HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7225 PCB SPCSEP 10-04 Medicaid
SPONSOR(S): Select Policy Council on Strategic & Economic Planning
TIED BILLS: HB 7223 **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Select Policy Council on Strategic & Economic Planning	15 Y, 1 N	Gormley	Bahl
1)				
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

House Bill 7225 conforms current law to the new provisions created in HB 7223 by repealing current provisions of law at specific landmarks when managed medical assistance, managed long-term care and managed long-term care for persons with developmental disabilities are implemented statewide; modifying duties of the Agency for Persons with Disabilities, the Department of Elderly Affairs and the Aging Resource Centers once the Medicaid managed long-term care and managed long-term care plans are implemented in each region; developing parts within Chapter 409, and repealing other outdated provisions.

The bill substantially rewrites the current Medicaid Reform statute – primarily modifying the format with several substantive changes. Most notably, the bill directs the Agency for Health Care Administration (AHCA) to seek an extension of the Section 1115 waiver no later than July 1, 2010, continue the pilot program in the existing five counties, and expand the pilot program to Miami-Dade County, with full implementation by June 30, 2011. Intergovernmental transfers in Miami-Dade County are protected and the Low Income Pool provisions remain unchanged. Additionally, recipients statewide may opt out of the Medicaid program and use their Medicaid financial assistance to pay for their share of cost in any employer sponsored health insurance plan or, upon federal approval, to pay for other insurance or related products providing access to health care services created pursuant to state law, such as Cover Florida plans, products in Florida's Health Choice Program or any state exchange.

HB 7225 makes several significant, immediate changes to Medicaid managed care by phasing in risk-adjusted rates for all managed care plans, requiring managed care plans statewide to report encounter data and information pertaining to medical loss ratios, and requiring managed care plans to provide enhanced benefits programs for recipients. The bill establishes reserve requirements for plans in order to fund enhanced benefits credits.

Provider service networks (PSNs) statewide may still remain fee-for-service for a limited period of time, but with a shared savings settlement. AHCA is required to conduct annual reconciliations to determine the amount of cost savings achieved by fee-for-service PSNs. PSNs are also authorized to provide comprehensive behavioral health care to Medicaid recipients.

The bill also makes immediate changes applicable to recipients who are dually eligible for both Medicare and Medicaid. The bill authorizes Medicare crossover- only providers to enroll in Medicaid for payment purposes only, authorizes AHCA to establish payments for Medicare Advantage Special Needs members who are also eligible for Medicaid and to develop a payments for Medicaid only covered services for which the state is responsible. The bill also provides certain regulatory relief to nursing homes so that they can prepare for the implementation of long-term care managed care.

Finally, the bill authorizes AHCA to designate plans or networks meeting specified requirements as medical homes. Medical home networks are given certain preferences in the statewide Medicaid managed care programs created in HB 7223.

The bill has a significant fiscal impact (see Fiscal Comments).

Except as otherwise provided, the bill is effective when HB 7223 or similar legislation is passed and becomes law.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid

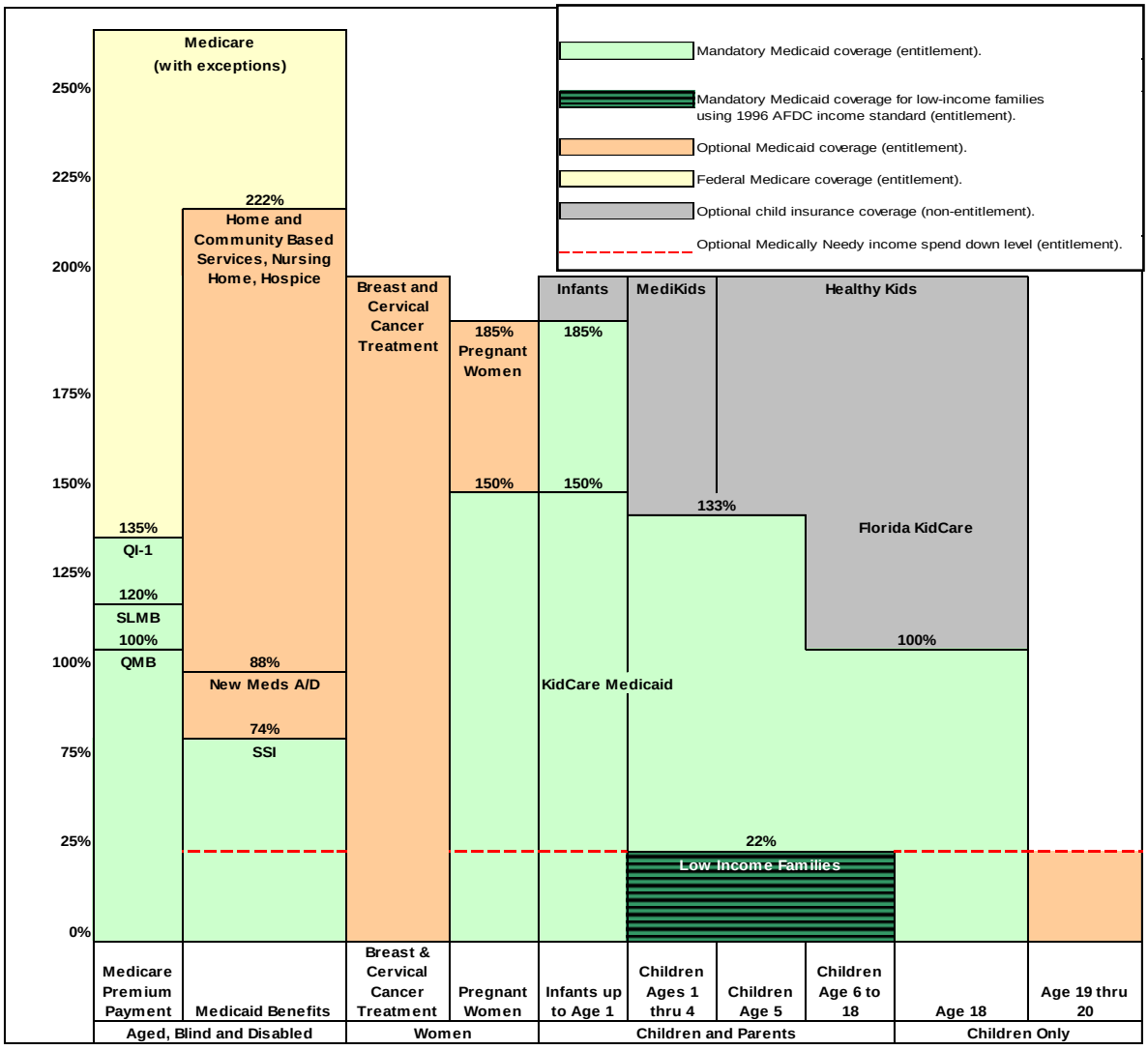
Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs. Key characteristics[1] of Florida's Medicaid program are as follows:

- 2.7 million enrolled recipients.
- $17.9 billion estimated spending in Fiscal Year 2009-2010.
- $6,625 estimated per recipient spending in Fiscal Year 2009-2010.
- 45 percent of all Medicaid expenditures cover:
  - Hospitals;
  - Nursing homes;
  - Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); and,
  - Low Income Pool and Disproportionate Share supplemental payments.
- 1.9 million of the 2.7 million recipients are enrolled in some type of managed care.
- Over 80,000 providers participate in Medicaid as fee-for-service providers
- 23 managed care organizations, which includes 16 HMOs and 7 PSNs.

The structure of each state's Medicaid program what states must pay for are largely determined by the federal government, as a condition of receiving federal funds. Federal law creates requirements for the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

[1] Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Medical Home Task Force, September 2009.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. In the chart below, the yellow and light green sections are mandatory populations by federal law. States can add eligibility groups, with federal approval. In the chart below, the orange sections show the groups Florida has added over the years. Once these optional groups are part of the Medicaid program the entitlement applies to them as well.



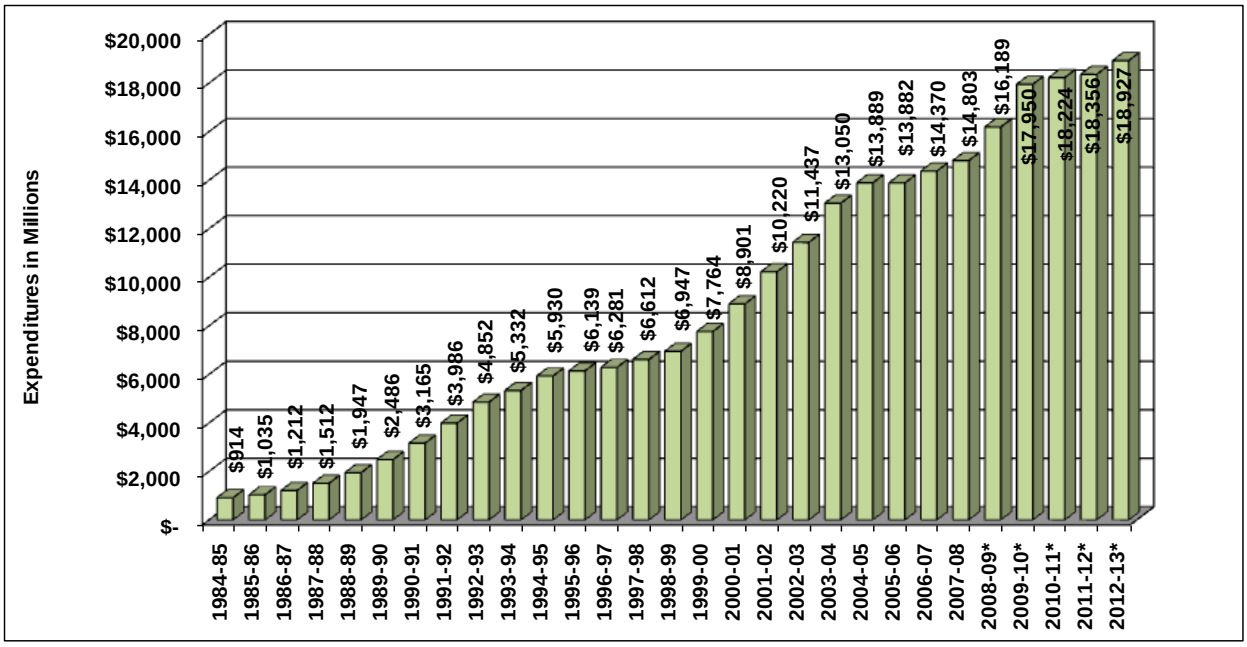
The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

