features needed to promote a coordinated response and analytical capabilities for producing trend reports. Include in the system a means to track indicators of inappropriate denial of care by health plans.
- The agency should develop plans to validate and utilize all available encounter data in evaluating access to care trends.
- The agency should pursue alternatives, such as a contract amendment, use of Choice Counselors and/or technological solutions to ensure beneficiaries have easy access to health plan preferred drug lists and pharmacy benefit information prior to choosing a health plan.

[6] http://ahca.myflorida.com/Executive/Inspector_General/docs/Program_Review_of_Medicaid_Reform_Pilot_Project.pdf (last visited on March 16, 2008).

- The agency should continue outreach and education activities with pharmacies and beneficiaries regarding the Enhanced Benefits Program and assess the feasibility of moving to a debit card system.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.91211, F.S., to exclude persons with developmental disabilities as defined by s. 393.063(9), F.S., children found to be dependent pursuant to s. 39.01(14), persons with severe and persistent mental illness, and recipients who meet the institutional or "ICP" level of care required for Medicaid nursing home care or enrollment in a Medicaid home-based or community-based waiver from mandatory enrollment in the pilot program until the service delivery systems required in this bill have been developed and evaluated for a period of at least 1 year and until the Legislature expressly authorizes their mandatory enrollment.

The bill requires additional information to be provided to a Medicaid recipient for the purpose of selecting a reform plan including: plan standards for granting services in excess of the plan's service caps; the plan's preferred drug lists, including listings of covered drugs according to the same therapeutic classification used in the agency's preferred drug list, and utilization review criteria for granting coverage of drugs not on the preferred drug list; and, information on the right to transitional coverage of services the recipient is receiving prior to enrollment in the plan.

The bill requires additional types of information and data to be collected by the AHCA's encounter data system relating to prescription drugs provided through the Medicaid reform plans and the cost and utilization of services under the plans, especially those related to the number of recipients exhausting benefits.

The bill expands the powers, duties, and responsibilities of the AHCA with respect to the pilot program to require AHCA to:

- Develop specialty service delivery systems within the Medicaid reform pilot for persons meeting Medicaid nursing home level-of-care requirements and for persons with severe and persistent mental illness sufficient to meet the medical, developmental, and emotional needs of these persons.
- Require Medicaid reform plans, through their contracts and by rule, to continue to provide any current service being received by the recipient while any prior authorization process is being conducted. These services must be continued at the current level until a notice is sent to the recipient and the recipient does not request a fair hearing or a hearing is requested and a decision affirms the adverse action.
- Have policies and procedures in place to identify and notify persons that are excluded from mandatory enrollment pursuant to subsection (1)(a), as amended.
- Adopt rules to establish policies for case-by-case exclusion of individuals from mandatory enrollment if they are not included in the identified populations described in subsection (1)(a), as amended.
- Develop improvement benchmarks in the areas of health plan and system readiness, timely claims processing, implementation of a consolidated complaint-tracking system that has analytical capabilities for producing trending reports, and receipt and validations of encounter data, including paid and denied claims. The bill specifies that before the program

may be expanded beyond the pilot project counties, the improvement benchmarks must be met and encounter data sufficient to conduct assessments of cost effectiveness and quality, and access to care must be available. The bill also requires future audits or evaluations of cost-effectiveness to examine indicators of cost-shifting, including, but not limited to, increases in emergency room admissions, incarceration rates, use of indigent drug program funds, outsourcing, and administrative costs.

- Perform monthly audits of reports of reform plan provider networks by comparing them with enrollee handbooks for discrepancies and contacting a statistically significant sample of providers to ensure accuracy.

The bill requires Medicaid reform plans to allow an SSI-related recipient to select a specialist within the provider network to serve as his or her primary physician due to a recipient's particular health condition, if the specialist is willing to serve as the recipient's primary care physician.

Section 2. Provides that the act takes effect on July 1, 2008.

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.

D. Other Constitutional Issues:

Lines 261 through 266 require the AHCA to establish policies by which exceptions to mandatory Medicaid reform enrollment may be made on a case-by-case basis. The bill authorizes the rules to include the specific criteria to be applied when making a determination regarding whether to exempt a recipient from mandatory enrollment. This provision gives unbridled discretion to the AHCA to determine the criteria. To the extent the bill does not provide sufficient guidelines to the AHCA, it raises the question of whether the bill provides adequate limitations and safeguards so that the Legislature's delegation to the AHCA is not a violation of Section 3, Article II of the Florida Constitution.