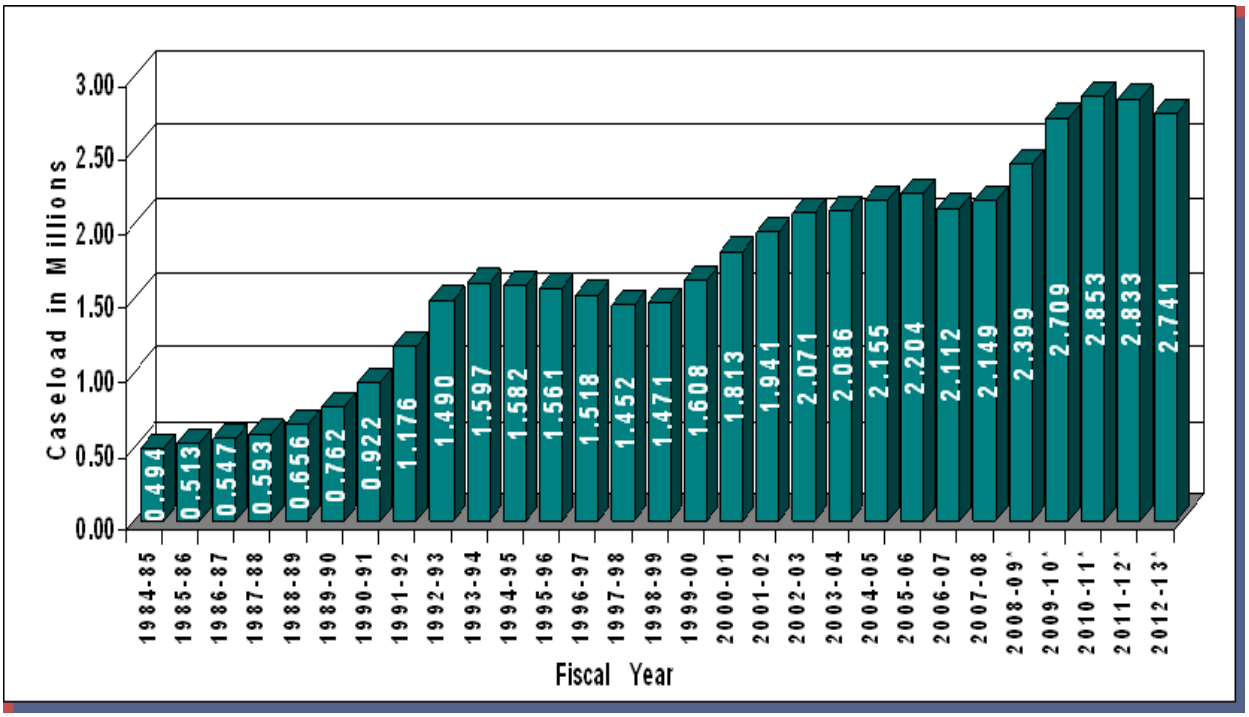
States do have some flexibility. States can ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has 20 separate waiver programs for distinct populations, services and service delivery models.

Florida Medicaid is the second largest single program in the state behind public education, representing 26.3 percent of the total FY 2009-10 budget. Medicaid general revenue expenditures represent 12.1 percent of the total General Revenue funds appropriated in FY 2009-10. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures.

[2] S. 409.905, F.S.
[3] S. 409.906, F.S.

Florida's Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. The growth in Florida's Medicaid population and expenditures is shown in the figures below.[4]





Current estimates indicate the program will cost $19.2 billion in FY 2010-2011. By FY 2013-2014, the estimated program cost is $22.1 billion. Florida has made numerous and repeated efforts to control costs in the program.[5] Since 1996, the Legislature has reduced $5.2 billion from the program through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives. For example, approximately 40 percent of the Medicaid prescription drug budget is funded by manufacturer rebates.

[4] *Supra*, note 1.
[5] *See,* Florida Medicaid Budget Reduction History, presented by staff of the House Health Care Appropriations Committee in the Select Council on Strategic and Economic Planning, October 7, 2009.

Medicaid and Federal Health Care Reform

The U.S. Congress spent the last year debating an extensive overhaul of the national health care system with particular focus on access to affordable coverage in the private market and a reorganization of public programs. On March 21, 2010, the House passed the Senate version of federal health care reform (H.R. 3590) and President Barak Obama signed the bill into law on March 23, 2010. Key policy areas of reform include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs. Several of these changes will affect the Florida Medicaid program.

Medicaid currently focuses on covering low-income children, pregnant women, and adults who are elderly or have a disability. The federal reform act increases the mandatory population to all adults, regardless of whether they are disabled or elderly, up to 133 percent of the poverty level. The reform law would finance the expansion by raising the federal match rate for the new groups. States would still have to pay a share for the new groups, but it would be smaller than for existing groups. However, the additional federal match is time-limited.

In addition, the federal reform law imposes a mandate on individuals to buy insurance, or pay a tax. Currently, many uninsured individuals are eligible for Medicaid coverage, but are not enrolled. The existence of the federal mandate to purchase insurance will result in many eligibles coming forward and enrolling in Medicaid who had not previously chosen to do so. While these eligibles are currently entitled to Medicaid coverage, their participation will result in increased costs and would not likely have occurred without the catalyst of the federal mandate.

Element	Senate Patient Protection and Affordable Care Act
Mandatory Expansion	Expand eligibility to 133% FPL ($29,326 for a family of 4), including non-disabled adults in 2014
FMAP/ Expansion	Enhanced federal matching funds for expansion population: • 100% CY 2014 • 100% CY 2015 • 100% CY 2016 • 57.44% + 34.3 = 91.74% CY 2017 • 57.44% + 33.3 = 90.74% CY 2018 • 57.44% + 32.3 = 89.74% in CY 2019 and beyond
FMAP/ Current Eligibility Level	Regular federal matching funds for current populations and currently non-enrolled eligibles (upon enrollment): 57.44%
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program in 2015
FMAP/ CHIP Transition	Enhanced FMAP for CHIP Population begins in 2013 (134% FPL and above) • October 2013 - 70.21% + 23.0 = 93.21%

The costs of federal reform to Florida Medicaid will be significant. Florida is expected to have over 708,000 new enrollees from the expanded federal reform population in 2014, at a cost of $2.8 billion (of which $150 million will be paid by the state), bringing the total cost of Medicaid that year to $24.9 billion.

By 2019, Florida Medicaid will have over 1.7 million additional enrollees, at an additional cost of over $7 billion (of which $1 billion will be paid by the state).[6] In subsequent years, the state share may increase.

Federal reform will create additional costs unrelated to caseload expansion. For example, the law increases the minimum federal rebate for brand drugs from 15.1 percent to 23.1 percent and requires that 100 percent of this portion of rebates be withheld by the federal government rather than the current procedure of sharing rebate revenue with the states. This provision will cost Florida approximately $33-$35 million annually at current levels. The current year impact will be a deficit in anticipated rebate general revenue of approximately $16,568,320. The FY 2010-2011 impact will be a loss in rebate general revenue of $34,893,412.11.[7]

Medicaid Managed Care

Florida, like most other states, turned to managed care for improving access to care, containing costs and enhancing quality. As of 2006, more than 65 percent of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models. Florida uses at least 16 different managed care models, including prepaid health plans (HMOs), primary care case management (MediPass)[8], provider service networks (PSNs)[9], minority physician networks[10] (MPNs), MediPass disease management, prepaid mental health plans, prepaid dental health plans and pediatric emergency room diversion[11].

The Florida Medicaid Program pays for services in three ways: (1) fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; (2) per-member, per-month payments to certain managed care organizations which bear full risk for recipient care; and (3) fee-for-service reimbursement to PSNs which must meet and share savings targets or reimburse the Medicaid program for failure to meet the target.

Medicaid uses a per-member, per-month, or capitated, payment model for Health Maintenance Organizations (HMOs), capitated PSNs, 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.

Rates for HMOs are set for specific demographic cohorts based on age, sex, geographic location and eligibility group. While these factors are linked with utilization patterns to some extent, they do not capture or reflect any detailed understanding of a person's clinical risk. The Medicaid reform pilot (see below) initiated a process for adjusting rates to reflect clinical risk. The adjustments were phased in over a three-year period with a 10 percent risk corridor to limit any dramatic changes in payment levels.

Medicaid uses fee-for-service reimbursement for PSNs, including MPNs. PSNs are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all

[6] Agency for Health Care Administration, Overview of National Reform Legislation, March 23, 2010.
[7] Agency for Health Care Administration, Impact of Patient Protection and Affordable Health Care Act, PPACA (P.L. 111-148) and changes made by the corrections measure through the Health Care and Education Reconciliation Act (H.R. 4872) approved by the House and Senate on March 25, 2010, March 31, 2010, on file with the Select Policy Council on Strategic & Economic Planning.
[8] MediPass is the Florida Medicaid primary care case management program. Services to MediPass members are reimbursed on a fee-for-service basis, and MediPass primary care providers (PCPs) are paid a $2.00 per member per month case management fee. PCPs are responsible for providing primary care and authorizing the specialty care provided to their enrollees. PCPs do not bear risk for their patients but do have requirements in place for case management, care coordination, and preventive care.
[9] S. 409.912(4)(d), F.S.
[10] Minority Physician Networks (MPNs) networks of primary care physicians predominantly owned by minorities. Services to MPN members are reimbursed on a fee-for-service basis, and primary care providers are paid a $2.00 per-member per-month case management fee. MPNs are also paid an administrative fee and may share in savings. MPNs bear limited financial risk as they must repay administrative fees if savings targets are not reached.
[11] 2009-2010 Florida Medicaid Summary of Services, Agency for Health Care Administration.

minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

Federal regulations require Medicaid beneficiaries to have a choice of managed care providers. This requirement may be satisfied with a choice of HMOs, or a choice between an HMO and MediPass, or a choice among MediPass providers. Upon enrollment in Medicaid, recipients have 30 days to exercise their choice of providers. Choice counseling is available during this period through a toll-free help line in non-reform counties. Those who select a managed care plan are enrolled for a 12-month period. After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next nine months. For those who do not make a choice, current law requires AHCA in non-reform counties to assign recipients "until an enrollment of 35 percent in MediPass and 65 percent in managed care plans" is achieved. The law further requires enrollment procedures to maintain this same proportionate distribution over time. After these considerations, assignment procedures may consider past choices of the participants.

Managed Behavioral Health Care in Florida

AHCA provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs. Florida began testing managed care models for providing mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration project in 1996 in the Tampa Bay area. The purpose of the demonstration was to create a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the initial demonstration project, Florida has continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the MediPass plan, both physical health and pharmacy benefits were paid for on a fee-for-service basis. For beneficiaries enrolled in a HMO, physical health and pharmacy benefits were paid for through a capitated arrangement.

State Plan services for mental health include:

- Inpatient psychiatric services
- Outpatient hospital services for covered diagnoses
- Community mental health services
- Mental health targeted case management
- Psychiatrist physician services

In 2005, with federal approval, Florida expanded managed care for mental health coverage under capitated Medicaid managed care plans throughout the state to serve Medicaid recipients not enrolled in HMOs. Current law requires Medicaid to competitively procure a single prepaid behavioral health plan in each AHCA area, with a few exceptions.[12] AHCA has competitively procured a single prepaid behavioral health plan in each non-reform AHCA area. Those single plans currently exist in each AHCA area, with some exceptions and variances.[13] In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (*see* "Managed Behavioral Health Care in Florida" above).[14] Instead, when a PSN enrollee requires

[12] s. 409.912(4)(b), F.S.

[13] In AHCA Area 11, AHCA contracts with several managed care organizations. While many of these organizations provide comprehensive health care that includes physical and behavioral health, there are two prepaid mental health plans that provide comprehensive behavioral health care. One of the prepaid mental health plans is a public hospital-operated PSN providing behavioral health services to a minimum of 50,000 MediPass and PSN recipients. Initially, in AHCA Area 6, the comprehensive behavioral health providers already under contract with AHCA were used and their contracts were later amended to include substance abuse treatment services. For children enrolled in Home SafeNet, Florida Safe Families Network comprehensive behavioral health services are provided through a specialty prepaid plan operated by a community based lead agency pursuant to s. 409.912(8), F.S.

[14] s. 409.912(4)(b); Medicaid 2009-2010 Summary of Services.

comprehensive behavioral health care[15], enrollees are referred by the PSN to a prepaid behavioral health plan for services.

Medical Homes

The term "medical home" was first coined by the American Academy of Pediatrics in 1967. A medical home is a patient-centered model of care that provides a home base—a personal health care professional, usually a physician, who coordinates and facilitates access to medical care. The personal provider is the patient's first contact as well as his continuing contact throughout the delivery of a comprehensive range of services. Medical homes are characterized by use of health information technology, the coordination of specialty and inpatient care, preventive services, disease management, behavioral health care, patient education, and the diagnosis and treatment of acute illness. A variety of studies have validated the model and indicated that this approach to services results in lower hospitalization rates, lower rates of death for heart disease, cancer and stroke, and reduced rates of medical errors. The model is supported by the American Academy of Family Physicians and the American College of Physicians. The National Committee for Quality Assurance (NCQA) released standards in January 2008 for patient-centered medical homes.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized 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 five-year waiver expires June 30, 2011, unless renewed by AHCA.[16]

Reform is characterized by:

- A managed, coordinated system of care
- Choices and new options for recipients:
  - Different managed care plans, which can offer additional and varying benefits
  - Different models of managed care - between a traditional HMO model and a new provider-based model
  - Opt-out – Opportunity to use Medicaid dollars to purchase employer-based insurance
  - Enhanced benefits - Opportunities to be rewarded for healthy behaviors
- Financing: actuarially sound, risk-adjusted, capitated premiums based on encounter data, with comprehensive and catastrophic components.
- Low-Income Pool

Provider Service Networks

Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements. PSNs are networks owned and operated by providers to deliver comprehensive health care to their enrolled population. By statute, providers in PSNs must have a controlling interest in the governing body of the PSN, and may make arrangements with physicians or other health care professionals, health institutions, or any combination thereof, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians, by other health professionals, or through the institutions.[17]

[15] "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.

[16] According to AHCA, it must submit the renewal request by June 30, 2010. The federal Centers for Medicare and Medicaid Services must approve or deny the request within six months of receiving it.

[17] S. 409.912(4)(d), F.S.

In Medicaid reform counties, PSNs may be paid one of two ways: PSNs may receive the capitated, risk-adjusted payment used by the HMOs; or, for the first three years and at the PSN's option, PSNs may be reimbursed on a fee-for-service basis which includes the savings reconciliation element required for non-reform areas.[18] In Medicaid reform, current law requires all managed care organizations to bear risk; however, PSNs may choose to be reimbursed on a fee-for-service basis, with a savings settlement mechanism consistent with non-reform requirements. The ability for PSNs to be reimbursed on a fee-for-service basis was originally intended to apply to the first three years of reform; however, the deadline was subsequently extended to 2011.[19]

In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (see "Managed Behavioral Health Care in Florida" above).[20] Instead, when a PSN enrollee requires comprehensive behavioral health care[21], enrollees are referred by the PSN to a prepaid behavioral health plan for services.

Under Medicaid reform, PSNs participate as managed care organizations in the pilot counties and compete with HMOs for recipient enrollment. PSNs may choose to be reimbursed on a fee-for-service basis or on a risk-adjusted capitated basis for the initial three years of the program, and then must convert to risk-adjusted capitated methodology used by HMOs in reform at the end of the third year of operation.[22]

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,[23] and the fully risk-adjusted payment methodology of reformed Medicaid will create the ability to adequately compensate and incentivize the development of these and other specialty PSNs. The 1115 Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services mandates that the State review and approve specialty plans pursuant to criteria that includes the appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population.

The five-year Medicaid Reform Waiver will expire in October, 2011.

Risk-Adjusted Rates

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially sound, risk-adjusted, capitated rates.

Risk-adjusted rates 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. The current risk adjustment methodology relies on claims data for prescription drug use. In the future, encounter data will provide the clinical history for managed care enrollees. Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs. Similarly, clinical risk adjustment creates opportunity for innovative managed care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

[18] S. 409.91211(3)(e), F.S.
[19] Section 409.91211(3)(e), F.S.
[20] *See* s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, *available at* http://ahca.myflorida.com/Medicaid/pdffiles/SS_07_070701_SOS.pdf.
[21] "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.
[22] S. 409.91211(3)(e), F.S.
[23] S. 409.91211(3)(bb)-(dd), F.S.

Encounter Data

Prior to reform, Florida law did not require Medicaid managed care plans to report patient diagnosis and service information, or encounter data, about their recipients. For the first time in Medicaid, reform requires at-risk plans to report encounter data, for use in evaluating plan quality and in setting risk-adjusted rates, and set a three-year process for establishing the new system.[24] AHCA created the Medical Encounter Data System (MEDS) to track this information. Both the plans and AHCA encountered difficulties in generating, reporting, and receiving the encounter data. However, all historical encounter data was received by AHCA by the end of 2009, and plans are continuing to submit current data. AHCA is reviewing and validating the data to ensure completeness and accuracy, and expects to be able to use the encounter data as part of the rate-setting process for FY 2010-2011.

Plan Choice and Opt Out Program

Upon enrollment in Medicaid, recipients in reform counties have 30 days to voluntarily select a managed care plan. For those who do not make a choice, current law requires AHCA to assign the recipient to a plan "based on the assessed needs of the recipient as determined by the agency." In making such assignments, the agency must take into account several factors: the plan's network capacity; a prior relationship between the recipient and the plan or one of the plan's primary care providers; the recipient's preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.[25] Recipients in reform counties may receive choice counseling through telephone, face-to-face counseling, mailings and outreach activities.

Evaluation by the University of Florida found the most common bases for recipient plan choice are primary care physicians in the network, and the prescription drugs covered by the plan.[26] Voluntary plan choice (as opposed to automatic assignment by AHCA) has increased.

Making Medicaid premiums available to help recipients purchase private insurance is a key component of Medicaid reform. The reform waiver allows recipients with access to employer-sponsored insurance to use their Medicaid dollars to purchase coverage through the employer. While few recipients currently use the Opt Out program, those who do are highly satisfied.

Customized Benefits

Reform allows plans to design vary the amount, duration and scope of benefits to develop customized benefit packages for the general population or to meet the needs of specific groups. A variety of plan choices allows recipients to select a plan that best meets their needs. The customized plans must provide coverage for all mandatory and optional services required by plan enrollees, and may cover services not traditionally covered by Medicaid. As a result of this flexibility, reform plans have expanded certain services above current levels and have added services not currently covered.

Enhanced Benefits

Personal responsibility for health is a primary goal of Medicaid reform. Medicaid reform creates a flexible approach to meeting those needs within comprehensive systems of care that compete to improve the health of Medicaid recipients. AHCA establishes a list of activities for which recipients can earn credits. Recipients can spend their funds at community pharmacies on health care products and supplies, such as over-the-counter medication, vitamins, diapers, and first aid supplies. Recipient can save their credits for larger purchases.

For example, recipients can earn enhanced benefits with preventive health care visits like child dental and vision checkups, and participation in exercise programs, disease management programs, and

[24] In the interim, risk-adjusted rates in reform are achieved using clinical data from recipient pharmacy records.
[25] S. 409.91211(4)(a), F.S.
[26] Florida Medicaid Reform Quarterly Progress Report April 1, 2009 – June 30, 2009, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).

smoking cessation programs. In FY 2009-2010, over 82,000 recipients in reform earned and spent over $3 million in enhanced benefits.