Under the nondelegation doctrine, the Florida Supreme Court struck down a former section of law respecting the power of the Board of Psychological Examiners to grant

certificates with the title "psychologist" and to determine the qualifications of applicants as unconstitutional in that it failed sufficiently to fix the standards to be applied and in effect delegated the application of the statute without sufficient limitations on the board's discretion.[7]

Section 3, Article II of the Florida Constitution provides that the powers of the state government shall be divided into legislative, executive, and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.

Under Article II, Section 3 of the Constitution, the Legislature "may not delegate the power to enact a law or the right to exercise unrestricted discretion in applying the law."[8] This prohibition, known as the nondelegation doctrine, requires that "fundamental and primary policy decisions . . . be made by members of the [L]egislature who are elected to perform those tasks, and [that the] administration of legislative programs must be pursuant to some minimal standards and guidelines ascertainable by reference to the enactment establishing the program."[9]

The Florida Supreme Court has acknowledged that "[w]here the Legislature makes the fundamental policy decision and delegates to some other body the task of implementing that policy under adequate safeguards, there is no violation of the [Delegation of Powers] doctrine."[10] "In other words, statutes granting power to the executive branch must clearly announce adequate standards to guide . . . in the execution of the powers delegated. The statute must so clearly define the power delegated that the [executive branch] is precluded from acting from whim, showing favoritism, or exercising unbridled discretion."[11]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

[7] See *Husband v. Cassel*, 130 So.2d 69 (1961).
[8] See *Bush v. Schiavo*, 885 So.2d 321 at 331 citing *Sims v. State*, 754 So.2d 657, 668 (Fla.2000).
[9] See *Bush v. Schiavo*, 885 So.2d 321 at 331 citing *Askew v. Cross Key Waterways*, 372 So.2d 913, 925 (Fla.1978).
[10] See *Askew v. Cross Key Waterways*, 372 So.2d 913 at 921 (Fla.1978).
[11] See *Bush v. Schiavo*, 885 So.2d 321 at 331 citing *Lewis v. Bank of Pasco County*, 346 So.2d 53, 55-56 (Fla.1976).

C. Government Sector Impact:

Agency for Health Care Administration

Choice Counseling Costs
This bill proposes excluding certain groups from mandatory assignment in the Medicaid reform pilot project. Because some of these groups do not have identifying information in the Florida Medicaid Management Information System (FMMIS), this will result in additional costs to the AHCA regarding collecting the data necessary to perform these exclusions and providing the information to recipients through the agency's choice counseling vendor. It also requires the provision of additional information to all recipients eligible for Medicaid reform prior to enrollment. In particular, the pharmacy and service level detail that would be required to be provided to recipients would require choice counseling staff with higher educational levels and an increase in customer service talk-time which would drive up vendor costs.

The additional material information that would have to be provided would also increase choice counseling costs. The promulgation of rules required by the proposed bill, increased oversight required relative to these excluded groups, and review of materials provided would all increase administrative costs to the agency relative to choice counseling.

Based on the above, the AHCA estimates that it would need to hire two pay grade (PG) 26 (Government Analyst II) positions for choice counseling. Additional vendor costs are estimated to total $218,000 per month, or $2,616,000 per year. These costs are based on the additional operational staff for the choice counseling call center and field choice counseling to include: 30 Call Center Choice Counselors, 3 Field Choice Counselors, 2 Supervisors, 2 Pharmacists, and 1 Advanced Registered Nurse Practitioner.

Encounter Data System Changes
This bill proposes significant changes to the existing Medicaid Encounter Data System (MEDS). The existing encounter database collects patient-level detail claim information from capitated entities (managed care plans) that have paid those claims. The information requested in the above language cannot be obtained from denied pharmacy encounters as there is no indicator on the standard transaction codes necessary to capture the plan's reason for denial (the AHCA uses these claims to establish disease states and for risk-adjustments of reform plan capitation rates). Therefore, it cannot be ascertained from the incoming encounter information whether the denial at the plan level was for preferred drug list limitations or capitation limit reasons.