Low Income Pool

The terms and conditions of the Medicaid reform waiver created a Low Income Pool (LIP) to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. Based on the waiver, Florida was able to increase these payments to hospitals and other providers by approximately $250 million. The federal waiver sets a capped annual allotment of $1 billion for each year of the 5-year demonstration period for the LIP.[27] The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

Florida law provides that distribution of the Low-Income Pool funds should:[28]

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

In 2009, $1 billion in LIP payments were made to hospitals and other providers. The LIP expires in 2011, unless renewed.

Reform Objectives

Reform has five objectives:

1. To ensure there is an increase in the number of plans from which an individual may choose and an increase in the different type of plans.
2. To ensure that there is access to services not previously covered and improved access to specialists.
3. To improve enrollee outcomes.
4. Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).
5. To ensure that patient satisfaction increases.

[27] Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration, at 24.
[28] S. 409.91211(c), F.S.

Reform met the first objective. Pre-reform, AHCA contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, and two MPNs, for a total of twelve managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. AHCA currently has contracts with nine HMOs and five PSNs for a total of fourteen health plans in Broward County; and four HMOs and three PSNs for at total of seven health plans in Duval County.

Reform met the second objective. By allowing plans to customize their benefit designs, and by making recipient choice the driving factor of plan enrollment, reform encouraged plans to offer new and additional services at no extra cost to the state. Currently, plans offer several services not previously covered:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult preventive dental care;
- Acupuncture;
- Additional adult vision services - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional hearing services – up to $500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition therapy.

Reform is meeting the second objective. The figure below shows the Year One data on the numbers of certain specialists in Duval County pre- and post-reform, compared to national adequacy standards. After factoring in estimates of need for each specialty, AHCA concluded that access to care for the five identified specialties in Duval County either improved under reform or is more than adequate to meet recipient needs based on national benchmarks.

Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

	Pre-Reform (June 2006)						Post-Reform (June 2007)		Adequacy Benchmarks	
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	Specs per 100K	Health Plan Count	Specs per 100K	Estimate of Need per 100k (Low)	Estimate of Need per 100k (High)
Pain Mgmt	2	4.9	143	351.3	145	**178.1**	58	**84.0**	**1.2**	**10.6**
Dermatology	3	7.4	3	7.4	6	**7.4**	9	**13.0**	**0.7**	**2.9**
Neurology	21	51.6	44	108.1	54	**66.3**	67	**97.0**	**1.2**	**3.4**
Orthopedics	32	78.6	31	76.2	48	**58.9**	64	**92.7**	**1.5**	**7.7**
General Dentistry	14	34.4	32	78.6	45	**55.3**	31	**44.9**	**17.5**	**30.8**
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

AHCA conducts quarterly network validation surveys to confirm that plans have active contracts with providers - particularly primary care physicians and specialists. The two most recent (2009) surveys found 99 percent and 100 percent of the providers listed by plans actually had contracts with them.[29] These efforts resulted in the discovery that plans did not consistently maintain up-to-date provider files.

For Objective 3, AHCA measured enrollee outcomes based on national standards developed by the National Committee for Quality Assurance.[30] The Healthcare Effectiveness Data Information Set (HEDIS) is a tool used to measure health plan performance in patient care and service. The HEDIS allows policy-makers to compare varying plans with a standard measure. The most recent results for reform plans indicate that more reform plans than non-reform plans exceed the national mean in HEDIS measures. The shaded areas in the table below indicate mean-exceeding measures.

[29] Florida Medicaid Reform Year 3 Annual Report July 1, 2008 – June 30, 2009, Agency for Health Care Administration, *available at* http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).
[30] *See*, National Committee for Quality Assurance, http://www.ncqa.org/tabid/675/Default.aspx.

	Non-Reform			Reform			
Measure	2008	2009	Difference	2008	2009	Difference	National Mean
Annual Dental Visit	n/a	n/a	n/a	15.2%	28.5%	13.3%	42.5%
Adolescent Well-Care	41.9%	**46.0%**	4.1%	**44.2%**	**46.5%**	2.3%	43.6%
Controlling Blood Pressure	52.7%	51.6%	-1.1%	46.3%	**55.9%**	9.6%	52.9%
Cervical Cancer Screening	56.6%	53.8%	-2.8%	48.2%	52.2%	4.0%	65.7%
Diabetes – HbA1c Testing	74.7%	75.1%	0.4%	**78.9%**	**80.1%**	1.2%	78.0%
Diabetes - HbA1c Poor Control INVERSE	48.5%	51.7%	3.2%	**48.3%**	**46.8%**	-1.5%	48.7%
Diabetes - Eye Exam	36.3%	41.9%	5.6%	35.7%	44.0%	8.3%	51.4%
Diabetes - LDL Screening	**75.6%**	**76.3%**	0.7%	**80.0%**	**80.2%**	0.2%	71.1%
Diabetes - LDL Control	29.5%	29.4%	-0.1%	29.3%	**35.9%**	6.6%	30.6%
Diabetes – Nephropathy	**77.1%**	**76.1%**	-1.0%	**79.2%**	**80.3%**	1.1%	74.6%
Follow-Up after Mental Health Hospital – 7 day	30.5%	37.2%	6.6%	20.6%	29.3%	8.7%	39.1%
Follow-Up after Mental Health Hospital – 30 day	47.0%	51.7%	4.8%	35.5%	46.6%	11.1%	57.7%
Prenatal Care	71.7%	69.1%	-2.6%	66.6%	67.4%	0.8%	81.2%
Postpartum Care	58.5%	50.1%	-8.4%	53.0%	51.5%	-1.5%	59.1%
Well-Child First 15 Months – Zero Visits INVERSE	**2.8%**	**3.0%**	0.2%	4.9%	**1.6%**	-3.3%	3.8%
Well-Child First 15 Months – Six Visits	44.0%	51.0%	7.0%	44.4%	49.3%	4.9%	55.6%
Well-Child 3-6 years	**71.1%**	**72.5%**	1.5%	**71.3%**	**75.7%**	4.4%	66.8%
Adults' Access to Preventive Care – 20-44 Years	n/a	69.3%	n/a	n/a	71.8%	n/a	76.8%
Adults' Access to Preventive Care – 45-64 Years	n/a	82.2%	n/a	n/a	**84.7%**	n/a	82.4%
Adults' Access to Preventive Care – 65+ Years	n/a	**74.7%**	n/a	n/a	**83.6%**	n/a	78.8%
Antidepressant Medication Mgmt – Acute	n/a	**45.6%**	n/a	n/a	**52.0%**	n/a	42.8%
Antidepressant Medication Mgmt -- Continuation	n/a	**31.2%**	n/a	n/a	**29.8%**	n/a	27.4%
Appropriate Medications for Asthma	n/a	**87.0%**	n/a	n/a	83.6%	n/a	86.9%
Breast Cancer Screening	n/a	47.5%	n/a	n/a	**51.4%**	n/a	50.0%
Childhood Immunization Combo 2	n/a	61.8%	n/a	n/a	63.6%	n/a	72.3%
Childhood Immunization Combo 3	n/a	52.0%	n/a	n/a	53.8%	n/a	65.6%
Frequency of Prenatal Care	n/a	51.6%	n/a	n/a	52.6%	n/a	59.3%
Lead Screening	n/a	46.0%	n/a	n/a	54.8%	n/a	61.5%

For Objective 4, AHCA established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. Since 2006, 61 individuals have enrolled in the Opt Out Program. Of those, 40 individuals have disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance. In 2009, there were 21 individuals enrolled in the Opt Out Program. AHCA analysis indicates recipients choose the Opt Out Program because the desired primary care physician was not enrolled with a Medicaid Reform health plan or recipients elected to use the Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.[31]

[31] Florida Medicaid Reform Year 3 Annual Report July 1, 2008 – June 30, 2009, Agency for Health Care Administration, *available at* http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).

For Objective 5, AHCA contracted with the University of Florida to measure recipient satisfaction. The most recent report[32] indicates satisfaction was generally high. Most enrollees in Broward and Duval Counties indicated:

- It was "not a problem" to get a doctor or a nurse they were happy with;
- They communicate will with their providers;
- They chose their health plan; and
- Their overall satisfaction rating was at the highest level (9 or 10).

Approximately 85 percent of surveyed recipients said it was not difficult to get an appointment with a physician, and about 50 percent said it was easy to get an appointment with a specialist. Ratings by enrollees in rural counties (Baker, Clay and Nassau) were similar to those in Broward and Duval. Generally, there were no statistically significant differences between patient satisfaction pre- and post-reform, with a couple of exceptions in Broward County.

In addition to the five objectives, Medicaid reform was intended to reduce the rate of growth to a more sustainable rate and improve the financial predictability of the program in the long term. In the most recent fiscal evaluation report by the University of Florida, researchers reported that expenditures have been reduced by shifting patients from unmanaged, fee-for-service care to managed care.[33] Expenditures in Broward and Duval Counties were lower (on a per-member, per-month basis) in the first two years of reform than they would have been in those counties without reform.

Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) is responsible for providing services to persons with developmental disabilities.[34] A developmental disability is defined in chapter 393, F.S., as "a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely."[35] Children who are at high risk of having a developmental disability and are between the ages of 3 and 5 are also eligible for services.[36]

Services to Persons with Developmental Disabilities

APD provides an array of home and community based services through contract providers, as well as services in Developmental Disabilities Centers and Forensic program services. APD administers home and community based services through 14 area offices that are responsible for day to day operations. As of January 2010, APD was serving 53,216 persons in all programs.[37]

Four-Tier Medicaid Waiver System

The 2007 Legislature directed APD to establish a four-tier waiver system to replace the current waiver program. APD currently serves 29,903[38] people in the Medicaid waiver tier system and has a waitlist of over 18,800[39] people for the program. Each of the tier waivers target a specific group of people with certain needs. Three of the four tier waivers have caps on annual expenditures per person and one of

[32] Duncan, Paul, et al. Medicaid Reform Enrollee Satisfaction Year One Follow-On Survey, March 20, 2009, Department of Health Services Research, Management and Policy, University of Florida, *available at* http://mre.phhp.ufl.edu/publications/ (last viewed April 8, 2010).
[33] Duncan, Paul, et al. An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration, Department of Health Services Research, Management and Policy, University of Florida, June 2009, *available at* http://mre.phhp.ufl.edu/publications/ (last viewed April 8, 2010)
[34] s. 20.197(3),F.S.
[35] s. 393.063(9), F.S.
[36] "High-risk child" is defined in s. 393.063(19) F.S.
[37] Email from Susan Chen, APD, dated 2-5-10, on file with House Health Care Services Policy Committee.
[38] Tier Waiver Enrollment Summary by Year and Month, December 2009.
[39] APD Quarterly Report to the Legislature on Agency Services, February 2010

the tier waivers has no cap and is reserved for individuals with the most intense needs.[40] The purpose of the tier system is to create a predictable spending model for the program and help control over utilization of services which has lead to significant program deficits in recent years. APD has had some success in controlling spending through the implementation of the Medicaid waiver tier legislation. When the tier legislation was passed, APD was projecting a deficit of over $150 million for FY 2007-2008. This deficit was reduced to $12 million for FY 2007-2008, in part by the implementing tier caps and other legislative actions.[41] As the result of litigation, delays have occurred in fully implementing the tiers; 5,500 people in the waiver program requested hearings on their tier assignments. This, in effect, freezes their current services and cost to the program until their hearing outcome is decided. This delay in assigning people to tiers has partially resulted in continued deficits in the waiver program including a $26.7 million deficit for FY 2008-2009 and projected deficit of $36 million for the current year.

Long-term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients though nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution.

Home and Community Based services are provided through six Medicaid Waiver programs and one State Plan administered by the Department of Elder Affairs in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers[42] and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care.

These waivers and the state program are described below.

Waiver	Population	Enrolled[43]	Services	Area
Adult Day Health Care[44] (2004)	Adults age 75 years or older with functional or cognitive impairments and live with a caregiver	33	Intake and assessment, case management and other direct care services such as transportation, medication management, rehabilitation and services which allow frail elders to remain in their home or community instead of going to a nursing facility.	Palm Beach, Lee
Aged and Disabled Adult (1982)	• Frail adults over age 60 or older • Adults with disabilities ages 18-59 • Adults over age 20 who age out of Children's Medical Services	9,656	Adult companion, attendant care, caregiver training, case management, consumable medical supplies and others.	Statewide
Alzheimer's Disease[45] (2005)	Medicaid eligible adults age 60 or older with a diagnosis of Alzheimer's disease who meet Nursing Home Level of Care and live with a caregiver in a private residence	273	Adult day health care, behavioral assessment and intervention, caregiver training, incontinence supplies, personal care, respite care, wanderer alarm systems, wanderer identification and location programs and other services.	Broward, Miami-Dade, Palm Beach, Pinellas
Assisted Living for the Frail	Frail elders age 65 or older or disabled elders age 60 to 64 who reside in Assisted Living Facilities	2,650	Attendant call system, attendant care, behavior management, case management, companion services, intermittent nursing, medication	Statewide

[40] s. 393.0661(3), F.S.
[41] APD Medicaid Expenditure ,Social Services Estimating Conference, January 29, 2010
[42] Area Agencies on Aging (AAAs) are designated private not-for-profit local entities that are responsible for the planning, coordination and distribution of funds for services to elders
[43] 2009-2010 Florida Medicaid Summary of Services; *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 10-10, January 2010, Office of Program Policy Analysis & Governmental Accountability
[44] This waiver includes the Consumer-Directed Care Plus (CDC+) Program. The CDC+ program allows participants to hire workers and vendors of their own choosing to help with daily needs such as housecleaning, cooking, and getting dressed. The program offers consultants to help individuals manage their budgets and make decisions. See, *Summary of Programs & Services*, Department of Elderly Affairs.
[45] S. 430.502(9), F.S., provides that the Alzheimer's Disease Waiver will expire on April 30, 2010. The Department of Elderly Affairs is transitioning enrollees into other waivers. Contained in correspondence on file with the Elder & Family Services Policy Committee from the Department of Elderly Affairs.

Waiver	Population	Enrolled[43]	Services	Area
Elderly (1995)			administration, therapeutic social and recreational activities and other services.	
Channeling (1985)	Frail elders age 65 or older	1,489	Adult day health care, adult companion, case management, chore services, family training, financial assessment, personal care, respite care, special drug and nutritional assessment, home delivered meals, medical equipment and supplies, therapies and other services	Miami-Dade Broward
Nursing Home Diversion Program (1998)	Frail elders age 65 or older at risk for nursing home placement	16,500	Under this program, applicants can choose to continue living in their own homes or a community setting such as an assisted living facility. Coordinated acute and long-term care services to frail elders in the community, including acute medical services such as dental, community mental health, inpatient hospital, outpatient hospital emergency, physicians and prescribed drugs and long-term care community services such as adult companion, assisted living, case management, chore, family training, home health care, nutritional assessment, personal emergency response system, nursing facility services, therapies and other services.	33 counties; authorized to expand to 27 additional counties
PACE - All-Inclusive Care for the Elderly (2002)	Medicaid and Medicare eligible adults age 54 or older who qualify for nursing home care and live in a PACE service area *State plan service; not a waiver program	550	Managed care program providing a comprehensive range of medical and home and community-based services adult day health care, home care, prescription drugs, nursing home and inpatient care	Miami-Dade, Lee

Aging Resource Centers

The 2004 Legislature created the Aging Resource Center[46] initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed the Department of Elder Affairs to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers. The legislation required each area agency to transition to an Aging Resource Center by taking on additional responsibilities, while at the same time maintaining its identity as a local area agency on aging. All 11 area agencies on aging are now functioning as Aging Resource Centers. The Aging Resource Centers are to perform eight primary functions that are intended to improve the elder services system:[47]

- Increase access to elder services;
- Provide more centralized and uniform information and referral;
- Increase screening of elders for services;
- Improve triaging and prioritizing of elders for services;
- Streamline Medicaid eligibility determination;
- Improve long-term care options counseling;
- Enhance fiscal control and management of programs; and
- Increase quality assurance.

Certificate of Need for Nursing Homes

The certificate of need (CON) is a regulatory review process administered by AHCA which requires specified health care providers to obtain prior authorization before offering certain new or expanded services or making major capital expenditures. A "Certificate of Need" is defined as: "…a written

[46] Section 8, Chapter 2004-386, Laws of Florida.
[47] s. 430.2053 (5), F.S.

statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice."

Florida's CON program has been in operation since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria. Each state was required to have a CON program in compliance with those standards as a condition for obtaining federal funds for health programs. The federal health planning legislation was repealed in 1986.

Pursuant to s. 408.036, F.S., with certain limited exceptions nursing homes in Florida are subject to CON. In addition to general criteria applicable to CON issuance, pursuant to s. 408.040, F.S., AHCA may issue a CON or exemption based upon a statement of intent from a nursing home. In doing so, AHCA may consider that a specified percentage of the annual patient days at a facility will be utilized by Medicaid recipients. AHCA's issuance of the CON to such nursing homes is issued as a condition of that utilization level, and any change in utilization level requires the certificateholder to seek a modification of conditions from AHCA. Failure to comply with these conditions can result in administrative fines against the certificateholder.

A moratorium on the approval of additional nursing home beds has been in effect since 2001. In 2006, the Florida Legislature extended the moratorium through July 1, 2011.[48]

Effect of Proposed Changes

HB 7225 makes immediate statutory changes to existing Medicaid provisions or provisions related to Medicaid providers; repeals existing provisions on a date certain, as they become outdated based upon the full implementation of managed medical assistance, managed long-term care, or managed long-term care for persons with developmental disabilities pursuant to ss. 409.961 through 409.992, F.S.; and repeals other outdated provisions immediately.

Immediate Statutory Changes

Medicaid Reform

The bill substantially rewrites the Medicaid pilot program statute - s. 409.91211, F.S. – in order to better organize and articulate the requirements of the pilot program. The primary substantive changes to the existing statute are as follows:

- Waiver Extension: AHCA is required to seek an extension of the Section 1115 waiver approved on October 19, 2005, no later than July 1, 2010, and report at least monthly to the Legislature regarding the progress of negotiations. Any changes to the terms and conditions relating to the Low Income Pool must be approved by the Legislative Budget Commission.
- Miami-Dade Expansion: The pilot program is expanded to Miami-Dade County so that eligible recipients are enrolled in a qualified plan no later than June 30, 2011.
- Opt-Out: The current opt-out requirements available to recipients, which authorize recipients with access to employer-sponsored health insurance to opt out of the plans and use Medicaid financial assistance to pay their share of cost in such plans is expanded, subject to federal approval, to allow recipients to use their share of cost to pay for other health insurance or related products authorized under state law, including Cover Florida plans, any products available in the Florida Health Choices Program, or any health exchange.
- Risk Adjusted Rates: Risk-adjusted rates are continued for plans in existing reform counties, and risk adjusted rates are phased in over a three-year period in Miami-Dade County.
- Enhanced Benefits: Plans are required to establish enhanced benefits program. Currently AHCA administers the program for recipients. These benefits are used to purchase otherwise uncovered health and related services during the entire period of, and for a maximum of 3 years

[48] s. 408.0435(1), F.S.

after, the recipient's Medicaid eligibility, whether or not the recipient remains continuously enrolled in the plan in which the credits were earned. Enhanced benefits must be structured to provide greater incentives for those diseases linked with lifestyle, and conditions or behaviors associated with avoidable utilization of high cost services. In order to fund these credits, each plan must maintain a reserve account in the amount of up to 2 percent of the plan's Medicaid premium revenue (prepaid plan) or benchmark premium revenue (PSN) based on an actuarial assessment of the value of the enhanced benefit program.