If the agency were required to do this, it would increase workload and system processing costs and travel to health plans to determine the reason for denial. If this were the case, agency staffing needs would be one PG 26 (Government Analyst II), one PG 25 (Systems Project Consultant), and one PG 24 (Operations Review Specialist) for MEDS. The agency would also have to pay the fiscal agent to modify their system and process these additional encounters. These costs cannot be estimated at this time.

If instead, the agency handled this on a contract reporting basis (rather than encounter data submission), there would only be additional workload that would incur costs. The Bureau of Managed Health Care (BMHC) would require one PG 24 (Medical Health Care Program Analyst) and MEDS would require one PG 24 (Operations Review Specialist).

This bill also proposes additional encounter data analysis and evaluation of cost effectiveness. As part of the fiscal agent contract with EDS, Inc., there are requirements to develop benchmarks and validate encounter data; however, the current focus is on paid claims since denied claims are not collected. However, to perform the requirements of this bill, current staffing would need to be augmented for encounter data analysis. A PG 25 (Systems Project Consultant) for MEDS would be required to fill those encounter data analysis needs.

Health Plan Audits
This bill requires the Agency to perform monthly audits of health plan networks. This would create an additional workload on the Bureau of Health Systems Development (HSD) and BMHC. The additional staffing needs are as follows: one PG 24 (Medical Health Care Program Analyst) and one PG 23 (Database Analyst) for HSD, and one PG 21 (Government Operation Consultant) for BMHC.

Total Costs
Total staffing costs for the 11 new AHCA positions described above would be $740,571 for FY 2008-09 and $707,571 for FY 2009-10. In addition, $600,000 would be required for an amendment to the agency's contract with the University of Florida (UF), the agency's contracted evaluator for Medicaid reform, in order for UF to perform the detailed cost effectiveness evaluation.

Total fiscal impact for the AHCA in FY 2008-09 is estimated at $3,970,517 split between the General Revenue (GR) and Administrative Trust Fund (TF) as follows: $1,985,258 and $1,985,258, respectively. The second fiscal year (2009-10) impact is $3,337,517 with $1,668,758 from GR and $1,668,758 from the Administrative TF.

VI. Technical Deficiencies:

Page 1, line 3. There is a technical title deficiency. The reference in the title to the statute being amended is "s. 409.1211, F.S." The correct statutory reference is "s. 409.91211, F.S." The statutory reference is correct throughout the rest of the bill.

Page 2, line 42. The bill excludes persons with "severe and persistent mental illness" from being mandatorily enrolled in the reform pilot. The terms "severe" and "persistent mental illness" are not defined. It is unclear which conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR), published by the American Psychiatric Association, would be included within these terms and how acute a condition must be to exclude a person with a persistent mental illness.

VII. Related Issues:

Page 2, lines 40-50. This provision excludes a number of persons from being mandatorily enrolled in the Medicaid reform pilot until certain service delivery systems have been developed to meet their special needs, the systems have been evaluated for 1 year, and the Legislature expressly authorizes their mandatory enrollment. This raises three issues. First, the provision is unclear about what happens to individuals with these conditions if they are already enrolled in a reform plan. Are these individuals allowed to disenroll until these new systems have been developed, or does it only apply to new Medicaid recipients? Second, persons with these conditions cannot be required to enroll until the new systems have been evaluated for a period of 1 year. It is unclear how an evaluation can occur if there are no enrollees or if the only enrollees in the evaluation have enrolled on a voluntary basis (persons who voluntarily enroll will be more likely to report favorably). Finally, the Legislature must expressly authorize the AHCA to mandatorily enroll these four populations. This will require at least one, and as many as four, acts of the Legislature to include these populations in the future.

VIII. Additional Information:

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

None.

B. Amendments:

Barcode 032120 by Health Policy on March 19, 2008:
This technical amendment corrects an incorrect statutory reference in the title.

Barcode 874288 by Health Policy on March 19, 2008:
This amendment adds “children with special health care needs as defined by s. 391(2) or s. 391.029, F.S.,” to the list of groups that are excluded from the reform pilot until specialty networks are designed.

Barcode 956446 by Health Policy on March 19, 2008:
This amendment specifies that the AHCA must implement the reform pilot as amended to conform to this bill and strikes the goal of implementing reform by 2011.

Barcode 657392 by Health Policy on March 19, 2008:
This amendment replaces the undefined term “persons with severe and persistent mental illness” with “adults with serious mental illness as defined in s. 1912(c) of the Public Health Service Act.