- Automatic Enrollment: AHCA no longer is required to automatically enroll recipients who do not choose a plan based upon the needs assessment of the recipient. The criteria AHCA uses to make automatic assignments is modified and includes: the plan's network capacity; a prior relationship between the recipient and one of the plan's primary care providers; the geographic accessibility of primary care providers to the recipient.
- Intergovernmental Transfers (IGTs): The bill preserves intergovernmental transfers as the pilot program is expanded to Miami-Dade County by requiring AHCA to develop certain methodologies such as supplemental capitation rates, risk pool, or incentive payments that can be paid to prepaid plans or plans owned and operated by providers that contract with safety net providers, trauma hospitals, children's hospitals, and statutory teaching hospitals. AHCA is authorized to seek federal approval to implement a methodology to allow supplemental payments to be made directly to physicians employed or under contract with a Florida medical school, and capitated rates to exclude payments to these physicians so they can be paid directly. AHCA must develop a plan to preserve IGTs, based upon the approved methodologies and payment mechanisms, and submit that plan to the Legislative Budget Commission (LBC). AHCA must also report to the Legislature how the approved methodologies and payment mechanisms could be applied to other counties in the state. After all recipients are assigned and enrolled in plans in Miami-Dade County, AHCA will submit an amendment to the Legislative Budget Commission requesting authority to transfer from the appropriate Grant and Donations Trust Fund and Medical Care Trust Fund line items to the Prepaid Health Plans line item.

Consistent with current reform provisions, the bill requires AHCA to implement the Section 1115 waiver, which was approved by CMS on October 19, 2005. Additionally, the pilot program is continued in the 5 counties in which it is currently fully implemented. The LIP is still used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients, and recipients can receive choice counseling related to available plans. Plan selection requirements for recipients, disenrollment requirements, and automatic enrollment provisions remain relatively unchanged.

Provider Service Networks

The bill amends s. 409.912(4)(b), F.S. by authorizing capitated provider service networks to provide behavioral health services, in addition to physical health services, in areas of the state not under Medicaid reform.

Pursuant to s. 409.912(4)(d), F.S., any contract previously awarded to a PSN operated by a hospital shall remain in effect for three years after the current contract expiration date. The bill repeals this provision, and provides new guidelines for payments to PSNs. The bill clarifies that prepaid PSNs receive per member per month payments, while non-prepaid PSNs receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall only be available for the first five years of the plan's operation in a given region, or until the contract year beginning in October 2015, whichever is later. The bill requires AHCA to annually conduct cost reconciliations to determine the amount of cost savings achieved for fee-for-service PSNs for the dates of services in the period reconciled, and adds specific requirements to the method by which AHCA reconciles PSN spending. The changes include specifying the period of the reconciliation, providing for consideration of incurred but not reported claims, and limiting the time period for completing the reconciliation.

General Medicaid and Medicaid Managed Care Provisions

The bill makes several immediate changes applicable to Medicaid managed care plans in Florida. First, the bill requires full risk capitation of all managed care plans beginning on September 1, 2010. Additionally, the bill requires plans to begin reporting information pertaining to medical loss ratios – the amount spent on administrative functions versus direct patient care – to AHCA and the information must be made public. Plans statewide will have to report encounter data and will be required to establish enhanced benefits programs statewide for Medicaid recipients. Enhanced benefits are used to purchase otherwise uncovered health and related services during the entire period of, and for a maximum of 3 years after, the recipient's Medicaid eligibility, whether or not the recipient remains continuously enrolled in the plan in which the credits were earned. Enhanced benefits must be structured to provide greater incentives for those diseases linked with lifestyle, and conditions or behaviors associated with avoidable utilization of high cost services. In order to fund these credits, each plan must maintain a reserve account in the amount of up to 2 percent of the plan's Medicaid premium revenue (prepaid plan) or benchmark premium revenue (PSN) based on an actuarial assessment of the value of the enhanced benefit program.

The bill also expands statewide the opt-out option created in Medicaid reform, but also authorizes recipients to use their Medicaid funds to purchase or other insurance products that may be offered through state programs such as Florida Health Choice Program, Cover Florida, or health insurance exchanges in addition to employer sponsored health insurance.

The bill revises existing provisions related to school districts that participate in the certified school match program, which will be effective on October 1, 2013. This modification will authorize this program to stay in place after statewide implementation of managed care, but updates the requirements consistent with changes provided for in HB 7223.

Finally, the bill authorizes AHCA to exempt certain recipients from mandatory enrollment in managed care on a case-by-case basis when the recipient's situation is unique, time limited and disease or condition-related and enrollment in managed care would interfere with the recipient's on-going care because his or her provider does not participate in the managed care plans in the area. AHCA currently has rulemaking authority to provide such exemptions, but this amendment specifies the circumstances under which such exemptions shall apply. The existing rulemaking provision is immediately repealed in the bill.

Medical Homes

The bill amends s. 409.91207, F.S., relating to medical homes. The bill provides purposes and principles of medical home networks and authorizes AHCA to designate as a medical home network a qualified plan that has been accredited by the National Committee for Quality Assurance or:

- A qualified plan that establishes a method for enrollees to choose to participate as medical home patients and select a primary care provide that is certified as a medical home; and
- The qualified plan certifies that at least 85 percent of primary care providers in the medical home network:

    - Supply all medically necessary primary and preventive services and provide all scheduled immunizations.
    - Organize clinical data in electronic form using a patient-centered charting system.
    - Maintain and update patients' medication lists and review all medications during each office visit.
    - Maintain a system to track diagnostic tests and provide follow up services regarding test results.
    - Maintain a system to track referrals, including self-referrals by members.
    - Supply care coordination and continuity of care through proactive contact with members and encourage family participation in care.
    - Supply education and support using various materials and processes appropriate for individual patient needs.
    - Communicate electronically.

- Supply voice-to-voice telephone coverage to medical home patients 24 hours per day, 7 days per week, to enable medical home patients to speak to a licensed health care professional who triages and forwards calls, as appropriate.
- Maintain an office schedule of at least 30 scheduled hours per week.
- Use scheduling processes to promote continuity with clinicians, including providing care for walk-in, routine, and urgent care visits.
- Implement and document behavioral health and substance abuse screening procedures and make referrals as needed.
- Use data to identify and track patients' health and service use patterns.
- Coordinate care and follow up for patients receiving services in inpatient and outpatient facilities.
- Implement processes to promote access to care and member communication.
- Maintain electronic medical records.
- Develop a health care team that provides ongoing support, oversight, and guidance for all medical care received by the patient and documents contact with specialists and other health care providers caring for the patient.
- Supply post-visit follow up care for patients.
- Implement specific evidence-based clinical practice guidelines for preventive and chronic care.
- Implement a medication reconciliation procedure to avoid interactions or duplications.
- Use personalized screening, brief intervention, and referral to treatment procedures for appropriate patients requiring specialty treatment.
- Offer at least 4 hours per week of after-hours care to patients.
- Use health assessment tools to identify patient needs and risks.

A qualified plan must also provide support to its primary care providers including: case management and care coordination for patients; assessments of spending and service utilization; establishing specific methods to manage pharmacy and behavioral health services, and paying primary care providers at rates equal to or greater than 80 percent of the Medicare rate.

AHCA is required to maintain a record of all plans designated as a medical home and develop a standard form on which qualified plans can certify to AHCA that they meet the necessary service and primary care provider support capabilities to be designated as a medical home.

Nursing Homes

Specifically, the bill provides licensure and regulatory relief to nursing homes to enable them to have the capacity to service Medicaid recipients pursuant to the Medicaid managed long-term care program established in HB 7223. First, the bill creates s. 400.0713, F.S., which authorizes AHCA to establish a workgroup to develop a plan for licensure flexibility that will assist nursing homes in developing long-term care service capabilities. Second, the bill amends s. 408.040, F.S., by suspending the conditions on the issuance of a CON to nursing homes based on Medicaid patient utilization. Finally, the bill extends the current moratorium scheduled to expire July 1, 2011, until after statewide Medicaid managed care is implemented pursuant to ss. 409.961-409.992, F.S. or October 1, 2015, whichever occurs first.

Services to Dual Eligibles

The bill also makes immediate changes applicable to recipients who are dually eligible for both Medicare and Medicaid. Specifically, bill amends s. 409.907, F.S. by authorizing Medicare crossover-only providers to enroll in Medicaid for payment purposes only. This will enable Medicare providers already serving dual eligibles to become Medicaid providers and be reimbursed by Medicaid for services and amounts not reimbursed by Medicare but covered by Medicaid. Additionally, this puts

Medicaid in the proper posture for the Medicaid managed long-term care program and will provide efficiency for the providers.[49]

The bill creates certain requirements for crossover provider agreements, including that the provider must: be an eligible Medicare provider, have a current Medicare provider agreement with the Centers for Medicare and Medicaid Services, and verify provider good standing to AHCA; immediately notify AHCA, in writing, within five days of the provider's suspension or disenrollment as a Medicare provider or be subject to statutory sanctions, including the return of any funds paid to the provider by Medicaid during the period it was suspended or disenrolled from Medicare; maintain recipient records for a minimum of five years and provide them to AHCA or the Attorney General Medicaid Fraud Unit upon request. The bill clarifies that any Medicare Cross Over Provider that wishes to become a Medicaid provider for purposes other than serving dual eligibles must meet all other requirements of state law and administrative rules.

To fully facilitate the process of reimbursing providers for services to dual eligibles, the bill amends s. 409.9122, F.S., by authorizing AHCA to establish a per member per month payment for Medicare Advantage Special Needs members who are also eligible for Medicaid as a mechanism for meeting the state's cost sharing obligation. Additionally, AHCA is authorized to develop a per member per month payment for Medicaid only covered services for which the state is responsible. In conjunction with these payments, the state must develop a mechanism that ensures that such per member per month payments enhance the value to the state and enrolled members by limiting cost sharing, enhancing the scope of Medicare supplemental benefits that are equal to or greater than the Medicaid coverage for select services, and improving care coordination.

Finally, the bill amends s. 409.908, F.S., relating to Medicaid provider reimbursement to clarify that any Medicare providers must notify AHCA , in writing, within 5 days of the provider's suspension or disenrollment as a Medicare provider, or be subject to statutory sanctions, including the return of any funds paid to the provider by Medicaid during the period it was suspended or disenrolled from Medicare.

Elder Waivers

The bill repeals the Department of Elder Affairs' statutory authority to administer waivers for elders effective upon October 1, 2012, the deadline for full implementation of long-term care managed care statewide. The bill also requires DOEA to develop a transition plan for recipients receiving services in long-term care Medicaid waivers for elders or disabled adults on the date qualified plans become available in each recipient's region in order to enroll those recipients in qualified plans. Finally, the bill immediately repeals the Alzheimer's Dementia Specific Medicaid Waiver, which expires on April 30, 2010. DOEA is currently in the process of transferring individuals receiving services in this waiver to other waivers.

Aging Resource Centers

The bill repeals outdated provisions in s. 430.2053, F.S., related to Aging Resource Centers, repeals other provisions on a date certain and makes future, conforming changes related to the responsibilities the ARCs will have once the Medicaid long-term care managed care is implemented throughout the state. ARCs will assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program, provide choice counseling for the program by integrating choice counseling staff and services – physically or virtually. Pursuant to HB 7223, AHCA may contract directly with the ARCs to provide choice counseling services or with another vendor if an ARC does not choose to provide services. If an ARC does not choose to provide such services, it must enter into a memorandum of understanding with AHCA to coordinate staffing and

[49] When providers provide services to dual eligibles, the reimbursement request will only have to be submitted directly to Medicare. Medicare then pays its share of the reimbursement and directly submits the remaining Medicaid portion of the claim to Medicaid for payment.

collaborate with the choice counseling vendor. The MOU must identify the staff responsible for each function and provide staffing levels necessary to carry out the ARCs' functions.

ARCs will also assist Medicaid recipients enrolled in Medicaid long-term care managed care with informally resolving grievances with a managed care network and assist recipients in accessing the managed care network's formal grievance process. Once long-term care managed care is implemented in each region, the ARCs are prevented from providing direct services to recipients, other than choice counseling services and other information, referral and screening services.

Once managed long-term care is implemented in each region, DOEA is no longer authorized to make payments for recipients.

Agency for Persons with Disabilities

The bill amends s. 393.0661, F.S., relating to the four-tier waiver system used by the Agency for Persons with Disabilities (APD) to provide home and community-based services for persons with developmental disabilities. The bill requires APD to develop a transition plan to move persons receiving services through the four-tier structure to enrollment in a qualified Medicaid plan. The bill provides for expiration of the four-tier system on October 1, 2015.

Department of Elder Affairs

The bill amends s. 430.04, F.S., relating to the Florida Department of Elderly Affairs (DOEA) Medicaid waiver programs. The bill requires DOEA to develop a transition plan to move persons receiving services through a long-term care waiver program to enrollment in a qualified Medicaid plan as such plans are implemented in each region of the state. The bill provides for expiration of DOEA Medicaid waiver programs on October 1, 2012. Consistent with these changes, the Long-Term Care Community-Based Diversion Pilot and related provisions (Sections 430.701-430.709, F.S.) are repealed effective October 1, 2012.

Immediate Repeals of Current Law

The following provisions are repeals effective upon the bill becoming law:

- Requires AHCA and DCF work under a collaboration agreement to provide for Medicaid community mental health (s. 409.912(4)(b)2, F.S.)
- Requires implementation of statewide capitated prepaid behavioral health care system (s. 409.912(4)(b)4, F.S.)
- Provides requirements for statewide capitated prepaid behavioral health care system (s. 409.912(4)(b)6, F.S.)
- Requires 3-year contract extension for hospital-operated PSN (s. 409.912(4)(d)2, F.S.)
- Authorizes AHCA to contract for in-home medical services for high-cost conditions (s. 409.912(4)(f), F.S.)
- Authorizes pediatric networks to provide after-hours care for emergency room diversion (s. 409.912(4)(g), F.S.)
- Requires fixed-payment Medicaid program for recipients 60 years of age and older and dual eligibles (s. 409.912(5), F.S.)
- Requires the use of an "appropriate fee schedule" for exclusive provider organization provide who treats a Medicaid recipient in a rural area that lack an HMO; authorizes AHCA to seek a waiver for the program (s. 409.912(8)(b), F.S.)
- Requires AHCA to develop a cost-benefit analysis business case to test alternative means of providing goods and services in the Medicaid program (s. 409.912(14)(b)-(c), F.S.)
- Requires AHCA report on modifying the level-of-care criteria to eliminate Intermediate II level of care (s. 409.912(15)(g), F.S.)
- Authorizes AHCA to seek waivers for purchasing certain health care services and equipment (s. 409.912(37), F.S.)

- Requires AHCA to establish a Medicaid recipient utilization management program for occupational, physical, respiratory, and speech therapies; authorizes the AHCA to seek a waiver for the program (s. 409.912(42), F.S.)
- Requires AHCA to conduct a study regarding the availability of electronic identity verification systems (s. 409.912(49), F.S.)
- Provides AHCA rule-making authority for case-by-case exceptions to the mandatory managed care enrollment requirement (s. 409.9122(2)(a), F.S.)
- Requires AHCA to investigate the feasibility of providing Medipass and managed care plan options to certain Medicaid groups (s. 409.9122(7), F.S.)
- Authorizes AHCA to encourage public/private partnerships to develop HMO and prepaid health plans services for Medicaid recipients (s. 409.9122(8), F.S.)
- Provides for the enrollee assignment process for Miami-Dade County Medicaid managed prepaid plans (s. 409.9122(13), F.S.)

Repeals on Dates Certain

October 1, 2012

The following provisions are repealed on October 1, 2012, the date Medicaid long-term care managed care must be implemented in all regions pursuant to HB 7223:

- Exempts certain entities from health care services provisions of Part I of Ch. 641, F.S. Exempted entities provide services to elderly recipients on a prepaid or fix-sum basis from health care services (s. 409.912(4)(h), F.S.)
- Requires AHCA to operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program to screen nursing facility Medicaid recipients for proper placement (s. 409.912(15)(a-(f), F.S.)
- Requires AHCA to establish a long-term care demonstration project in Miami-Dade County for a predominantly minority, medical underserved and medically complex population (s. 409.912(41), F.S.)

October 1, 2013

The following provisions are repealed on October 1, 2013, the date Medicaid managed medical assistance must be implemented in all regions pursuant to HB 7223:

- Directs AHCA to work with DCF for access to mental health and substance abuse services (s. 409.912(1), F.S.)
- Authorizes AHCA to contract for Medicaid services with HMOs (s. 409.912(3), F.S.)
- Authorizes AHCA to contract for Medicaid prepaid health care services with entities owned and operated by a county, county health department or county-owned hospital (s. 409.912(4)(a), F.S.)
- Provides requirements for Medicaid behavioral health care services; authorizes fee-for-service payment for providers (s. 409.912(4)(b), F.S.)
- Exempts federally qualified health centers that are reimbursed on a prepaid basis from parts I and III of Ch. 641, F.S. (s. 409.912(4)(c), F.S.)
- Authorizes entities to provide comprehensive behavioral health care services to Medicaid recipients through an administrative services organization agreement (s. 409.912(4)(e), F.S.)
- Authorizes the Children's Medical Service Network, as defined in s. 391.021, F.S. (s. 409.912(4)(i), F.S.)
- Authorizes AHCA to contract with public and private entities for Medicaid services; authorizes contractors to subcontract with other entities under certain conditions; provides contracting conditions (s. 409.912(6), F.S.)
- Authorizes AHCA to contract with health insurers for Medicaid recipient coverage on a prepaid or fixed-sum basis (s. 409.912(7), F.S.)
- Authorizes AHCA to use fee-for-service for purchasing of chiropractic services through a statewide not-for-profit chiropractic preferred provider organization (s. 409.912(9), F.S.)

- Prohibits AHCA from contracting with entities whose officers, etc., committed certain crimes (s. 409.912(10), F.S.)
- Requires AHCA to identify Medicaid services misuse through the establishment of a postpayment utilization control program (s. 409.912(12), F.S.)
- Requires AHCA to develop coordinated systems of care for Medicaid recipients (s. 409.912(13), F.S.)
- Requires AHCA to identify and monitor Medicaid providers with respect to medical necessary services and treatment (s. 409.912(14)(a), F.S.)
- Requires AHCA to identify utilization and price patterns that are not cost-effective; authorizes AHCA to implement alternative methods to improve cost-effectiveness (s. 409.912(16), F.S.)
- Requires prepaid or fixed-sum contractors to meet surplus insurer requirements in Ch. 641, F.S. (409.912(17), F.S.)
- Authorizes AHCA to require prepaid or fixed-sum contractors to establish a restricted insolvency protection bank account (s. 409.912(18), F.S.)
- Requires prepaid or fixed-sum contractors to reimburse hospitals or physicians outside a contractor's geographic area at specific levels (s. 409.912(19), F.S.)
- Requires AHCA to approve assignment or transfer of prepaid Medicaid contracts for post-merger or acquisition contractors under certain conditions (s. 409912(20), F.S.)
- Prohibits certain Medicaid contractor business practices, including discrimination and false marketing (s. 409.912(21), F.S.)
- Authorizes AHCA to fine contractors for violations of Medicaid provisions (s. 409.912(22), F.S.)
- Prohibits Medicaid recipient solicitation via marketing material by HMOs and Ch. 641, F.S.-exempt individuals (s. 409.91223), F.S.)
- Authorizes HMOs and Ch. 641, F.S.-exempt individuals and entities to provide additional benefits under certain circumstances (s. 409.912(24), F.S.)
- Requires AHCA to use the statewide HMO complaint hotline for Medicaid and prepaid health plan complaints (409.912(25), F.S.)
- Requires AHCA to publish the complaint hotline phone numbers (s. 409.912(26), F.S.)
- Requires Medicaid contractors to achieve a 60% Early and Periodic Screening, Diagnosis and Treatment Service rate (s. 409.912(28), F.S.)
- Requires AHCA to enroll and disenroll eligible Medicaid recipients in MediPass or managed care plans; authorizes the AHCA to contract for enrollment services (s. 409.912(29), F.S.)
- Requires certain formatting for Medicaid provider information (s. 409.912(30), F.S.)
- Requires AHCA to establish an enhanced managed care quality oversight function; provides for required function components (s. 409.912(31), F.S.)
- Requires contracted managed care plan entities to perform background checks on persons with certain ownership interests; requires contractors to submit specified background results to AHCA (s. 409.912(32), F.S.)
- Requires AHCA to promulgate rules regarding Medicaid managed care plan enrollee requests to enter hospice (s. 409.912(33), F.S.)
- Requires Medicaid contractors to provide emergency services to recipients in compliance with emergency services provisions in Ch. 641, relating to health care services (s. 409.912(34), F.S.)
- Requires Medicaid providers to provide specific services to pregnant women and mothers with infants (s. 409.912(35), F.S.)
- Requires Medicaid prepaid health plan services entities to coordinate with assisted living facilities for Medicaid recipient residents (s. 409.912(36), F.S.)
- Requires AHCA to enter into agreements with not-for-profit organizations to provide vision screening for Medicaid recipients (s. 409.912(38), F.S.)
- Authorizes AHCA to contract for dental services on a prepaid or fix-sum basis (s. 409.912(43), F.S.)
- Requires Medicaid contracts to be cost effective; requires AHCA to conduct actuarially sound adjustments and publish findings; authorizes AHCA to make contract renewal decisions based on cost-effectiveness (s. 409.912(44), F.S.)
- Requires AHCA to implement a "lock-in" program for Medicaid recipients who have used services at a rate or amount not medically necessary (s. 409.912(45), F.S.)

- Requires AHCA to contract with minority physician networks to provide services to "historically underserved" minority patients; provides conditions for AHCA contracts; authorizes the AHCA to seek a waiver for implementation (s. 409.912(49), F.S.)
- Provides for Medipass intent language (s. 409.9122(1), F.S.)
- Requires AHCA to enroll all Medicaid recipients in Medipass or managed care plan, with certain recipients excepted; requires school districts to be reimbursed for "school based services" as defined in s. 1011.71, F.S. for Medicaid-eligible children; requires easily understandable information about Medipass and managed care plans; provides for mandatory assignment under certain circumstances; requires the AHCA to seek a waiver for the program (s. 409.9122(2), F.S.)
- Requires AHCA to establish quality-of-care standards for Medicaid managed care plans and Medipass program (s. 409.9122(3), F.S.)
- Authorizes an OBGYN to serve as a primary care provider under the designation of a Medipass primary care case manager; requires AHCA to establish a Medipass complaint and grievance process (s. 409.9122(4), F.S.)
- Requires AHCA to encourage dual eligibles to enroll in a Medicare HMO or prepaid health plan; if there is a demonstrated cost-effectiveness, requires AHCA to offer Medipass to dual eligibles (s. 409.91225), F.S.)
- Authorizes up to 10 chiropractor and up to 4 podiatrist visits to Medipass recipients without prior authorization (s. 409.9122(6), F.S.)
- Requires AHCA to develop a information program for Medicaid recipients advising them of choices and rights under managed care programs; requires AHCA to develop compliance programs for managed care plans and Medipass providers (s. 409.9122(9), F.S.)
- Requires AHCA to consult with Medicaid consumers regarding patient satisfaction and quality indicators (s. 409.9122(10), F.S.)
- Authorizes AHCA to extend eligibility for HMO enrollment period for Medicaid recipients (s. 409.9122(11), F.S.)
- Caps the per physician patient load at 3,000 active Medicaid patients (s. 409.9122(12), F.S.)

October 1, 2015

The following provisions are repealed on October 1, 2015, the date Medicaid long-term care managed care for persons with developmental disabilities must be implemented in all regions pursuant to HB 7223:

- Authorizes AHCA to enter into agreements with other state agencies and federal government to implement and operate Medicaid (s. 409.912(2), F.S.)
- Authorizes AHCA to apply for Medicaid waivers (s. 409.912(11), F.S.)
- Requires AHCA to establish a quality improvement system, subject to Medicaid Bureau of Health Care Financing Administration standards and guidelines (s. 409.912(27), F.S.)

Miscellaneous Other Changes

The bill amends cross references in several sections of law – 409.91195, 409.91196 and 641.386, F.S. - in order to conform to the changes in the bill.

The bill divides existing provisions of Chapter 409 into three statutory parts. Part I of Chapter 409, will be titled “Social and Economic Assistance,” and encompass ss. 409.016 – 409.803, F.S. Part II of Chapter 409, will be titled “Kidcare,” and encompasses ss. 409.810 – 409.821, F.S. Finally, Part III of Chapter 409, will be titled “Medicaid,” and encompasses ss. 409.901 – 409.9025, F.S.

The bill renumbers sections 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S., as sections 402.81, 402.82, 402.83, 402.84, 402.85, 402.86 and 402.87, respectively.

Finally, except as otherwise provided in the bill, the bill is effective upon HB 7223 or similar legislation passing during this session or an extension thereof and becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 393.0661, F.S., relating to home and community-based service delivery systems.

Section 2: Creates s. 400.0713, F.S., relating to the establishment of a nursing home licensure workgroup.

Section 3: Creates s. 408.040, F.S., relating to conditions and monitoring.

Section 4: Amends s. 408.0435, F.S., relating to a moratorium on nursing home certificates of need.

Section 5: Designates ss. 409.016 through 409.803 as part I of chapter 409, F.S., entitled "Social and Economic Assistance."

Section 6: Designates ss. 409.810 through 409.821 as part II of chapter 409, F.S., entitled "Kidcare."

Section 7: Designates ss. 409.901 through 409.9205 as part III of chapter 409, F.S., entitled "Medicaid."

Section 8: Amends s. 409.907, F.S., relating to Medicaid provider agreements.

Section 9: Creates s. 409.908, F.S., relating to reimbursement of Medicaid providers.

Section 10: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.

Section 11: Amends s. 409.91195, F.S., relating to Medicaid Pharmaceutical and Therapeutics Committee.

Section 12: Amends s. 409.91196, F.S, relating to Supplemental rebate agreements; public records and public meetings exemption.

Section 13: Amends s. 409.91207, F.S., relating to medical homes; authority; purpose and principles; designation; and agency duties.

Section 14: Amends s. 409.91211, F.S., relating to the Medicaid managed care pilot program.

Section 15: Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment; programs and procedures.

Section 16: Amends s. 430.04, F.S., relating to duties and responsibilities of the Department of Elderly Affairs.

Section 17: Amends s. 430.2053, F.S., relating to aging resource centers.

Section 18: Amends s. 641.386, F.S., relating to agent licensing and appointment required; exceptions.

Section 19: Repeals ss. 430.701, 430.702, 430.703, 430.7031, 430.704, 430.705, 430.706, 430.707, 430.708, and 430.709, F.S., effective October 1, 2012.

Section 20: Renumbers ss. 409.9301, 409.942, 409.944, 409.945, 409.946, 409.953, and 409.9531, F.S. as 402.81, 402.82, 402.83, 402.84, 402.85, 402.86 and 402.87, respectively.

Section 21: Provides that except as otherwise provided in the act, the bill is effective if HB 7223 or similar legislation is passed this session or in any extension thereof and becomes law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA will earn $2,632,642 in federal Medicaid matching funds for the administrative costs associated with the implementation of the provisions of the bill in FY 2010-2011.

2. Expenditures:

ESTIMATED NON-RECURRING EXPENDITURES	**Amount FY 10-11**	**Amount FY 11-12**
Expense	$37,200	$0
TOTAL Non-Recurring Expenditures	**$37,200**	**$0**

ESTIMATED RECURRING EXPENDITURES	**Rate**	**Amount FY 10-11**	**Amount FY 11-12**
Total Salary & Benefits (9.0 FTE)	445,436	$554,091	$604,085
OPS		$123,069	$123,069
Expense		$126,226	$134,642
Human Resources Services		$4,008	$4,008
Contracted Services		$4,420,689	$4,420,689
TOTAL RECURRING EXPENDITURES	**445,436**	**$5,228,083**	**$5,286,493**

	Amount FY 10-11	**Amount FY 11-12**
Non-Recurring Expenditures	$37,200	$0
Recurring Expenditures	$5,228,083	$5,286,493
TOTAL EXPENDITURES	**$5,265,283**	**$5,286,493**
General Revenue Fund	**$2,632,641**	**$2,643,246**
Medical Care Trust Fund	**$2,632,642**	**$2,643,247**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Counties that continue the current level of contributions for IGTs should continue to receive the same level of funding through their local health systems, contingent upon approval of a methodology developed by AHCA to continue supplemental payments.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The expansion of the pilot program to Miami-Dade County will increase recipients participating in qualified plans, which will allow qualified plans to grow their business with the addition of new lives covered.

The bill creates some additional reporting requirements for all qualified plans statewide related to encounter data and medical loss ratios, and creates reserve requirements for enhanced benefits

programs administered by plans. The bill will reduce barriers and create efficiencies for Medicare providers serving dual eligibles.

D. FISCAL COMMENTS:

AHCA will require $5,265,283 in FY 2010-2011 to implement the provisions of the bill. This includes funding and associated expenses for nine full time equivalent positions and three Other Personal Services positions for Area Offices. The positions will be utilized to assist with project management, risk adjustment of rates, and encounter data analysis. Contractual Services funding is also provided for Choice Counseling for the Miami-Dade County expansion.

Expanding the Section 1115 waiver to Miami-Dade County is projected to reduce Medicaid expenditures by $41.8 million in Fiscal Year 2010-2011 with annualized savings of $77.2 million in Fiscal Year 2011-2012. General Revenue savings in FY 2010-2011 will be between $3.2 and $16.0 million contingent upon approval of a methodology developed by AHCA to continue supplemental payments as directed in the bill. The General Revenue savings in FY 2011-2012 are estimated at $29.6 million contingent upon approval of a methodology developed by AHCA to continue supplemental payments. The calculations for these savings include increasing the managed care discount factor by 4.5 percent to account for fraud and abuse adjustments.

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:

AHCA has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES