The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Committee

BILL:	CS/CS/SB 1972
INTRODUCER:	Budget Subcommittee on Health and Human Services Appropriations; Committee on Health Regulations; Senators Negron, Gaetz, and others
SUBJECT:	Health and Human Services
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown, et al.	Stovall	HR	**Fav/CS**
2.	Kynoch	Hansen	BHA	**Fav/CS**
3.	Kynoch	Meyer, C.	BC	**Pre-meeting**
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill makes numerous changes to Florida law regarding health and human services, including those relating to services provided or regulated by the Agency for Health Care Administration (AHCA), the Agency for Persons with Disabilities (APD), the Department of Health (DOH), the Department of Children and Family Services (DCF), the Department of Elderly Affairs (DOEA), and the Florida Healthy Kids Corporation (FHKC). The bill provides that:

- Certain hospital districts, county hospitals with taxing authority, and public health trusts are exempted from the requirement to annually appropriate dollars into community redevelopment trust funds;
- Ad valorem revenues raised by certain hospital districts, county hospitals, and public health trusts may be used only to pay for "health care services;"
- The Division of Statutory Revision is requested to parse ch. 409, F.S., into four parts:
  - Part I, SOCIAL AND ECONOMIC ASSISTANCE, comprises ss. 409.016 through 409.803, F.S.
  - Part II, KIDCARE, comprises ss. 409.810 through 409.821, F.S.
  - Part III, MEDICAID, comprises ss. 409.901 through, 409.9205, F.S.; and
  - Part IV, MEDICAID MANAGED CARE, comprises ss. 409.961 through 409.978, F.S.

- The minimum medical loss ratio (MLR) for a FHKC contract for health care services is set at 90 percent (instead of 85 percent under current law);
- Each school district is required to collaborate with the FHKC to provide application information about Florida Kidcare or an application for Kidcare to students at the beginning of each school year, and modify the school district's application form for school breakfast and lunch programs to incorporate a provision that permits the school district to share data from the application form with the state agencies and the FHKC and its agents that administer Kidcare, unless the child's parent or guardian opts out of the provision;
- Medicaid eligibility is restricted to U.S. citizens and lawfully admitted non-citizens. Citizenship or immigration status must be verified. State funds may not be used for individuals who do not qualify under these standards unless the services are necessary for treating an emergency medical condition or for pregnant women;
- The DCF, when adopting rules relating to eligibility for institutional care services, hospice services, and home and community-based services (HCBS) waiver programs, must evaluate payment of fair compensation by a Medicaid applicant for a personal care services contract entered into on or after October 1, 2011, based on specific criteria created by the bill;
- Medicaid applicants must agree to certain conditions for Medicaid eligibility, including the payment of a $10 monthly premium, unless exempted, and participation in one or more health improvement programs under certain conditions;
- A person who is eligible for Medicaid services and has access to health care coverage through an employer-sponsored health plan may not receive Medicaid services under the state's Medicaid program but may use Medicaid financial assistance to help pay the cost of premiums for the employer-sponsored health plan for the eligible person and his or her Medicaid-eligible family members;
- A Medicaid recipient who has access to other insurance or coverage created by state or federal law may opt out of services under the state's Medicaid program and use Medicaid financial assistance to help pay the cost of premiums for the recipient and the recipient's Medicaid-eligible family members;
- Any state agency that administers a Medicaid program or waiver is prohibited from expending funds during any fiscal year in excess of the amount appropriated in the General Appropriations Act (GAA). The agency is required to take action during the fiscal year to remedy the deficit, including submitting a budget amendment to the Legislative Budget Commission to reduce Medicaid program spending in that fiscal year;
- The medically needy program is replaced by the Medicaid Non-poverty Medical Subsidy program, and benefits for non-pregnant adults under the program are limited to physician services only effective April 1, 2012;
- The AHCA must assess a sliding-scale parental fee on all parents of children under age 18 being served by a HCBS waiver when the family has an adjusted household income over 100 percent of the federal poverty level;
- The AHCA is prohibited from paying for psychotropic medications prescribed for a child younger than the age approved by the federal Food and Drug Administration;
- The Medicaid program's fee-for-services payments to primary care physicians for primary care services must be at least 100 percent of the Medicare payment rate for such services, effective January 1, 2013;
- The requirement in existing law that the AHCA must purchase non-emergency transportation services through the community transportation system under the umbrella of the Commission

for the Transportation Disadvantaged, is removed from statute, and the AHCA is required to either competitively procure nonemergency transportation services or secure federal waiver authority necessary to draw down the highest federal match available for such services;

- Medicaid managed care plans are not required to purchase nonemergency transportation services through the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged;
- Medicaid recipients must pay copayments at the time of service. A $3 copayment is required for visiting a specialty physician. The AHCA is required to seek a waiver of the federal requirement that cost sharing amounts for nonemergency services and care furnished in a hospital emergency department must be nominal, and upon waiver approval, each Medicaid recipient must pay a $100 copayment for nonemergency services and care provided in a hospital emergency department (instead of $15 under current law);
- The Legislature intends that if any conflicts exists between part IV and other parts or sections of ch. 409 F.S., the provisions of part IV control;
- The Medicaid managed care program (MMCP) is established as a statewide, integrated managed care program for all covered services in the medical assistance component (MAC) and in the managed long-term care (managed LTC) component under part IV of ch. 409, F.S;
- The AHCA is required to submit waiver and state plan amendment requests by August 1, 2011, as needed to implement the MMCP. The requests must include waiver authority to permit HCBS to be preferred over nursing home services, require dual-eligibles to participate in the program, and allow Florida to limit enrollment in the managed LTC component;
- The AHCA is required to initiate a procurement processes for the MMCP as soon as practicable and no later than July 1, 2011, in anticipation of federal waiver authority. The AHCA is required to seek waiver approval by December 1, 2011, in order to begin implementation on December 31, 2011;
- The AHCA is required to begin implementing on December 31, 2011. If the necessary waivers are not timely received, the AHCA is required to notify the federal Centers for Medicare and Medicaid Services (federal CMS) of the state's implementation of the MMCP and to request the federal agency to continue providing federal funds, as provided under the current Medicaid program, to be used for the MMCP. If the federal CMS refuses to continue providing federal funds, the MMCP will be implemented to the extent state funds are available, under specified parameters;
- All Medicaid recipients are required to receive covered services through the MMCP unless specifically excluded. Specified individuals are exempt from mandatory enrollment in the MMCP but may voluntarily enroll. Medicaid recipients who are excluded or exempt from mandatory participation and who do not choose to enroll in the MMCP will be served though the Medicaid fee-for-service program under part III of ch. 409, F.S.;
- The AHCA is required to implement a competitive-bid procurement process for "qualified plans" that are managed care plans determined eligible to participate in the MMCP in 19 different regions. Selection criteria are established;
- The AHCA is prohibited from selecting more than one plan per 20,000 Medicaid recipients residing in each region who are subject to mandatory enrollment, with a minimum of 3 and a maximum of 10 plans per region;
- Standards for qualified plan contracts must include five-year durations, non-renewal of contracts, a primary care physician for each member, prompt pay, required rates of pay for non-contracted providers of emergency services, plan network adequacy, encounter data

reporting, quality and performance standards, fraud prevention, grievance resolution, penalties, performance bonds, solvency standards, and guaranteed savings;

- Payments for qualified plans in both the medical assistance component and managed LTC component will be made in accordance with a capitated managed care model;
- The AHCA is required to establish a uniform method for annual reporting of specified financial information for all Medicaid prepaid plans across all lines of business in all regions. Qualified plans are required to use the uniform method. The AHCA is required to determine achieved savings rebates owed to the state by the plans according to specified calculations. Qualified plans are required to refund dollars to the state if profit margins are greater than specified thresholds, according to parameters set by statute.
- Qualified plans are required to include three types of essential providers in their networks, including faculty plans of state medical schools, regional perinatal intensive care centers (RPICCs), and children's specialty hospitals. Qualified plans are required to pay essential providers at specified rates in the absence of contracted rates with those providers.
- Qualified plans and providers are required to negotiate in good faith. A procedure is established for dealing with provider contracting impasses in areas containing no capitated plans prior to July 1, 2011;
- Qualified plans are required to monitor the quality and performance of network providers based on metrics established by the AHCA;
- Qualified plans are required to compensate primary care physicians with payments equivalent to or greater than the Medicare rate for primary care services no later than January 1, 2013;
- Unresolved disputes between a qualified plan and a provider will proceed in accordance with s. 408.7057, F.S., which is the existing statewide provider and health plan claim dispute resolution program;
- Qualified plans will be paid per-member, per-month capitation payments based on an assessment of each member's acuity level. Payment for managed LTC capitations will be combined with rates for medical assistance capitations;
- The AHCA is required to develop a methodology and request authority from the federal CMS that ensures the availability of certified public expenditures in the MMCP to support non-institutional teaching faculty providers that have historically served Medicaid recipients. Such funding is commonly known as "physician UPL." The AHCA is required to make direct supplemental payments to such providers or to a statewide entity on behalf of such providers that contract with qualified plans;
- MMCP recipients may choose from plans available in their region of residence. Recipients who have not chosen within 30 days of becoming eligible will be automatically assigned to a plan, based on specified criteria;
- MMCP recipients diagnosed with HIV/AIDS residing in region 11, 15, or 16 will be assigned to an HIV/AIDS specialty plan if those recipients do not choose a plan within 30 days;
- The AHCA is required to maintain and operate the Medicaid Encounter Data System. The AHCA and qualified plans are required to adhere to guidelines for data reporting, validation, and analysis. Qualified plans are required to submit encounter data according to deadlines established by the AHCA;
- The AHCA is required to begin implementing the medical assistance component by December 31, 2011, and finish implementing the component in all regions no later than December 31, 2012;

- Qualified plans must provide a specified set of services in the medical assistance component. Plans may provide for additional services as specified in the GAA. Plans may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services, subject to standards of sufficiency and actuarial equivalence. Services provided must be medically necessary;
- The AHCA is required to begin implementing the managed LTC component by March 31, 2012, with full implementation in all regions by March 31, 2013;
- The DOEA is required to assist the AHCA with the LTC component by helping to develop specifications for procurement and a model contract, determine clinical eligibility for enrollment in managed LTC plans, monitor plan performance and measure the quality of service delivery, assist clients and families to address complaints with the plans, facilitate working relationships between plans and providers serving elders and disabled adults, and perform other functions specified in a memorandum of agreement with the AHCA;
- MMCP recipients are required to receive covered LTC services through the managed LTC component unless excluded. Specifically excluded from both the medical assistance component and the managed LTC component are persons residing in a nursing home facility or are considered residents under the nursing home's bed-hold policy on or before July 1, 2011. To participate in the managed LTC component, a recipient must be 65 years of age or older or eligible for Medicaid by reason of a disability and determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) program to meet the requirements for nursing facility care;
- Qualified plans participating in the managed LTC component are required to provide all medical assistance component services, nursing facility services, and HCBS, including, but not limited to, assisted living facility (ALF) services;
- The AHCA is required to operate the CARES preadmission screening program to ensure that only recipients whose conditions require LTC services are enrolled in managed LTC plans. The AHCA is required to operate the CARES program through an interagency agreement with the DOEA;
- For a child 10 years of age or younger who is in an out-of-home placement and in the DCF's legal custody, the DCF must file a motion seeking a court's authorization to initially provide or continue to provide psychotropic medication to the child, and motion must be supported by the prescribing physician's signed medical report providing the results of a review of the administration of the medication by a child psychiatrist who is licensed under ch. 458 or 459, F.S. The review must meet certain criteria and be provided to the child and the parent or legal guardian before final express and informed consent is given. If a child who is in out-of-home placement is 10 years of age or younger, psychotropic medication may not be authorized by a court absent a finding of a compelling governmental interest;
- The definition of "blood establishment" is clarified that a person, entity, or organization that uses a mobile unit and performs any of the activities under the definition of "blood establishment" is also a blood establishment. The requirements and parameters for operating a blood establishment are amended;
- The definition of "developmental disability" specifically includes Down syndrome;
- The standards for civil actions against nursing homes and parties related to nursing homes are amended in various ways. Requirements are revised for suing an officer or director of a nursing home or its management company for alleged negligence or a violation of rights. In wrongful death actions brought against a nursing home, the noneconomic damages may not

exceed $250,000, regardless of the number of claimants. A hearing is required for the evaluation of evidence proffered by all parties for a judge's consideration of a punitive damages claim against a nursing home. The requirements for the recovery of punitive damages from a nursing home are revised;

- The existing statewide provider and health plan claim dispute resolution program is amended to establish that the program creates a procedure for dispute resolution and not an independent right of recovery;
- A medical physician licensed in another state or Canada is required to obtain a certificate from the Board of Medicine to provide expert medical opinions in Florida in a medical malpractice action. Grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of medicine are created;
- An osteopath licensed in another state or Canada is required to obtain a certificate from the Board of Osteopathic Medicine to provide expert medical opinions in Florida in a medical malpractice action. Grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of osteopathic medicine are created;
- Insurers issuing group or individual health benefit plans are allowed to offer a voluntary wellness or health improvement program and to encourage or reward participation in the program by authorizing rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts or rebates, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts;
- The requirement that a medical malpractice insurance contract must authorize the insurer to admit liability and make a settlement offer or offer of judgment on behalf of the insured physician, without the insured physician's permission, if the offer is within the policy limits, is stricken from statute;
- The standard of care for Medicaid providers is altered relating to the recovery of civil damages. The liability of health care providers who provide covered medical services to Medicaid recipients is limited to $200,000 per claimant or $300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, medical services to a Medicaid recipient, unless the claimant proves that the provider acted in a wrongful manner;
- The limited waiver of sovereign immunity is extended to a state not-for-profit college or university that owns or operates an accredited medical school and its employees and agents when the employees or agents of the medical school are providing patient services at a teaching hospital that has an affiliation agreement with the medical school. The medical school and its employees when providing patient services to patients at the public teaching hospital would be considered an agent of the public teaching hospital for purposes of sovereign immunity, under certain parameters;
- The limited waiver of sovereign immunity is extended to certain providers or vendors, 75 percent of whose client population consists of individuals with developmental disabilities, individuals who are blind or severely handicapped, or individuals with mental illness, which have contractually agreed to act on behalf of certain state agencies to provide services to such individuals. Those providers or vendors and their employees or agents are considered agents of the state under certain parameters;
- The limited waiver of sovereign immunity is extended to specified entities related to the Univ. of Florida and Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville

Medical Center, Inc., and Shands Jacksonville Healthcare, Inc. Those entities and certain not-for-profit subsidiaries are considered instrumentalities of the state for purposes of sovereign immunity;

- The AHCA is required to submit a reorganizational plan to the Governor, the Speaker of the House of Representative, and the President of the Senate by January 1, 2012, which converts the AHCA from a check-writing and fraud-chasing agency into a contract compliance and monitoring agency;
- The AHCA is required to seek federal waiver authority for many of the bill's provisions;
- If the Legislature has not received a letter from the Governor stating that the federal CMS has approved waivers necessary to implement the Medicaid managed care reforms contained in the bill by December 1, 2011, the State of Florida will withdraw from the Medicaid program effective December 31, 2011;
- If the federal government does not provide Florida with funds to support its Medicaid program, medical services would be provided to children in the child welfare system through the state-funded-only program, which would allow the state to remain eligible for federal funds under Title IV-E for foster care and adoption assistance and for the Temporary Assistance for Needy Families (TANF) block grant. Medical services would be procured by community-based care lead agencies with funds appropriated for that purpose; and
- If any provision in the bill is held invalid, the invalidity does not affect other provisions that can be given effect without the invalid provision, and to this end the provisions of the bill are severable.

The bill will take effect upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 163.387, 200.186, 393.0661, 409.016, 409.813, 409.8132, 409.815, 409.818, 154.503, 408.915, 1006.06, 409.901, 409.902, 409.9021, 409.903, 409.904, 409.905, 409.906, 409.9062, 409.907, 409.908, 409.9081, 409.912, 409.915, 409.9126, 430.04, . 430.2053, 39.407, 216.262, 381.06014, 393.063, 400.023, 400.0237, 408.7057, 458.331, 459.015, 499.003, 499.005, 499.01, 626.9541, 627.4147, 766.102, 766.104, 766.106, 766.1115, 766.203, 768.28, 1004.41, and 443.111.

The bill creates the following sections of the Florida Statutes: 409.16713, 409.9022, 409.961, 409.962, 409.963, 409.964, 409.965, 409.966, 409.967, 409.968, 409.969, 409.970, 409.971, 409.972, 409.973, 409.974, 409.975, 409.976, 409.977, 409.978, 458.3167, 459.0078, 766.1183, and 766.1184.

The bill transfers, renumbers, and amends the following sections of the Florida Statutes: 624.91 to 409.8115; 409.9301 to 409.9067; and 409.9122 to 409.987.

The bill transfers and renumbers the following sections of the Florida Statutes: 409.91207 to 409.985; 409.91211 to 409.986; 409.9123 to 409.988; 409.9124 to 409.989; 409.942 to 414.29; 409.944 to 163.464; 409.945 to 163.465; and 409.946 to 163.466.

The bill repeals the following sections of the Florida Statutes: 409.9121, 409.919, and 624.915.

II. Present Situation:

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 AHCA and financed by federal and state funds. The AHCA delegates certain functions to other state agencies, including the DCF, the APD, and the DOEA. Key characteristics[1] of Florida's Medicaid program are as follows:

- Over 2.9 million enrolled recipients.
- $19.8 billion estimated spending in Fiscal Year 2010-2011;
- $6,759 estimated per recipient spending in Fiscal Year 2010-2011;
- Over half the childbirths in Florida are paid for by the Medicaid program;
- 27 percent of Florida's children are covered by Medicaid;
- Over 1.9 million of the 2.9 million recipients are enrolled in some form of managed care;
- 936,000 of the 2.9 million recipients are enrolled in fee-for-service Medicaid;
- 24 managed care organizations, including 19 HMOs and 6 PSNs; and
- 100,000 fee-for-service providers.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets 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.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program and the minimum mandatory benefits to be covered in every state Medicaid program. These benefits 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 28 percent of the total FY 2010-11 budget. Medicaid General Revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures.

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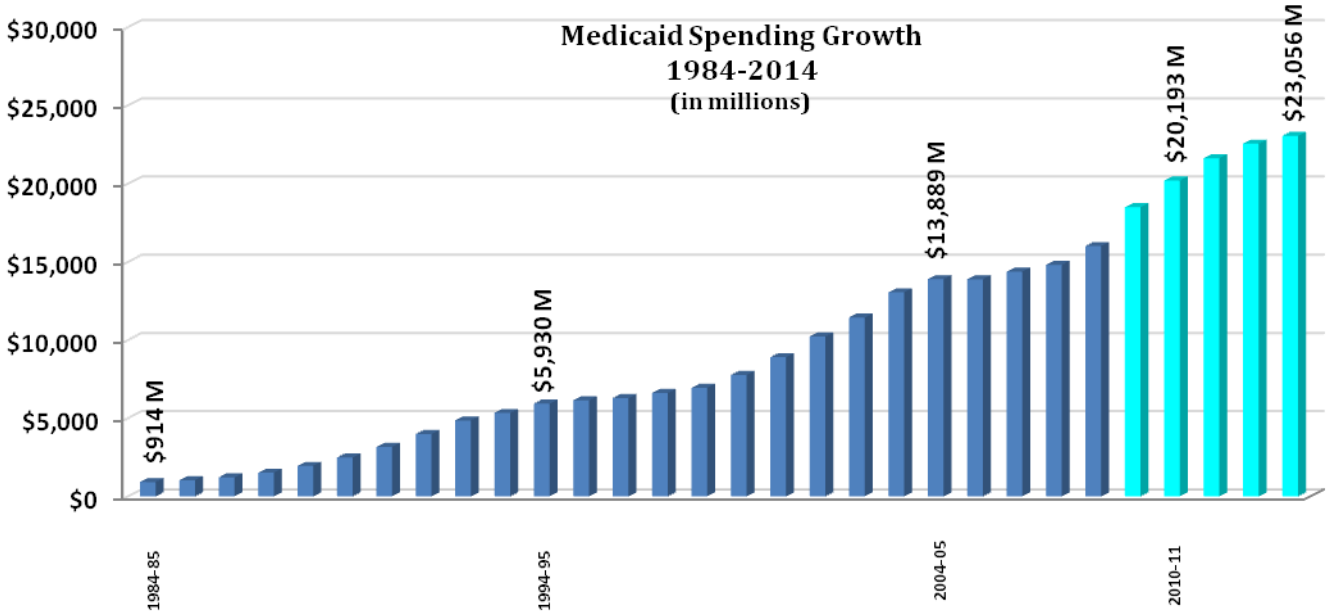
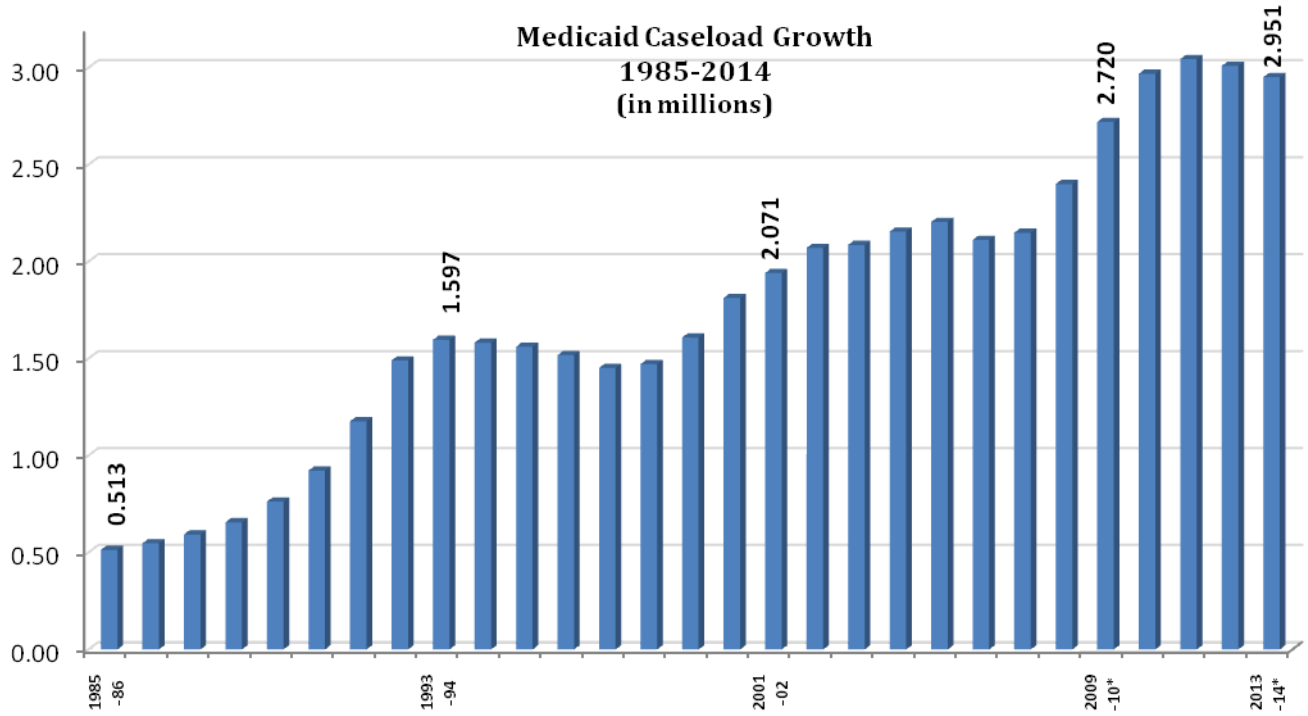
[1] Social Services Estimating Conference (SSEC) February 2011 Medicaid Expenditures; Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Senate Subcommittee on Health and Human Services Appropriations, February 2011; Comprehensive Medicaid Managed Care and Medicaid Pilot Enrollment Report, February 2011, Agency for Health Care Administration.

[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]





[4] *Supra*, note 1.

Current estimates indicate the Medicaid program will cost $21.4 billion in FY 2011-2012. By FY 2013-2014, the estimated program cost is $23.6 billion. Florida has made many efforts to control costs in the program. 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.

Medicaid Mandatory Benefits

Federal law requires that each participating state must provide a core package of mandatory benefits in its Medicaid program. Section 409.905, F.S., requires the AHCA to provide the following mandatory services to recipients when such services are deemed medically necessary:

- Advanced registered nurse practitioner services;
- Early periodic screening diagnosis and treatment services for children;
- Family planning services and supplies;
- Home health agency services;
- Hospital inpatient services;
- Hospital outpatient services;
- Laboratory and X-ray services;
- Nursing facility services;
- Physician services;
- Rural health clinic services; and
- Transportation to access covered services.

Medicaid Optional Benefits

The mandatory benefits may be supplemented by many optional benefits. Under s. 409.906, F.S., the AHCA may provide specified optional services, subject to an appropriation, including:

- Adult dental services;
- Adult health screening;
- Ambulatory patient services;
- Anesthesiologist assistant services;
- Assistive services;
- Birth center services;
- Case management;
- Chiropractic services;
- Community mental health services;
- Dental services;
- Dialysis services;
- Durable medical equipment;
- Healthy start services;
- Hearing services;
- Home and community-based services;
- Hospice services;
- Intermediate care facilities for the developmentally disabled;

- Intermediate care services;
- Lung transplants;
- Optometric services;
- Physician assistant services;
- Podiatric services;
- Prescription drugs;
- Registered nurse first assistant services;
- State mental hospital services; and
- Vision services.

Medicaid Benefits Compared to Private Small-Group Health Insurance

Private employers with 50 or fewer employees may obtain coverage in the small group market in Florida. Section 627.6699, F.S., mandates the coverage of certain specified benefits. However, insurers and health maintenance organizations (HMOs) may offer additional coverage and varied copayments, coinsurance, and deductibles to meet the needs of employers and their covered employees. Three insurers and HMOs that represent approximately 60 percent of the market share by premiums were surveyed in 2011 by staff of the Senate Committee on Banking and Insurance regarding their coverage.

Medicaid Mandatory Benefits Compared to Small-Group

Generally, subject to prior authorization, deductibles, copayments, and limits on the number of days or visits, small group plans provides coverage for many of the mandatory Medicaid services, such as, inpatient and outpatient hospital services, nursing facility services, home health care services, family planning, laboratory services and X-ray services. However, some plans exclude or limit coverage for private duty nursing care. Childhood screenings and health evaluations are covered under group plans until a child reaches age 16. These exams typically include routine physical examinations, immunizations, hearing tests, and vision screenings. Plans do not cover ambulance services provided for routine transportation for the provision of inpatient and outpatient services. However, transportation for newborns needing specialized care is covered.

Medicaid Optional Benefits Compared to Small-Group

Generally, small group plans do not provide coverage for diagnostic or corrective dental, hearing, or vision services. However, hearing and vision screenings for children age 16 or under are covered, as discussed above. Except in certain circumstances, hearing aids are not covered. The plans provide care for the treatment of an accidental dental injury or coverage for necessary dental treatment that, if left untreated, is likely to result in a medical condition. Plans are mandated to provide specified cleft lip and cleft palate services and coverage for procedures involving bones or joints of the mandible and procedures medically necessary to treat a condition caused by congenital or developmental deformity, disorder, or injury. For vision services, many plans limit coverage to physician services needed to treat injury, disease, or covered conditions of the eyes.

Small group plans generally provide coverage for adult health screening, ambulatory surgical center services, birth center services, hospice services, transplant services, prescription drugs, dialysis facility services, and durable medical equipment are covered. Substance abuse and

mental health services can be subject to maximum number of days or visits for inpatient and outpatient care, deductibles, or coinsurance. Occupational, physical, respiratory, and speech therapy can be subject to maximum number of visits and copayments. For chiropractic services, services are limited by an annual dollar benefit or number of visits. For podiatric services, foot care including any health care service, is excluded in the absence of a disease.

Medicaid and Federal Health Insurance Reform

The U.S. Congress passed the Patient Protection and Affordable Care Act (PPACA)[5] and President Barack Obama signed the bill into law on March 23, 2010.[6] Key policy areas include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and taxes or penalties for non-compliance; employer taxes or penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs. If implemented, 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 PPACA increases the mandatory population to all adults, regardless of whether they are disabled or elderly, up to 133 percent of the poverty level. The PPACA 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 PPACA imposes a mandate on individuals to buy insurance, or pay a penalty. 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.

The costs of PPACA to Florida Medicaid will be significant. Florida is expected to have over 379,000 new enrollees from the expanded PPACA Medicaid population in 2014, at a cost of $1.5 billion (of which $142 million will be paid by the state), bringing the total cost of Medicaid that year to $25 billion. By 2019, Florida Medicaid will have 1.9 million additional enrollees, at an additional cost of over $7.7 billion (of which $1 billion will be paid by the state).[7] In subsequent years, the state share may increase.

The PPACA 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

[5] Pub.L. No. 111-148, 124 Stat. 119 (2010)

[6] The act is currently being challenged as unconstitutional by Florida and 25 other states. The law was declared unconstitutional by the court in State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.) However, the ruling was stayed and the matter is on appeal to the United States Court of Appeals for the Eleventh Circuit, Case No. 11-11021-HH.

[7] Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 13, 2010; State of Florida Long-Range Financial Outlook Fiscal Year 2011-12 through 2013-14, Fall 2010 Report.

than the current procedure of sharing rebate revenue with the states. This provision will cost Florida approximately $37 million annually at current levels.[8] The FY 2010-2011 impact is estimated to be a loss in rebate general revenue of $39.8 million. This will be a recurring loss. Additionally, when the federal enhanced payments to primary care providers expire in 2014, it is estimated that continuing the payments will cost the state $247.9 million in 2015.

Medicaid Managed Care

Florida, like other states, has turned to managed care for improving access to care, containing costs, and enhancing quality. As of March 1, 2011, 67 percent of Medicaid participants were enrolled in some form of managed care for primary and acute care services. Florida has authorized at least 15 different managed care models, including primary care case management (PCCM), provider service networks (PSNs), health maintenance organizations (HMOs), minority physician networks (MPNs), prepaid mental health plans (PMHPs), prepaid dental plans (PDHPs), and the nursing home diversion (NHD) waiver. Some managed care models are designed to deliver comprehensive care while others are limited to specialty care. Florida operates several of its Medicaid managed care programs through a section 1915(b) waiver obtained from the federal Centers for Medicare and Medicaid Services in 1991. The Medicaid Reform demonstration project operates under a federal section 1115 waiver.

Managed Care Payment Methods

Florida Medicaid uses two main methods of payment within managed care. When services are delivered to beneficiaries and billed to the state on an individual or itemized basis, payment is made via "fee-for-service" (FFS), i.e. payment is made for each service after the service has been rendered and the state has been billed. Conversely, the state also contracts to make payments on a prepaid basis, which results in a fixed, lump-sum payment per beneficiary, typically made on a monthly basis, designed to cover services needed in the aggregate for any given month in a 12-month period. Such a fixed, prepayment is known as a "capitation."

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitated entities sometimes assume full risk, i.e. the coverage is comprehensive with no mitigation factors for the risk assumed, and others assume partial risk, i.e. the coverage is limited as opposed to comprehensive and/or the risk may be mitigated by loss prevention or shared-savings arrangements. Capitation is designed to provide the state with less risk and more predictability for Medicaid spending and to incent the capitated entities to manage the provision of services in a cost-effective manner.

The AHCA is charged by statute with developing capitation rates for managed care plans by administrative rule.[9] The rule is designed to represent a discount from what the state would otherwise pay for the same services provided to comparable populations on a FFS basis. Capitation rates must be certified as actuarially sound by a third-party actuary in compliance with federal guidelines.

[8] Agency for Health Care Administration, Patient Protection and Affordable Care Act Overview of Medicaid Prescribed Drug Changes, October 21, 2010.
[9] *See* s. 409.9124, F.S.

MediPass

The Medicaid Provider Access System (MediPass)[10] is a managed care program consisting of a PCCM system established in 1991. MediPass is available statewide to all beneficiaries who are eligible for managed care except for most beneficiaries in "Medicaid Reform" counties.[11] MediPass was designed to provide Medicaid beneficiaries with coordinated primary care while decreasing the inappropriate utilization of medical services. The state contracts with a health care provider – usually the beneficiary's primary care physician (PCP) – to provide basic care and to coordinate any needed specialty care or other services furnished by other physicians or providers. The MediPass PCP is paid a case management fee per person per month, and the PCP's services, as well as services from other providers, are paid for by the state on a fee-for-service basis. The PCPs are expected to monitor the appropriateness of health care provided to their patients. MediPass is managed care but is administered at the individual provider level, not by a managed care organization or managed care plan.

The AHCA has contracted with disease management organizations to provide disease management services to MediPass-enrolled beneficiaries living with certain diseases.[12]

Provider Service Networks

A provider service network (PSN) in the Medicaid program is a managed care plan that is majority-owned and operated by Florida health care providers, such as hospitals, physician groups, and/or federally qualified health centers. The PSN program began in 1997 when the Legislature authorized the AHCA to establish a Medicaid PSN demonstration project to capitalize on high-volume Medicaid providers and their ability to manage the medical care of Medicaid beneficiaries they serve. The first Medicaid PSN became operational by 2000.

The initial PSN contract was awarded by competitive bid. The AHCA currently awards PSN contracts based on an open application process, meaning the AHCA will offer a PSN contract to every applicant that applies for and meets the state's standards for a Medicaid PSN contract. There are currently six Medicaid PSNs statewide,[13] operating in 12 counties. The AHCA is authorized to pay PSNs a capitation if the PSN chooses to assume financial risk, or services rendered to PSN members may be paid on a fee-for-service basis. Fee-for-service PSNs are paid monthly primary care case management fees, as well as administrative allocations per member. Florida Statutes direct the AHCA to conduct periodic financial reconciliations to determine cost-savings. PSNs in the Medicaid program are required to demonstrate cost effectiveness.[14] If cost savings do not occur, the PSN may be required to refund a portion of the payment it receives through its monthly administrative allocations.

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[10] *See* s. 409.9121, F.S.

[11] The Medicaid Reform pilot project, authorized under s. 409.91211, F.S., is currently in operation in Broward, Duval, Nassau, Baker, and Clay counties. See later in this analysis for more information on Medicaid Reform.

[12] *See* <http://ahca.myflorida.com/Medicaid/MediPass/dm.shtml>, (Last visited on March 27, 2011).

[13] List of Florida Medicaid Provider Services Networks, as of July 12, 2010, published by the AHCA, available at: <http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MCAID/LIST_MEDICAID_PSNs.pdf>, (Last visited on March 27, 2011).

[14] *See* s. 409.912(44), F.S.

Health Maintenance Organizations

The AHCA is authorized to contract with health maintenance organizations (HMOs) for the provision of services to Medicaid beneficiaries. Medicaid HMOs are required to be licensed by the Office of Insurance Regulation (OIR) under ch. 641, F.S.[15] The AHCA typically contracts with HMOs in an open application process for the provision of comprehensive health coverage to Medicaid beneficiaries who become HMO members. HMOs are paid a fixed capitation to assume full financial risk for delivering a set of comprehensive primary and acute care services. HMOs are expected to employ managed care principles in order to achieve cost effectiveness and to eliminate overutilization, fraud, and abuse, while providing for all covered, medically necessary services. Like commercial HMOs, Medicaid HMOs are subject to regulations and solvency standards required by OIR for HMO licensure.

Minority Physician Networks

In 2003, the AHCA established agreements with two physician-owned minority physician networks (MPNs)[16] composed mostly of physicians representing racial minorities. MPNs provide primary care case management services. In addition, the MPNs are responsible for supporting the primary care case managers by providing administrative and utilization management services as a means of containing cost and enhancing the quality of care. The MPN financial structure is fee-for-service, based upon a shared-savings arrangement with an advanced monthly case management fee of $12. MPNs are eligible to receive a portion of savings that are achieved, but a percentage of the administrative fee is required to be returned to the AHCA if no savings are achieved.

By October 2010, both minority physician networks had been acquired or had entered into acquisition agreements with two Medicaid HMOs, and Florida's minority physician network enrollees transitioned into Medicaid HMO membership during 2009 and 2010.[17]

Children's Medical Services Networks

The Florida Children's Medical Services (CMS)[18] program provides a family-centered, PCCM system of care for children with special health care needs. Children with special health care needs are those children younger than 21 years of age whose chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. Roughly 60 percent of children covered by CMS networks are Medicaid eligible.

CMS networks offer a full range of care that includes prevention and early intervention services, primary and specialty care, as well as long-term care for medically-complex, fragile children. Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS-affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices. Families may enroll their Medicaid children with special health care needs in CMS

[15] *See* s. 409.912(3), F.S.
[16] *See* s. 409.912(49), F.S.
[17] Issue Brief 2011-221, *Overview of Medicaid Managed Care Programs in Florida,* Senate Committee on Health Regulation, November 2010, p. 4.
[18] Not to be confused with the federal Centers for Medicare and Medicaid Services, also known as CMS.

networks. The CMS program is administered by the Florida Department of Health and partly funded with Medicaid dollars on a fee-for-service basis.

Exclusive Provider Organizations
The AHCA is authorized to contract for Medicaid services with exclusive provider organizations (EPOs), which are individual providers or groups of providers who have entered into written agreements with a licensed health insurer to provide health care services to EPO members.[19] There are currently no EPOs operating within Florida Medicaid.

Prepaid Limited Health Service Organizations
The AHCA employs prepaid limited health service organizations, commonly known as prepaid limited health plans or prepaid limited plans, to provide a number of limited or specialized services to certain Medicaid beneficiaries. Prepaid limited plans are partial risk-bearing entities regulated by OIR under ch. 636, F.S., and, in return for a fixed capitation, provide for limited types of health services to enrollees through an exclusive panel of providers. Prepaid limited plans are typically engaged by the AHCA as prepaid mental health plans or prepaid dental health plans.

Prepaid Mental Health Plans
In 1996, Florida began contracting with prepaid mental health plans (PMHPs) to provide behavioral health services in a cost-effective manner to eligible beneficiaries. The PMHPs are selected through competitive procurement[20] to provide, on a limited, prepaid basis, the following mental health services:

- Community mental health;
- Behavioral health targeted case management;
- Inpatient psychiatric hospitalization (emergency and non-emergency); and
- Outpatient psychiatric hospitalization (behavioral health and physician services).

PMHPs assume risk for the limited set of services they provide. Medicaid beneficiaries who receive services via PMHPs are typically in MediPass or unmanaged fee-for-service for primary and acute care, except that most Medicaid-eligible children statewide who are receiving child welfare services from the DCF, including those enrolled in managed care plans, are provided enhanced PMHP services via a specialty PMHP operated by community-based lead agencies.[21]

Prepaid Dental Health Plans
In July 2004, the AHCA contracted with a prepaid dental health plan (PDHP) to provide dental services on a limited, prepaid basis to Medicaid-eligible children under the age of 21 in Miami-Dade County who are not enrolled in a managed care plan that provides its own dental services.[22] Currently there are two PDHPs in Miami-Dade County. PDHPs are paid a capitated rate for providing all covered dental services.

[19] *See* s. 409.912(8), F.S.
[20] *See* s. 409.912(4)(b), F.S.
[21] *See* s. 409.912(4)(b)8., F.S.
[22] *See* s. 409.912(43), F.S.

Nursing Home Diversion

The nursing home diversion (NHD) waiver program was originally implemented in December 1998 in the Orlando and Palm Beach areas and currently offers services in 37 counties.[23] The DOEA operates the program in conjunction with the AHCA. The primary objective of the program is to provide frail elders who meet eligibility criteria with an alternative to nursing home placement. Under this voluntary managed care program, enrollees can choose to continue living in their own homes or a community setting such as an ALF. The program makes this option possible by offering coordinated acute care, long-term care, and case management services to frail elders in a community setting. All participants select a case manager and a NHD provider. NHD service providers are NHD managed care organizations that are approved for each county and are reimbursed at a monthly capitated rate for each plan member.

The case manager develops an individualized care plan used in coordinating medically necessary acute and long-term care services. Long-term care services include adult companion, adult day health, assisted living, case management, chore services, consumable medical supplies, environmental accessibility and adaptation, escort services, family training, financial assessment and risk reduction, home delivered meals, homemaker, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health, and nursing facility services. Acute care services include community mental health services, dental, hearing and visual services, independent laboratory and X-ray, hospice, inpatient hospital and outpatient hospital/ emergency, physicians, prescribed drugs, and transportation (optional) services.

Florida Medicaid Reform

In 2005, Florida was approved to implement a 5-year Medicaid experimental demonstration pilot project (Medicaid Reform) under a section 1115 waiver.[24] Medicaid Reform was initially implemented in 2006 in Broward and Duval counties and then expanded to Nassau, Baker, and Clay counties in 2007. The demonstration pilot project requires mandatory participation in managed care plans for specified Medicaid populations, offering customized benefit packages that may vary in amount, duration, and scope. Beneficiaries who are employed and who have access to employer-sponsored insurance, have the ability to opt-out of Medicaid services and use Medicaid funding to pay their share of their employers' private health insurance premium.

Key managed care components of the Medicaid Reform pilot include:

- Comprehensive choice counseling;
- Customized benefit packages;
- Enhanced benefits resulting from participation in healthy behaviors;
- Risk-adjusted capitations for prepaid managed care plans, based on enrollee health status;
- An optional "catastrophic component" of the capitation, i.e. state reinsurance to encourage development of managed care plans in rural and underserved areas of the state; and

[23] Agency for Health Care Administration, *2010-2011 Florida Medicaid Summary of Services*, p. 108. NHD is approved for all 67 counties. NHD providers have been engaged to provide services in 37 counties. *See* <http://ahca.myflorida.com/Medicaid/pdffiles/SS_10_100501_SOS_ver2.4_1164_1011_FINAL2.pdf>, (Last visited on March 27, 2011).

[24] Florida Medicaid Reform Extension Request, submitted to CMS on June 30, 2010 by the Agency, available at: <http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/fl_1115_research_and_demonstration_waiver_extension_request_06-30-2010.pdf>, (Last visited on March 27, 2011).

- Managed care plans participating in the Reform pilot may include health insurers, EPOs, PSNs, HMOs, and CMS networks. MPNs that formerly participated in Reform were classified as PSNs, and CMS networks in Reform are classified as specialty PSNs for children with chronic conditions.

Each managed care plan participating in Medicaid Reform must cover all mandatory services as outlined in federal law. Unique to Reform is that plans may vary the coverage level and offer more or less coverage to adults than is typically covered by Medicaid for the following services: prescribed drugs, hospital outpatient services (excluding emergency care), durable medical equipment (DME) and supplies, home health services, chiropractic, podiatric, physical and respiratory therapy, vision, dental, and hearing. Any limits imposed by Reform managed care plans that are more restrictive than non-Reform coverage do not apply to pregnant women or children. The state must pre-approve all benefit packages to ensure they are sufficient to meet the needs of the enrolled population.

The state pays HMOs participating in Reform a capitation that is subject to a risk-adjustment methodology, designed specifically for the Reform pilot, to help ensure that capitations reflect the health status of each managed care plan's membership as much as possible. PSNs participating in Reform have the option to be paid via risk-adjusted capitation or to be paid case management fees and administrative allocations while health care services for their members are paid on a fee-for-service basis.[25] No PSNs in the Reform pilot have opted to be paid via capitation. Under current law, all Reform PSNs must be paid via capitation no later than the beginning of the Reform pilot's final year of operation under a waiver extension, if an extension is granted.

Medicaid Reform Waiver Extension

On April 30, 2010, the Florida Legislature passed legislation directing the AHCA to seek federal approval of a 3-year waiver extension in order to maintain and continue operation of the section 1115 waiver.[26] The AHCA submitted the extension request on June 30, 2010.[27] On August 17, 2010, the federal CMS advised the AHCA that it would review and process the state's request to renew the Reform Demonstration under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the state. This authority would allow the federal CMS to request changes to the terms and conditions of the waiver. Under section 1115(a), there is no prescribed timeframe by which the federal CMS must process a waiver request. The AHCA has indicated that there is no formal processing timeframe.

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

[25] *See* s. 409.91211(3)(e), F.S.
[26] *See* ch. 2010-144, LOF.
[27] *Supra* note 24.

demonstration period for the LIP.[28] 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[29] provides that distribution of the LIP funds should:

- 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 coverage 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 2010, $1 billion in LIP payments were made to hospitals and other providers. The LIP expires in 2011, unless renewed. Per the Legislature's directive in 2010, AHCA is currently negotiating the extension of the reform waiver, including the LIP funding.

Other States' Experiences with Medicaid Managed Care

Forty-eight states have some portion of their Medicaid population enrolled in managed care; 20 states have over 80 percent managed care enrollment.[30] Seventeen states have implemented statewide mandatory managed care programs for Medicaid recipients under an 1115 waiver.[31] There are many differences among states regarding payment structure and what specific populations are served through managed care. Generally, "states have chosen this model for the savings it can achieve and the added fiscal predictability."[32] In particular, Arizona, Texas and Georgia represent three distinct approaches to Medicaid managed care serving multiple eligible populations with great geographic variety.

[28] Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration.
[29] s. 409.91211(c), F.S.
[30] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: key Data, Trends, and Issues* (February 2010).
[31] *Id*. The seventeen states are: Arkansas, Arizona, Delaware, Florida Hawaii, Indiana, Kentucky, Massachusetts, Maryland, Minnesota, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah and Vermont.
[32] The Pacific Health Policy Group, *Medicaid Managed Care Study*, Prepared for the Florida House of Representatives (March 2010).

Arizona
Arizona has implemented statewide managed care providing comprehensive services for children and pregnant women as well as behavioral services for all eligible recipients. The state selects plans through a competitive procurement process and plans service specific geographic regions statewide. A total of 14 private health plans serve Medicaid recipients, with a minimum of two plans serving each geographic region. The plans are capitated and the rates are established through competitive bid.

Arizona also uses a managed care model to provide HCBS long-term care for elderly, blind and developmentally disabled Medicaid recipients. However, eligibility for long-term care is tightly controlled; it is estimated that 75 percent of applicants are denied.[33]

Managed care enrollment is at 93 percent of the Medicaid eligible recipients.[34] In the first 8 years of statewide managed care, Arizona cut the growth in Medicaid expenditures to 6.8 percent compared to a 9.9 percent growth in fee-for-service.[35] From 1983 to 1993, the state achieved cost savings of 11 percent for medical services (or seven percent in total cost savings with plans' administrative costs and operating margins factored in.[36]

Georgia
The Georgia Medicaid managed care program serves TANF and TANF-related population through fully capitated plans. The state selects plans through a competitive procurement process and the selected plans serve six geographic regions statewide. Only three health plans serve Medicaid recipients. Georgia provides for elderly, blind and developmentally disabled Medicaid recipients through a traditional fee-for-service system, rather than through managed care. Managed care enrollment is at 84 percent of Medicaid eligible recipients.[37]

To fund the managed care program, Georgia implemented an assessment on premiums for health plans serving the Medicaid population. It is estimated that the state saved between $132.6 and $194.9 million over the first three years of the program.[38]

Texas
The Texas Medicaid program serves children, low-income families, and pregnant women. Managed care also provides long-term care for SSI and SSI-related populations, but with a carve-out for inpatient hospital services which are provided on a fee-for-service basis. The state selects plans through a competitive procurement and the selected plans serve specific portions of the state. The plans are fully capitated. The state also utilizes a capitated arrangement to provide behavioral health services to eligible recipients.

Managed care enrollment is at 70 percent of the Medicaid eligible recipients. It is estimated that the Texas long-term care program saved $123 million over its first two years.[39]

[33] *Id*.
[34] Pacific, *supra* note 32.
[35] The Lewin Group, *Medicaid managed Care Cost Savings – A Synthesis of Fourteen Studies* (July 2004).
[36] *Id*.
[37] Pacific, *supra* note 32.
[38] Pacific, *supra* note 32.
[39] Pacific, *supra* note 32.

Medicaid 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, which provide care in a community setting instead of a nursing home or other institution.

Regardless of whether persons are seeking services in the community or in a nursing home, the individual must meet nursing home level of care criteria.[40] The CARES program in the DOEA conducts medical eligibility determinations on all individuals seeking Medicaid coverage for nursing home care. CARES also certifies medical eligibility for potential clients in certain Medicaid Waivers that provide community services and conducts reviews of nursing home residents to ensure that they continue to meet the level of care criteria.[41]

In Calendar Year 2009 statewide, Medicaid clients had over 68,000 stays in a nursing home, ranging from a few days to the entire year.[42] The median resident age was 81, and two-thirds were female. The vast majority of residents needed the same or greater levels of support and assistance during that year, suggesting that a transition back to the community was unlikely, and almost 21,000 clients died while in nursing home care.

Disabled and elder adults may also be served through several Medicaid HCBS programs:[43] the Aged and Disabled Adult (ADA) Waiver; the Consumer-Directed Care Plus (CDC+) program; the Long-Term Care Community Diversion Pilot Project (the Nursing Home Diversion program); the Program of All-Inclusive Care for the Elderly (PACE); the Alzheimer's Disease Waiver; the Assisted Living for the Frail Elderly (ALE) Waiver; the Channeling Waiver; and the Adult Day Health Care (ADHC) Waiver.

ADA Waiver

The ADA program is dually administered by the DCF and the DOEA. DCF administers the program for disabled adults age 18 to 59, while DOEA administers the program for persons age 60 and older. This program serves Medicaid-eligible frail elders and persons with disabilities at risk of nursing home placement. ADA provides services and items in the client's home --- including chore, homemaker, personal care, respite, case management, adult day health care, counseling, case aide, physical therapy, caregiver training and support, emergency alert response, consumable medical supplies, home-delivered meals, environmental modifications, health risk management, and speech and occupational therapy.

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[40] Section 409.912(15), F.S.

[41] *See* generally *OPPAGA Government Program Summaries: Department of Elder Affairs Nursing Home Pre-Admission Screening (CARES)*, last updated 1/21/11. Available at http://www.oppaga.state.fl.us/profiles/5029/ (last visited March 23, 2011).

[42] This is not an unduplicated count, *i.e.*, one client could account for several stays throughout the year. The August 2010 Revenue Estimating Conference projects a total (unduplicated) nursing home caseload of almost 43,000 (exclusive of General Care use) for State Fiscal Year 2010-2011. *Social Services Estimating Conference - August 2010 Long Term Medicaid Forecast*. Available at http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited November 1, 2010).

[43] The program descriptions derive generally from *2010 Summary of Programs and Services*, March 2010, Florida Department of Elder Affairs, available at http://elderaffairs.state.fl.us/english/pubs/pubs/sops2010/First_page_2010SOPS.html (last visited November 1, 2010).

CDC+ Program
The Consumer-Directed Care Plus (CDC+) Program is a self-directed option for seniors participating in the Aged and Disabled Adult Waiver. The CDC+ Program allows participants to hire workers and vendors of their own choosing – including family members or friends – to help with daily needs such as house cleaning, cooking and getting dressed. The program provides trained consultants to help consumers manage their budgets and make decisions. Participants may manage their own care or they may elect to have a friend or family member represent them in making decisions about their services. The Department also provides fiscal employer agent services for individuals served through the Department of Health's Traumatic Brain and Spinal Cord Injury Waiver, as well as for adults with disabilities under the age of 60 served through DCF.

Nursing Home Diversion
The Nursing Home Diversion program serves the most frail individuals age 65 and older, otherwise eligible for Medicaid nursing home placement, through a managed care provider. By receiving integrated acute and long-term services, such as home-delivered meals, coordination of health services and intensive case management, clients are better able to remain in the community.

Program of All Inclusive Care for the Elderly
The PACE model is a project within the Nursing Home Diversion Program that targets individuals 55 and older who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home- and community-based services at a cost less than nursing home care. PACE enrollees have both their medical and long-term care needs managed through a single provider. In addition to services covered under the Nursing Home Diversion program, the PACE project includes all services covered by Medicare. PACE providers receive both Medicare and Medicaid capitated payments and are responsible for providing the all necessary medical and long-term care services. In addition, PACE sites receive an enhanced capitation payment from Medicare, beyond that of a traditional Medicare health maintenance organization. PACE delivers many services being through adult day care centers and case management is provided by multi-disciplinary teams. The program is available in Miami-Dade, Martin and St. Lucie, and Lee counties.

Alzheimer's Disease Waiver
This program provides specialized services designed to maintain individuals aged 60 or older with Alzheimer's disease within the community. Each recipient's service package is tailored to meet his or her needs as indicated by the needs assessment and care planning process --- clients in the later stages of Alzheimer's disease are expected to require a more intense service package than those in the earlier stages. The waiver program provides case management, adult day health care, respite care, wanderer alarm system, wanderer identification and location program, caregiver training, behavioral assessment and intervention, incontinence supplies, personal care, environmental modification and pharmacy review. The Alzheimer's Disease Waiver is available in Broward, Miami-Dade, Palm Beach and Pinellas counties.

Assisted Living for the Frail Elderly Waiver
The ALE Waiver is for individuals age 60 and older who are at risk of nursing home placement and who meet additional specific criteria related to their ability to function. Because of their

frailty, recipients need additional support and services, which are made available in ALFs with extended congregate care or limited nursing services licenses.

Channeling Waiver

The Channeling waiver is operated through an annual contract with an organized health care delivery system in Miami-Dade and Broward counties. Eligible clients are age 65 and older who meet nursing home level of care criteria and who live in the service area. Through contracts with the Department, the organization receives a per-diem payment to provide, manage and coordinate enrollees' long-term care service needs. Services include adult day health care, case management, chore services, companion services, counseling, environmental accessibility adaptations, family training, financial education and protection services, home health aide services, occupational therapy, personal care services, personal emergency response systems, physical therapy, respite care, skilled nursing, special home-delivered meals, special drug and nutritional assessments, special medical supplies, and speech therapy.

Adult Day Health Care Waiver

The ADHC waiver provides a combination of integrated health and social services with the goal of delaying or preventing placement into a long-term care facility. The services are aimed at preserving the individual's physical and mental health while providing relief for the family/caregiver from 24-hour care responsibilities. To be eligible for ADHC, an individual must be a resident of Lee or Palm Beach counties age 75 or older, meet nursing home level of care, and live in the community with a caregiver. Services include case management, nursing, social services, personal care assistance, rehabilitative therapies, meals, counseling, transportation and caregiver assessments. An individualized plan of care is developed to meet the client's health and supportive needs, and all services are provided at the day health care facility.

In state fiscal year 2009-2010, the DOEA served over 37,000 persons in the HCBS Medicaid Waiver programs.[44] Over 36,000 persons are on the waiting list for the various DOEA programs as of October 28, 2010.[45]

Area Agencies on Aging

The DOEA is created in s. 20.41, F.S. This section directs the DOEA to plan and administer its programs and services through planning and service areas. The DOEA is designated as the state unit on aging as defined in the federal Older Americans Act (OAA).[46]

The statutorily stated purposes of DOEA include but are not limited to:

- Serving as the primary state agency responsible for administering human services programs for the elderly and for developing policy recommendations for long-term care;[47]
- Recommending state and local level organizational models for the planning, coordination, implementation, and evaluation of programs serving the elderly population;[48] and,

[44] Attachment 5, *HCBS Medicaid Waiver Programs 2005-2010*, provides program-specific enrollment information.
[45] *Department of Elder Affairs StateWide Analysis Assessed Prioritized Consumer List Totals by Assessed Rank Level and Program as of 10/28/2010*, Unduplicated Consumer Count by Programs. On file with the Senate Committee on Children, Families, and Elder Affairs.
[46] Section 20.41(5), F.S.
[47] Section 430.03(1), F.S.
[48] Section 430.03(6), F.S.

- Overseeing implementation of federally funded and state funded programs and services for the state's elderly population.[49]

Federal law directs the department to administer the OAA using Florida's 11 area agencies on aging (AAAs).[50] DOEA works closely with the 11 AAAs in Florida. The AAAs operate as 501(c)(3) public- and privately-funded non-profit corporations.[51] The agencies administer funds locally and contract with a variety of provider agencies to offer a wide array of services designed to address the needs of their senior constituencies.

Each of the 11 AAAs is a designated Aging Resource Center.[52] An Aging Resource Center (ARC) is a single, coordinated system of information and access for all persons seeking long-term care resources. An ARC allows the public to find information and services through multiple entry points, ensuring uniform information and referral and streamlined access to public and private long-term care services.[53]

Among other duties,[54] for persons residing in their respective geographic service areas, the ARCs:

- Provide an initial screening of persons requesting long-term care services to determine which programs – state, federal, local, or private – would most appropriately serve them;
- Determine eligibility for and priority placement of clients in certain long-term care programs;[55] and
- Manage the financial resources for those programs.

Medicaid Long-term Care Eligibility

In the last several years, reports have surfaced in the popular press of use of the Medicaid nursing home program by persons who would appear to be able to afford to pay for their own care.[56] This practice of Medicaid estate planning has been both lauded, as a necessary and legitimate part of long-term financial planning, and vilified, as an evasion of personal responsibility through use of loopholes in a government program intended to aid the needy.

The DCF administers the financial eligibility determination portion of the Medicaid program for the AHCA.[57] Those determinations require examination of an applicant's current assets, in addition to recent transfers of those assets.[58] The DCF has published policies on many of the

[49] Section 430.03(7), F.S.
[50] 42 U.S.C.S§3025. The department is required to designate and contract with AAAs to fulfill programmatic and funding requirements pursuant to s. 20.41(6), F.S.
[51] As required by federal and state law.
[52] Section 430.2053(7), F.S.
[53] Aging Resource Centers. Department of Elder Affairs. Available at http://elderaffairs.state.fl.us/english/arc.php (last visited March 23, 2011).
[54] See s. 430.2053(5), F.S.
[55] Community care for the elderly; home care for the elderly, contracted services, Alzheimer's disease initiative, aged and disabled adult Medicaid waiver, assisted living for the frail elderly Medicaid waiver, Older Americans Act.
[56] *See*, e.g., *Compensating a Family Caregiver*. Wall Street Journal, August 29, 2010. Available at http://online.wsj.com/article/SB10001424052748703669004575458151412654506.html (last visited March 23, 2011).
[57] Section 409.902, F.S.
[58] Assets transferred within the 60-month look-back period may cause an applicant to lose or delay eligibility for long-term care services.

instruments used to transfer assets[59] but has been unable to establish a policy on the use of personal care contracts.

Personal care contracts are agreements designed to compensate individuals, often relatives, for the provision of certain services to the institutionalized recipient. The contracts are frequently structured to pay a lump sum amount in advance to the caregiver for services to be rendered during the institutionalized recipients' remaining lifetime; when the recipient dies, the caregiver retains the remaining value of the contract with no obligation to return the "unearned" funds to the estate. In addition, the services to be performed frequently are services that would ordinarily be performed by a relative out of love and affection or are duplications of services paid for by Medicaid. Federal law does not prohibit the use of personal care contracts or provide guidelines to the states in determining their reasonableness.

Statewide Inpatient Psychiatric Program (SIPP) for Under Eighteen

The Medicaid Statewide Inpatient Psychiatric Program (SIPP) provides medically necessary, inpatient psychiatric residential treatment services to recipients under the age of 18 who meet the Medicaid eligibility requirements. The SIPP waiver is funded by the federal CMS and matching state dollars.[60]

Treatment planning and interventions must be oriented around discharge planning from the time of admission. Treatment services are required to be active, individualized, family centered, culturally sensitive, trauma informed and focused on problems necessitating the child's or adolescent's placement in an inpatient treatment setting.

There are currently 14 SIPP providers in the state[61] with a total of 414 beds. The daily rate for the treatment services, which are all-inclusive, is set by the Legislature at $406.00 per day.[62]

The Medically Needy Program

The Medically Needy program serves individuals, including pregnant women and children, who have income or assets that exceed the limits for regular Medicaid. Individuals enrolled in Medically Needy incur a monthly share of cost (which is like an insurance deductible) and the amount varies depending on the family's size and income. There is no income limit to qualify for the Medically Needy program; however, there is an asset limit, which varies based upon the family's size.

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[59] For example, life estates, promissory notes, and annuities. *See*, generally, *ACCESS Florida Program Policy Manual*. Section 1600 Assets. Available at http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/1630.pdf (last visited March 23, 2011).

[60] The Centers for Medicare and Medicaid Services (CMS) allows states the option of providing Medicaid coverage for children in Institutions for Mental Disease (IMD) under Psychiatric Inpatient Services for Individuals Under 21, 42 CFR 441, Subpart D. This waiver is operated by AHCA and expires on December 31, 2011.

[61] SIPP providers are licensed pursuant to Chapter 395, Part I, F.S., for hospitals, and Rule 65E-9, F.A.C. for residential treatment centers.

[62] SIPP services are governed by 42 C.F.R. Parts 435, 440, 441, and 456. The Florida SIPP program is authorized by proviso in the annual General Appropriation Act, under Section 3 Human Services AHCA, "Special Categories, Hospital Inpatient Services".

Once a person is determined eligible for the Medically Needy program and the amount of their share of cost has been set by the DCF, accumulated medical bills that meet allowable medical expenses criteria must be submitted to DCF. The beneficiary needs to continue to submit medical bills until the share of cost has been met. Once the share of cost is met, the individual can receive full Medicaid benefits for the remainder of the month in which their share of cost has been met.

Medically Needy Program Authorization and History

Under Federal regulations, states have the option of implementing a Medically Needy program under their state plan. If states choose to implement a Medically Needy program it is required to cover, at a minimum, some level of ambulatory service and must provide prenatal and delivery services to pregnant women. States can chose to provide one or more ambulatory service, although states must provide all medically necessary services to children. Currently Florida's Medically Needy program includes all Medicaid covered services with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

In 1984 the Florida Legislature passed the Public Medical Assistance Trust Fund (PMATF) Act, which was originally used to fund Medically Needy, largely to compensate hospitals that provide services to the uninsured. The Legislature authorized the Medically Needy program to start in July 1986. Historical highlights include:

- April of 1992: Program was eliminated and then reinstated during the same month;
- December 2001: Medically Needy program for adults eliminated effective July 2002;
- May 2002: Medically Needy restored coverage to adults. Program continued with non-recurring funds;
- April 2004: Medically Needy was funded for FY 2004-05 with non-recurring funds;
- Required to cover prescribed drugs only, effective July 1, 2005;
- May 2005: Medically Needy changed to remove limitation to cover prescribed drugs only;
- May 2008: Medically Needy to cover pregnant women and children only effective July 1, 2009;
- May 2009: Medically Needy extended for all covered groups through December 31, 2010; January 1, 2011 coverage to be limited to pregnant women and children only; and
- May 2010: Medically Needy extended for all covered groups through June 30, 2011; July 1, 2011 coverage to be limited to pregnant women and children only.

Recent Enrollment and Expenditures for Medically Needy

	Total Program Costs		Average Monthly Caseload
SFY 2009-2010	Actual Expenditures	$763,151,149	33,447
SFY 2010-2011	Budgeted Expenditures	$1,040,352,327	40,621
SFY 2011-2012	Projected Expenditures	$1,429,238,766	46,096

Medicaid's Effect on the State Budget

The Medicaid program is an entitlement program, which means that participating states must pay for all covered services for all persons who are eligible for the program. Medicaid is growing more rapidly than any other major program in the Florida budget.

In state fiscal year 2010-11 budget, Medicaid costs exceeded $20 billion and accounted for 29 percent of the state budget. Just 10 years ago, Medicaid accounted for only 17 percent of the state budget and cost $8.9 billion.

Annual Medicaid expenditures are estimated by the Social Services Estimating Conference (SSEC) and each year the Legislature funds the estimated cost of the Medicaid program minus any reductions or additions the Legislature decides to make. Costs estimated for the Medicaid program by the SSEC are often incorrect. If program costs exceed appropriations, the legislature must fund these additional costs in a "back of the bill" appropriation (an appropriation which covers prior year shortfalls). For example, the Legislature was required to appropriate $256 million in general revenue in the fiscal year 2010-11 GAA to cover a budget shortfall in fiscal year 2009-10.

Medicaid is the only major program funded by state government which functions in this fashion. Like Medicaid, funding for Pre-K-12 education is calculated based on the projected growth in student enrollment. However, unlike Medicaid, if enrollment increases beyond projections, the state is not responsible for paying the additional costs. Instead, the dollar increase per student is automatically decreased to match the appropriation.

The rapid growth of Medicaid, linked with the often unanticipated cost overruns, is crowding out the state's ability to fund other critical programs like education and public safety. This is not only the case in Florida but in many other states as well. Many states are making efforts to limit the growth of Medicaid spending through reducing eligibility and services covered by the program. The federal government has recently signaled an interest in assisting states in managing their Medicaid costs.

Temporary Assistance for Needy Families and Children in Foster Care

Federal law includes several provisions that require states to meet certain requirements in order to qualify for federal funds. Title IV-E of the Social Security Act contains state plan requirements that must be met for a state to be eligible to receive federal matching funds for foster care and adoption assistance and Title IV-A of the Social Security Act contains state plan requirements for states to be eligible for the Temporary Assistance for Needy Families (TANF) block grant.[63]

Title IV-E requires a state to provide health insurance coverage for children in foster care and adopted children with special needs for whom there is an adoption assistance agreement between the state and the adoptive parents. The state has the option of meeting this requirement by providing that such children are eligible for Medicaid under Title XIX of the Social Security Act. If the state provides this coverage through a state medical assistance program other than

[63] TANF is a federal block grant program to help move recipients into work and turn welfare into a program of temporary assistance. Under the welfare reform legislation of 1996, TANF replaced the old welfare programs known as the Aid to Families with Dependent Children (AFDC) program, the Job Opportunities and Basic Skills Training (JOBS) program, and the Emergency Assistance (EA) program. The law ended Federal entitlement to assistance and instead created TANF as a block grant that provides States, Territories, and Tribes Federal funds each year. These funds cover benefits and services targeted to needy families. *See* "Temporary Assistance for Needy Families (TANF) Overview," http://www.hhs.gov/recovery/programs/tanf/tanf-overview.html (last visited March 27, 2011).

Medicaid, the services provided must be of the same type and kind as those that would be provided under Medicaid.

The provisions of the Temporary Assistance for Needy Families program requires that a state certify that the state will operate a foster care and adoption assistance program that meets the requirements of Title IV-E including taking actions to assure that children are eligible for medical assistance. Florida currently meets the requirements of Title IV-E through providing for Medicaid eligibility for children in foster care and for children with special needs under an adoption assistance agreement.

Psychotropic Medications for Children

Psychotropic medications are one of many treatment interventions that may be used to address mental health problems. Medication may be recommended and prescribed for children with mental, behavioral, or emotional symptoms when the potential benefits of treatment outweigh the risks. This is particularly true when the problems experienced by the child are so severe that there would be serious negative consequences for the child if the child is left untreated and when other treatment interventions have not been effective. However, public concern is growing over reports that very young children are being prescribed psychotropic medications, which is not generally the first option of treatment for a child, that some children are on multiple medications, and that these medications are sometimes used inappropriately to control a child's behavior.

Some of the concerns regarding the use of psychotropic medications by children stem from the limited information that is available regarding the efficacy and the potential side effects of these drugs with children. Most clinical trials for these drugs were conducted on an adult population.

The same results are not always obtained when these drugs are used with children, and the side effects for children are frequently different than those experienced by adults. The federal Food and Drug Administration has expressed concern regarding the use of antidepressants in children and established an advisory committee to further study and evaluate the use of such medications.

Many children in the United States receive psychotropic medications and this number has increased over time. The use of multiple psychotropic medications has also been reported to have increased among children. The efficacy and short- and long-term safety knowledge base for pediatric psychopharmacology has increased in recent years but remains limited.[64]

An issue that has increasingly received national attention over the past decade has been the concern for the overuse of psychotropic medications among our nation's youth in general, with a potentially disproportionate increase among children in foster care.[65] Among community-based populations, children in foster care tend to receive psychotropic medication as much as, or more than, disabled youth and three to four times the rate among children with Medicaid coverage

[64] Alfiee M. Breland-Nobel et al., *Use of Psychotropic Medications by Youths in Therapeutic Foster Care and Group Homes*, PSYCHIATRIC SERVICES, Vol. 55, No. 6., 706 (June 2004), *available at* http://ps.psychiatryonline.org/cgi/reprint/55/6/706 (last visited March 23, 2011).

[65] Laurel K. Leslie, MD MPH FAAP, Am. Acad. of Pediatrics, *Hearing on the Utilization of Psychotropic Medication for Children in Foster Care*, 6 (May 8, 2008), *available at* http://www.aap.org/advocacy/washing/Testimonies-Statements-Petitions/05-08-08-Leslie-Psychotropics-Meds-Testimony.pdf (last visited March 23, 2011).

based on family income.[66] Children in foster care and disabled youth have the greatest likelihood of receiving complex, poorly evidenced, high cost medication regimens.[67]

In Florida, information received from the AHCA revealed that more than 9,500 children in Florida on Medicaid had been treated with psychotropic drugs in the year 2000. [68] The Legislature directed the AHCA to improve the quality of behavioral health drug prescribing, and in 2005, the AHCA implemented the Florida Medicaid Drug Therapy Management Program for Behavioral Health.[69]

To assure that the use of atypical antipsychotic medications in very young children (those younger than six) within the Medicaid population is confined to specific circumstances, the AHCA put in place a prior authorization process in April 2008. Within the first six months of the program, the AHCA reported that the prior authorization process resulted in fewer prescriptions, and at lower dosages, for antipsychotic medications for these young children.[70]

- For the period May to December 2007, 3,167 prescriptions were written for children under age 6.
- For the period May to December 2008, only 844 prescriptions were written for this age group.[71]

The AHCA has also instituted the Florida Pediatric Psychiatry Consult Hotline. It is a call-in service available to health care providers who have questions about medications used to treat children and adolescents with psychiatric needs.[72]

Blood Establishments

A blood establishment is defined in s. 381.06014, F.S., to mean any person, entity, or organization, operating within Florida, which examines an individual for the purpose of blood donation or which collects, processes, stores, tests, or distributes blood or blood components collected from the human body for the purpose of transfusion, for any other medical purpose, or for the production of any biological product.

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[66] Julie M. Zito, PhD, Professor of Pharmacy and Psychiatry, U. of Maryland, *Prescription Psychotropic Drug Use Among Children in Foster Care*, 2-3 (May 8, 2008), *available at* http://www.hunter.cuny.edu/socwork/nrcfcpp/teleconferences/2-10-10/Zito%20Medication%20handout.doc (last visited March 23, 2011).
[67] *Id*. at 2.
[68] Florida Statewide Advocacy Council, *Accomplishments*, http://www.floridasac.org/state_accomplish.html (last visited Apr. 8, 2010).
[69] Section 409.912(39)(a)10, F.S.
[70] Medicaid Prescribed Drug Program. *Report of Policy Review: Oversight of Off-Label Prescribing of Atypical Antipsychotic Medications for Children Under Six Years of Age Covered by the Florida Medicaid Program*, March 27, 2009. Available at http://www.dcf.state.fl.us/initiatives/GMWorkgroup/docs/Atypical_antipsychotics_in_children_policy_report.pdf (last visited March 23, 2011).
[71] *Approval process lowers the number of kids on atypical prescriptions.* St. Petersburg Times, in print Sunday, March 29, 2009. Available at http://www.tampabay.com/news/health/article987612.ece (last visited March 23, 2011).
[72] Florida Pediatric Psychiatry Hotline. Available at http://medicaidmentalhealth.org/NewsAndAnnouncements/news-detail.aspx?id=44 (last visited March 23, 2011).

The state of Florida does not issue a specific license as a blood establishment. Florida law[73] requires a blood establishment operating in Florida to operate in a manner consistent with the provisions of federal law in Title 21 Code of Federal Regulations (C.F.R.) parts 211 and 600-640, relating to the manufacture and regulation of blood and blood components. If the blood establishment does not operate accordingly and is operating in a manner that constitutes a danger to the health or well-being of blood donors or recipients, the AHCA or any state attorney may bring an action for an injunction to restrain such operations or enjoin the future operation of the establishment.

Federal law classifies blood establishments as follows:[74] community (non-hospital) blood bank (community blood center), hospital blood bank, plasmapheresis center, product testing laboratory, hospital transfusion service, component preparation facility, collection facility, distribution center, broker/warehouse, and other. Community blood centers are primarily engaged in collecting blood and blood components from voluntary donors to make a safe and adequate supply of these products available to hospitals and other health care providers in the community for transfusion. Blood establishments that focus on the collection of plasma that is not intended for transfusion, but is intended to be sold for the manufacture of blood derivatives[75] routinely pay donors.

Community blood centers in Florida are licensed as clinical laboratories by the AHCA, unless otherwise exempt.[76] As a part of the clinical laboratory license, the facility is inspected at least every 2 years.[77] The AHCA may accept surveys or inspections conducted by a private accrediting organization in lieu of conducting its own inspection.[78] The clinical laboratory personnel are required to maintain professional licensure by the DOH. Community blood centers must also have appropriate licenses issued by the DOH and must comply with laws related to biomedical waste[79] and radiation services.[80]

Florida Kidcare

The Florida Kidcare Program was created by the Florida Legislature in 1998 in response to the federal enactment of the state Children's Health Insurance Program (CHIP) in 1997. Initially authorized for 10 years and then recently re-authorized again through 2019 with federal funding through 2015, CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but meet other eligibility requirements.

[73] Section 381.06014, F.S.
[74] A description of these classifications may be found at: http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/EstablishmentRegistration/BloodEstablishmentRegistration/ucm055484.htm (Last visited on January 6, 2011).
[75] Blood derivatives are classified as prescription drugs. *See* s. 499.003(43), F.S. and s. 503(b) of the Federal Food, Drug, and Cosmetic Act.
[76] *See* ch. 59A-7.019, F.A.C., and part I of ch. 483, F.S., related to Health Testing Services.
[77] Section 483.061(1), F.S.
[78] Section 483.061(4), F.S.
[79] *See* ch. 64E-16, F.A.C., Biomedical Waste, and s. 381.0098, F.S.
[80] *See* ch. 64E-5, F.A.C., Control of Radiation Hazards. If a blood center irradiates blood products using radioactive materials, the location in which this occurs must be licensed. If a blood center irradiates blood products using a machine, then the community blood center must register the machine.

The umbrella name of Florida Kidcare encompasses four subsidized programs: Medicaid for children, MediKids, CMS Network, and Healthy Kids. Florida's Healthy Kids program predates enactment of the CHIP program. Subsidized Kidcare coverage is funded through state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the Federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI components of the program based on their household size, income, and other eligibility factors. For families above the income limits for subsidy or who do not otherwise qualify for subsidy, Kidcare also offers a buy-in option under Healthy Kids and MediKids.

Eligibility for the four subsidized Kidcare components funded by Title XXI is determined in part by age and household income, as follows:[81]

- Medicaid for Children: Title XXI funding is available from birth until age 1 for income between 185 percent and 200 percent of the Federal Poverty Level (FPL);
- MediKids: Title XXI funding is available from age 1 until age 5 for income between 133 percent and 200 percent of FPL;
- Healthy Kids: Title XXI funding is available from age 5 until age 6 for income between 133 percent and 200 percent of FPL. For age 6 until age 19, Title XXI funding is available for income between 100 percent and 200 percent of FPL; and
- CMS Network: Title XXI and Title XIX funds are available from birth until age 19 for income up to 200 percent of FPL for children with special health care needs. The DOH assesses whether children meet the program's clinical requirements.

Florida Kidcare is administered jointly by the AHCA, the DCF, the DOH, and the FHKC. Each entity has specific duties and responsibilities under Kidcare as detailed in the Florida Kidcare Act. The DCF determines eligibility for Medicaid, and the FHKC processes all Kidcare applications and determines eligibility for CHIP, which includes a Medicaid screening and referral process to DCF, as appropriate.

To enroll in Kidcare, families utilize a joint form that is both a Medicaid and CHIP application. Families may apply using the paper application or an online application. Both formats are available in English, Spanish, and Creole. Income eligibility is determined through electronic data matches with available databases or, in cases where income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms.

School Food Service Programs

Florida's school food service programs are authorized under the K-20 Education Code in recognition of the demonstrated relationship between good nutrition and the capacity of students to develop and learn. The State Board of Education is required to adopt rules covering the administration and operation of the school food service programs. Each district school board is required to consider recommendations of the district school superintendent and adopt policies for an appropriate food and nutrition program for students consistent with federal law and rules of the State Board of Education.[82]

[81] Florida Kidcare Eligibility, Florida Kidcare website, http://www.floridakidcare.org/images/data/FKC-eligibilityflag-accessible.pdf

[82] *See* s. 1006.06(1)-(3), F.S.

Free and reduced-price school meal programs are funded jointly by states and the federal government. In Florida's 2010-11 General Appropriations Act, $823.8 million is appropriated for school lunch and breakfast programs, including $16.9 million from the General Revenue Fund.[83]

Currently in Florida, 82 charter schools, 50 private schools, and all 67 public school districts participate in the national free and reduced-price school meal programs. In the 2010-11 school year, 56 percent of the 2.6 million public school students, including charter schools, are eligible for free or reduced-price meals. The number of private school students eligible in 2010-11 is 13,191.

Children may be deemed eligible for free or reduced-price school meals based largely on household income and by filling out an application. Eligibility is capped at 185 percent of the federal poverty level. There is no uniform, statewide application form for families to use when applying for free or reduced-price meals. School districts may design their own forms based on the requirements of federal and state regulations. The Food and Nutrition Service within the United States Department of Agriculture provides a model application form that school districts may modify and use as needed for local circumstances and nomenclature.[84] A few school districts offer only an electronic form.

Kidcare Information Delivered by School Districts

Information about Kidcare is currently offered to all 67 Florida school districts in the summer for distribution at the beginning of the school year. For the past several years, this information has been a postcard that includes information on how to apply with English on one side, Spanish on the reverse, and instructions for how to receive information in Creole along the bottom. These postcards are provided free of charge to the districts and shipped to the location of their choice by the FHKC. Most, but not all, school districts accept this offer every year. In the 2009-10 school year, 54 of the 67 school districts participated in this back-to-school Kidcare outreach.[85]

Additionally, some school districts have also modified their application forms for school food service programs to include a check-off for families to indicate they would like more information about Kidcare. For those families indicating they would like more Kidcare information or which agree to release their information, the school districts vary in how those requests are handled, based on available resources. In some cases, the districts send the requests directly to Florida Kidcare for applications to be mailed to the requesting families. In other areas, the school districts utilize local community partners or designated staff to contact families to provide application assistance on a one-on-one basis.

Nursing Home Regulation

Nursing Homes and Related Health Care Facilities is the subject of ch. 400, F.S. Part I of ch. 400, F.S., establishes the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils. Part II of ch. 400, F.S., provides for the regulation of nursing homes, and part III of ch. 400, F.S., provides for the

[83] *See* ch. 2010-152, L.O.F., line items 101-102.
[84] The model application can be found at the USDA web site at http://www.fns.usda.gov/cnd/frp/frp.process.htm.
[85] Office of Program Policy Analysis and Government Accountability, *Research Memorandum: Several Options Exist to Improve Florida Kidcare Outreach and Enrollment Efforts through Schools,* March 1, 2010, p. 4.

regulation of home health agencies. The AHCA is charged with the responsibility of developing rules related to the operation of nursing homes.

Section 400.023, F.S., creates a statutory cause of action against nursing homes that violate the rights of residents specified in s. 400.022, F.S. The action may be brought in any court to enforce the resident's rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence.[86] Prevailing plaintiffs may be entitled to recover reasonable attorney's fees, and costs of the action, along with actual and punitive damages.[87]

Sections 400.023-400.0238, F.S., provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022, F.S. No claim for punitive damages may be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages.[88] A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence as specified in s. 400.0237(2), F.S.[89]

In the case of an employer, principal, corporation, or other entity, punitive damages may be imposed for conduct of an employee or agent only if the conduct meets the criteria specified in s. 400.0237(2), F.S., and the employer actively and knowingly participated in the conduct, ratified or consented to the conduct, or engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.[90]

Statewide Provider and Health Plan Claim Dispute Resolution Program

Section 408.7057, F.S., requires the AHCA to establish a program to provide assistance to contracted and non-contracted providers and health care plans for resolution of claim disputes that are not resolved by the provider and the health plan. The AHCA must contract with a resolution organization to timely review and consider claim disputes submitted by providers and health plans and recommend to the AHCA an appropriate resolution of those disputes. The conclusions of law contained in the written recommendation of the resolutions organization are not currently required to identify the provisions of law or contract which, under the peculiar facts and circumstances of each case, entitle the provider or health plan to the amount awarded, if any.

Physician Expert Witness

Chapter 458, F.S., provides for the regulation of the practice of medicine by the Board of Medicine. Physicians are subject to discipline for failure to comply with the appropriate standards of practice, including: making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine;[91]

[86] Sections 400.023 and 400.0237, F.S.
[87] *Id.*
[88] Section 400.0237(1), F.S.
[89] Section 400.0237(2), F.S.
[90] Section 400.0237(3), F.S.
[91] Section 458.331(1)(k), F.S.

or being found by any court in Florida to have provided corroborating written medical expert opinion attached to any statutorily required response rejecting a claim, without reasonable investigation.[92]

The Board of Medicine may enter an order denying licensure or imposing one or more of the following penalties for a disciplinary violation of any applicable regulations: refusal to certify, or certify with restrictions, an application for a license; suspension or permanent revocation of a license; restriction of practice or license; imposition of an administrative fine not to exceed $10,000 for each count or separate offense; issuance of a reprimand or letter of concern; placement of the licensee on probation for a period of time and subject to such conditions as the board may specify; corrective action; imposition of an administrative fine in accordance with s. 381.0261, F.S., for violations regarding patient rights; refund of fees billed and collected from the patient or a third party on behalf of the patient; or a requirement that the practitioner undergo remedial education.[93] Osteopathic physicians are similarly regulated by the Board of Osteopathic Medicine under ch. 459, F.S.[94]

Legal issues surrounding physician expert witness testimony have raised issues regarding whether a state medical peer-review immunity statute shields a medical association, its peer-review committee, and physicians from a physician's claims and whether the federal Health Care Quality Improvement Act immunizes a medical association from liability. A physician who served as an expert witness in a medical malpractice action sued physicians and a medical association for defamation, tortuous interference with an advantageous business relationship, conspiracy, and witness intimidation after physicians initiated the medical association's peer-review of the physician's testimony.[95] The First District Court of Appeal held that the state medical peer-review immunity statute did not shield the medical association, its peer-review committee, and physicians from the physician's claims; and that the federal Health Care Quality Improvement Act did not immunize from liability professional-review of a physician's testimony given in a medical malpractice action.[96]

The Board of Medicine has had difficulty in enforcing the current disciplinary provision imposed on medical physicians that relates to "*being found* by any court in this state to have provided corroborating written medical expert opinion attached to any statutorily required notice of claim or intent or to any statutorily required response rejecting a claim, without reasonable investigation."[97] The physician asserted that (1) no "finding" was ever made by the court that issued an order because the order was the result of an ex parte hearing where no evidence was reviewed by the court; (2) the Board of Medicine erred in refusing to make a probable cause determination based upon the board's new reading of s. 458.331(1)(jj), F.S.; (3) the Board of Medicine's new reading of s. 458.331(1)(jj), F.S., is unreasonable because it "interjects material

[92] Section 458.331(1)(jj), F.S.
[93] Sections 458.331 and 456.072(2), F.S.
[94] See ss. 459.015 and 456.072(2), F.S.; and s. 459.015(1)(mm), F.S.
[95] *Fullerton v. Florida Medical Association, Inc.*, 938 So. 2d 587 (Fla. 1st DCA 2006).
[96] *Id.*
[97] Section 458.331(1)(jj), F.S. See *Department of Health v. Francisco Vazquez, M.D.*, DOAH Case No. 07-424PL, Respondent's Post-hearing Memorandum of Law, and *Board of Medicine v. Francisco Vazquez, M.D.*, 11 So .3d 994 (Fla. 1st DCA 2009) (affirming the findings of the administrative law judge that the challenged agency statement asserting a new reading of s. 458.331(1)(jj), F.S., constitutes a rule that has not been adopted pursuant to s. 120.54, F.S.).

terms found nowhere in the statute;" and (4) it is unconstitutional violation of his due process.[98] The respondent alleged that his procedural due process was violated because s. 458.331(1)(jj), F.S., does not provide the disciplined physician with any opportunity to defend himself or herself against the charge being brought by the Board of Medicine.[99] For purposes of the specific disciplinary violation, the respondent argued that the physician is a witness and not a party to the medical malpractice action where his opinion was proffered, so the physician has not had sufficient opportunity or notice to be heard in the court proceeding.[100] As a result, the physician has not had an opportunity to refute the entry of a previous circuit court order where the order, itself, forms the basis of the physician's discipline by the Board of Medicine.[101]

Section 766.102, F.S., outlines qualifications for medical expert witnesses to meet in order to proffer testimony in medical negligence actions, and s. 766.102, F.S., provides that it does not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in that section. Relevant portions of the Florida Evidence Code provide requirements for expert opinion testimony.[102] The Florida Rules of Civil Procedure define "expert witness" as a person duly and regularly engaged in the practice of a profession who holds a professional degree from a university or college and has had special professional training and experience, or one possessed of special knowledge or skill about the subject upon which called to testify.[103]

Medical Malpractice Insurance Contracts

Section 627.4147, F.S., authorizes the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration made pursuant to s. 766.106, F.S., relating to medical malpractice, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, F.S., relating to medical malpractice, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer must be made in good faith and in the best interests of the insured.

Medical Malpractice

The failure of a health care provider to order, perform, or administer supplemental diagnostic tests is not actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care.[104] "Claim for medical negligence" or "claim for medical malpractice" means a claim, arising out of the rendering of, or failure to render, medical care or

[98] *Department of Health v. Francisco Vazquez, supra* note 12.
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] Sections 90.702 and 90.704, F.S.
[103] Fla. R. Civ. P. 1.390(a).
[104] Section 766.102(4), F.S.

services.[105] In order for a plaintiff to prevail in a medical malpractice action, the plaintiff must establish the standard of care in a claim for medical malpractice which must be determined by the consideration of expert testimony.[106]

No action may be filed for personal injury or wrongful death arising out of medical negligence, whether in tort or in contract, unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant.[107] The complaint or initial pleading shall contain a certificate of counsel that such reasonable investigation gave rise to a good faith belief that grounds exist for an action against each named defendant.[108] For purposes of this section, good faith may be shown to exist if the claimant or his or her counsel has received a written opinion, which shall not be subject to discovery by an opposing party, of an expert as defined in s. 766.102, F.S., that there appears to be evidence of medical negligence. If the court determines that such certificate of counsel was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court shall award attorney's fees and taxable costs against claimant's counsel, and shall submit the matter to The Florida Bar for disciplinary review of the attorney.[109]

"Health care provider" means any Florida-licensed hospital, ambulatory surgical center, or mobile surgical facility; a Florida-licensed birth center; a Florida-licensed physician, physician assistant, anesthesiology assistant, medical resident, osteopathic physician, chiropractic physician, podiatric physician, naturopathic physician, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist or dental hygienist, midwife, physical therapist, physical therapy assistant; a Florida-licensed clinical lab; a Florida-licensed health maintenance organization; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, joint venture, or other association for professional activity by health care providers.[110] An individual who is not a "health care provider" may be held vicariously liable for the acts of its agents and employees who are health care providers.[111]

Section 766.106, F.S., outlines presuit procedures for medical malpractice actions. Florida courts have stated that the presuit investigation procedures and requirements may not be interpreted to impose undue restrictions on a person's access to court.[112] Before issuing notification of intent to initiate medical negligence litigation, the claimant must conduct an investigation to ascertain that there are reasonable grounds to believe that any named defendant in the litigation was negligent in the care or treatment of the claimant and the negligence resulted in injury to the claimant.[113] No statement, discussion, written document, report, or other work product generated by the

[105] Section 766.106(1)(a), F.S.
[106] Section 766.102, F.S.; *Robbins v. Newhall*, 692 So. 2d 947 (Fla. 3rd DCA 1997); *Pate v. Threlkel*, 661 So. 2d 278, 281 (Fla. 1995).
[107] Section 766.104(1), F.S.
[108] *Id.*
[109] *Id.*
[110] Section 766.202, F.S.
[111] *Weinstock v. Groth*, 629 So. 2d 835, 837-838 (Fla. 1993).
[112] See *Ragoonanan by Ragoonanan v. Associates in Obstetrics & Gynecology*, 619 So. 2d 482 (Fla. 2d DCA 1993), and *Kukral v. Mekras*, 679 So. 2d 278 (Fla. 1996).
[113] Section 766.203(2), F.S.

presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party.[114] All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.[115]

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.[116]

Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to $100,000 for one incident and limits all recovery related to one incident to a total of $200,000.[117] Parties may pursue a claim bill with the Legislature for any excess judgment or equitable claim that is not recovered from a state agency or other entity covered by the waiver of sovereign immunity.[118]

Community-Based Care Lead Agencies and Providers

By the enactment of s. 409.1671, F.S., the Legislature required the DCF to outsource the provision of foster care and related services statewide to lead community-based care providers (CBCs). In doing so the Legislature found[119] that foster children have not traditionally had the right to recover for injuries beyond the limitations specified in s. 768.28, F.S.,[120] that the purpose for outsourcing is to increase the level of safety, security, and stability of children who are or become the responsibility of the state, and that one of the components necessary to secure a safe and stable environment for such children is that private providers maintain liability insurance.

[114] Section 766.106(5), F.S.
[115] *Id.*
[116] Section 768.28(9)(a), F.S.
[117] Section 1, ch. 2010-26, Laws of Florida, amended s. 768.28(5), F.S., effective October 1, 2011, to increase the limits to $200,000 for one person for one incident and $300,000 for all recovery related to one incident, to apply to claims arising on or after that effective date.
[118] Section 768.28(5), F.S. (provides that any portion of a judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature).
[119] Section 409.1671(1)(f)1, F.S.
[120] $100,000 ($200,000 effective October 1, 2011) per claim or judgment by any one person and $200,000 ($300,000 effective October 1, 2011) when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence.

Accordingly, the statute requires the lead community-based providers and their subcontractors to provide general liability insurance and put in place limitations on the tort liability of lead community-based providers and their subcontractors.

The CBCs and their subcontractors must provide general liability insurance coverage of $1 million per claim and $3 million per incident. Their tort liability for economic damages is limited to $1 million per liability claim and $100,000 per automobile claim, and tort liability for noneconomic damages is limited to $200,000 per claim.[121] The Legislature, being "cognizant of the increasing costs of goods and services each year and recognize[ing] that fixing a set amount of compensation actually has the effect of a reduction in compensation each year," provided for the limitations on damages to increase at the rate of 5 percent yearly.[122] There is no corresponding requirement that the CBCs increase their insurance coverage to match the increased limits.

Medicaid Services for Persons with Developmental Disabilities

The APD has the responsibility to provide optional Medicaid services to persons with developmental disabilities. A developmental disability is a disorder or syndrome attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome, which is diagnosed before age 18 and constitutes a substantial handicap expected to continue indefinitely.[123]

An individual is eligible for services if he or she meets financial eligibility criteria *and* if he or she has a developmental disability and is three years of age or older. Children who are between three and five years of age and are at high risk of having a developmental disability are also eligible for services. Services provided by the APD include community services and supports as well as a limited institutional program. The APD determines eligibility, assesses service needs, and provides funding for purchasing the supports and services identified in assessments.

The range of services and supports available to an individual include employment and training services, environmental adaptive equipment, personal or family supports, residential habilitation, support coordination, and therapeutic supports. The APD provides services to eligible individuals in state-run developmental disability centers, private intermediate care facilities, or in home and community-based settings.

The APD served 53,731 clients with developmental disabilities statewide as of August 12, 2010.[124] Of those, approximately 30,000 are receiving services through the APD waivers, and almost 20,000 persons are on the waiting list for services. The majority of clients are adults, and the most frequent primary disability is mental retardation. Some clients live independently in the community, while others are served in more restrictive settings dependent upon their individual circumstances. Notably, more than 36,000 clients live in their family homes, and over 7,000 reside in group homes.

[121] Section 409.1671(1)(h) and (j), F.S.
[122] Prorated from the effective date of the statute to the date at which damages subject to such limitations are awarded by final judgment or settlement. Section 409.1671(1)(l), F.S.
[123] Section 393.063(9), F.S.
[124] Because the number of clients fluctuates as persons enter or exit the wait list or a specific program, a "snapshot" count of the client base on a given day was determined to be most useful for these purposes.

Persons younger than 18 with developmental disabilities may become financially eligible, even if supported by their parents. Federal law[125,126] gives states the option to waive or disregard parental income and resources for children under 18 years of age who are living at home but who would otherwise be eligible for Medicaid-funded institutional care. Not counting parental income enables these children to receive Medicaid services at home or in other community settings. Florida has chosen this option.

Insurance Rebates for Healthy Lifestyles

In 2004, the Legislature required health insurers offering group or individual policies and HMOs, when filing rates, rating schedules, or rating manuals with the OIR, to provide for premium rebates based on participation in health wellness, maintenance, or improvement programs, based on certain parameters.[127]

Insurers issuing individual health insurance policies may provide for a rebate on premiums when a covered individual enrolls in and maintains participation in a health wellness, maintenance or improvement program approved by the health plan. To qualify for a rebate, a covered individual must provide evidence of maintenance or improvement of the individual's health status. The measurement is accomplished by assessing health status indicators, agreed upon in advance by the individual and the insurer, such as weight loss, decrease in body mass index, and smoking cessation. The premium rebate is effective for the covered individual on an annual basis, unless the individual fails to maintain his or her health status while participating in the wellness program or evidence shows that the individual is not participating in the approved wellness program. The rebate may not exceed 10 percent of paid premiums.[128]

For group health plans, a rebate may be provided when the majority of members of the health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators similar to those included for individual health policies. The group or health insurer may contract with a third party administrator to gather the necessary information regarding enrollees' health status and provide the necessary report to the insurer. The premium rebate, which may not exceed 10 percent of paid premiums, is effective for an insured on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program.[129]

For HMO coverage, a rebate may be provided when the majority of members of a group health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. Evidence of maintenance or improvement of the enrollees' health status is achieved through assessment of health status indicators similar to those included for individual and group health policies. The premium rebate,

[125] 42 CFR 435.217
[126] 42 CFR 435.602
[127] *See* ss. 32 through 34, ch. 2004-297, Laws of Florida.
[128] *See* s. 627.6402, F.S.
[129] *See* s. 627.65626, F.S.

which may not exceed 10 percent of paid premiums, is effective for a subscriber on an annual basis unless the number of participating members in the health wellness, maintenance or improvement program becomes less than the majority of total members eligible for participation in the program. In addition to group contracts, HMOs are also allowed to offer a premium rebate on individual contracts for a healthy lifestyle program, consistent with the parameters for group contracts.[130]

III. Effect of Proposed Changes:

Section 1 amends s. 163.387(2)(c), F.S., to provide that:

- Hospital districts that are special districts as defined in s. 189.403, F.S.;
- County hospitals that have taxing authority under ch. 155, F.S.; and
- Public health trusts established under s. 154.07, F.S.

are exempt from s. 163.387(2)(a), F.S., which requires that upon the adoption of an ordinance providing for funding of a community redevelopment trust fund,[131] each taxing authority listed above must make an annual appropriation to the redevelopment trust fund for a duration determined by statutory criteria. Under the bill, the taxing authorities listed above are exempt from annually appropriating funds to the redevelopment trust fund.

Section 2 creates s. 200.186, F.S., to provide that, notwithstanding any law governing the expenditures of ad valorem revenues, such revenues raised:

- Pursuant to a special act that establishes a hospital district;
- By a county hospital pursuant to ch. 155, F.S.; or
- By a public health trust established pursuant to s. 154.07, F.S.;

and disbursed by the district, county hospital, or trust to municipalities or other organizations, may be used only to pay for "health care services."

Section 3 amends s. 393.0661, F.S., to direct the APD to impose and collect a fee upon approval from the federal CMS. The fee is created in section 24 of the bill and is a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL.

Section 4 requests the Division of Statutory Revision to designate ss. 409.016 through 409.803, F.S., as part I of ch. 409, F.S., entitled "SOCIAL AND ECONOMIC ASSISTANCE."

Section 5 amends s. 409.016, F.S., to make some technical clarifications to definitions.

Section 6 creates s. 409.16713, F.S., to require that all children in foster care, all children who are covered by adoption assistance agreements, and youth and young adults eligible to receive services under the "Road to Independence" program[132] are eligible for the medical managed care program established in the bill if medical assistance under Medicaid is not available due to the refusal of the federal agency to provide federal funds under Title XIX.

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[130] *See* s. 641.31(40), F.S.

[131] Section 163.387, F.S., establishes a redevelopment trust fund for each community redevelopment agency after approval of a community redevelopment plan.

[132] *See* s. s. 409.14519(5), F.S.

The bill provides that such medical assistance shall be obtained by the community-based care lead agencies subject to the availability of funds appropriated for this purpose.
The bill further provides that it is the intent of the Legislature that provision of such medical assistance fully meet the requirements of the applicable sections of Title IV-E of the Social Security Act and thus permit the state to certify in the TANF state plan that the state will operate a foster care and adoption assistance program that meets the requirements of Title IV-E. This will enable the state to remain eligible for a block grant under the TANF program.

The effect of this section of the bill is to permit the state to continue to receive federal funds other than Medicaid funds if the federal agency refuses to grant requested waivers under Title XIX and refuses to provide the requested federal funds for Medicaid.

Section 7 requests the Division of Statutory Revision to designate ss. 409.810 through 409.821, F.S., as part II of ch. 409, F.S., and entitled "KIDCARE."

Section 8 transfers s. 624.91, F.S., to s. 409.8115, F.S.:
- Changes the minimum MLR for health plans in the Healthy Kids program from 85 percent to 90 percent; and
- Requires the Florida Healthy Kids Corporation, in the development and implementation of a plan for publicizing the Florida Kidcare program, to include the use of application forms for school lunch and breakfast programs.

Section 9 amends s. 409.813, F.S., to make some technical changes to Kidcare statutes.

Section 10 amends s. 409.8132, F.S., to make some technical changes to Kidcare statutes.

Section 11 amends s. 409.815, F.S., to make some technical changes to Kidcare statutes.

Section 12 amends s. 409.818, F.S., to make a technical change to Kidcare statutes.

Section 13 amends s. 154.503, F.S., to make a technical change for Kidcare.

Section 14 amends s. 408.915, F.S., to make a technical change for Kidcare.

Section 15 amends s. 1006.06, F.S., to requires that school districts must provide application information about Kidcare or an application for Kidcare to students at the beginning of each school year, and modify the school district's application form for school breakfast and lunch programs to incorporate a provision that permits the school district to share data from the application form with the Florida Healthy Kids Corporation state agencies that administer Kidcare, unless the child's parent or guardian opts out of the provision.

Section 16 requests the Division of Statutory Revision to designate ss 409.901 through 409.9205, F.S., as part III of ch. 409, F.S., and entitled "MEDICAID."

Section 17 amends s. 409.901, F.S., to make some technical and clarifying changes to Medicaid definitions.

Section 18 amends s. 409.902, F.S., regarding Medicaid eligibility and rules:

- Medicaid eligibility is restricted to U.S. citizens and lawfully admitted non-citizens. Citizenship or immigration status must be verified. State funds may not be used for individuals who do not qualify under these standards unless the services are necessary for treating an emergency medical condition or for pregnant women; and
- Includes new language to provide criteria for DCF to use when evaluating personal care contracts. Intended to address concerns about Medicaid estate planning techniques. Provides DCF rulemaking authority.

Section 19 amends s. 409.9021, F.S., relating to conditions for Medicaid eligibility. Additional conditions for Medicaid eligibility are created, subject to federal regulation and approval:

- An applicant must consent to the release of her or his medical records to the AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs;
- An applicant must consent to forfeit all entitlement to Medicaid goods or services for 10 years if found to have committed Medicaid fraud;
- A recipient may be required to pay a $10 monthly premium for Medicaid coverage subject to the approval of a federal waiver, except for SSI recipients in institutional care. The language authorizes the AHCA to adopt rules providing for premium collection, advance notice of cancellation, and waiting periods for reinstatement of coverage upon cancellation for nonpayment of premiums. The AHCA is also directed to seek federal waiver authority to implement the provisions designed to assist recipients mitigate lifestyle choices and avoid behaviors associated with high-cost medical services; and
- An applicant must consent to participate, in good faith, in a medically-approved smoking cessation program if the applicant smokes, a medically-directed weight loss program if the applicant is or becomes morbidly obese, and a medically-approved alcohol or substance abuse recovery program if the applicant is or becomes diagnosed as a substance abuser.

Requires that a person eligible for Medicaid and who has access to coverage through an employer-sponsored health plan may not receive Medicaid services reimbursed under Medicaid but may use Medicaid financial assistance to pay the cost of premiums for the employer-sponsored coverage for himself/herself and his/her Medicaid-eligible family members. Also, a Medicaid recipient who has access to other insurance coverage created by state or federal law may opt-out of Medicaid-provided services and use Medicaid financial assistance to pay the cost of premiums for the recipient and his/her Medicaid-eligible family members.

The bill allows for Medicaid financial assistance to pay premiums in either of the above cases, not to exceed the capitation that would have been paid to a qualified Medicaid health plan for such coverage under the new managed care system created later in the bill.

Section 20 creates s. 409.9022, F.S., to prohibit any state agency that administers a Medicaid program or waiver from expending Medicaid funds in excess of the amount appropriated in the General Appropriations Act. If at any time a state agency determines that Medicaid expenditures may exceed the amount appropriated during a fiscal year, the agency is required to notify the Social Services Estimating Conference, which is required to meet and determine whether a deficit will occur. Any time the SSEC determines that Medicaid expenditures will exceed appropriations for the fiscal year, the state agency must develop and submit a plan for revising Medicaid expenditures in order to remain within the annual appropriation. The plan must include

cost-mitigating strategies to negate the projected deficit for the remainder of the fiscal year and must be submitted in the form of a budget amendment to the Legislative Budget Commission.

In preparing the budget amendment to revise Medicaid expenditures in order to remain within appropriations, a state agency shall include the following revisions to the Medicaid state plan, in the priority order listed below:

- Reduction in administrative costs;
- Elimination of optional benefits;
- Elimination of optional eligibility groups; and
- Reduction to institutional and provider reimbursement rates.

Section 21 amends s. 409.903, F.S., to make some technical and clarifying changes.

Section 22 amends s. 409.904, F.S., to rename the Medically Needy program as the Medicaid Non-poverty Medical Subsidy (MNMS). Effective April 1, 2012, benefits for the program are limited to physician services only, except for pregnant women and children, who will continue to receive the full range of Medicaid benefits with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

Section 23 amends s. 409.905, F.S., to require the AHCA to prior-authorize home health services. Also requires an assessment of need for private-duty nursing services to specifically include medical necessity for such services instead of other more cost-effective services.

Section 24 amends s. 409.906, F.S., relating to optional Medicaid services and creates a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL. Prohibits the AHCA from paying for psychotropic medications prescribed for a child younger than the age for which the FDA has approved its use.

Section 25 amends s. 409.9062, F.S., relating to lung transplant services, to make some technical and clarifying changes.

Section 26 amends s. 409.907, F.S., relating to Medicaid provider agreements, to conform to provisions created in ss. 766.1183 and 766.1184 later in the bill.

Section 27 amends s. 409.908, F.S., relating to reimbursement of Medicaid providers:

- Specifies that the direct care subcomponent of long-term care reimbursement and cost-reporting includes medically necessary dental and podiatric care.
- Requires that Medicaid fee-for-services payments to primary care physicians for primary care services must be at least 100 percent of the Medicare payment rate for such services, effective January 1, 2013.
- Removes the requirement in existing law that the AHCA must purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged. Further requires the AHCA to either competitively procure transportation services or secure federal waiver authority necessary to draw down the highest federal match available for transportation services.

- Requires Medicaid qualified plans to provide access to covered Medical services under Part IV and states that plans are not required to purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged.

Section 28 amends s. 409.9081, F.S., relating to Medicaid copayments and requires that Medicaid recipients must pay copayments at the time of service, subject to federal waiver authority. Creates a $3 copayment for visiting a specialty physician. Directs the AHCA to seek a waiver of the federal requirement that cost sharing amounts for non-emergency services and care furnished in a hospital emergency department be nominal. Upon waiver approval, each Medicaid recipient must pay a $100 copayment for non-emergency services and care provided in a hospital emergency department (instead of $15 under current law).

Section 29 amends s. 409.912, F.S., relating to cost-effective purchasing of health care. Most notably:

- Paragraph (b) of subsection (4) relating to managed behavioral health care is amended to require that 90 percent (as opposed to 80 percent in current law) of the capitation paid to prepaid plans contracted to provide behavioral health services must be spent on behavioral health services and that if a plan spends less, it must return the difference to the AHCA; and
- Paragraph (b) of subsection (4) is also amended to enroll foster children who reside in Highlands, Hardee, and Polk counties into the statewide behavioral managed care system for such children. Foster kids in those counties are currently excluded, as are foster kids in Escambia, Okaloosa, Santa Rosa, Walton, and Manatee counties. Foster kids in the latter counties would remain excluded under the bill.

Section 30 amends s. 409.915, F.S., relating to county contributions to Medicaid, to make a technical change.

Section 31 transfers and renumbers s. 409.9301, F.S. as s. 409.9067, F.S., and amends subsections (1) and (2) to make some technical changes.

Section 32 amends s. 409.9126, F.S., relating to children with special health care needs, to make a technical change.

Section 33 requests the Division of Statutory Revision to create part IV of ch. 409, F.S., consisting of ss. 409.961 through 409.978, entitled "MEDICAID MANAGED CARE."

Section 34 creates s. 409.961, F.S., to expresses legislative intent that if any conflict exists between ss. 409.961-409.978 and other parts or sections of ch. 409, the provisions of ss. 409.961-409.978 control, and those sections apply only to the Medicaid managed care program.

Section 35 creates s. 409.962, F.S., relating to definitions for pt. IV of ch. 409, F.S.

Section 36 creates s. 409.963, F.S., and establishes the new Medicaid managed care program. Directs the AHCA to submit waiver and state plan amendment requests by August 1, 2011, as needed to implement the program. At a minimum, the requests must include a waiver to permit

home and community-based services to be preferred before nursing home services and a waiver to require dual-eligibles to participate in the program. Also, the waiver is supposed to allow Florida to limit enrollment in managed LTC.

The bill requires the AHCA to initiate procurement processes as soon as practicable and no later than July 1, 2011, in anticipation of federal waiver authority. The bill requires the AHCA to seek waiver approval by December 1, 2011, in order to begin implementation on December 31, 2011. Requires public notice and opportunity for public comment.

The bill requires the AHCA to begin implementing on December 31, 2011. If necessary waivers are not timely received, the bill directs the AHCA to notify the federal CMS of the state's implementation of the program and request the federal agency to continue providing federal funds, as provided under the current Medicaid program, to be used for Florida's new program. If the federal CMS refuses to continue providing federal funds, the managed care program will be implemented to the extent state funds are available.

- If implemented as a state-only-funded program, priority will be given to providing:
  - Nursing home services to persons eligible for nursing home care;
  - Medical services for persons served by APD;
  - Medical services to pregnant women;
  - Physician and hospital services to persons who are eligible for Medicaid;
  - Healthy Start waiver services;
  - Medical services provided to persons in nursing home diversion;
  - Medical services provided to persons in ICF/DDs; and
  - Medical care for children in the child welfare system, whose medical care shall beprovided in accordance with s. 409.16713 as authorized by the GAA.

- If implemented as a state-only-funded program, all provisions related to eligibility standards of the state and federal Medicaid program remain in effect except as specifically provided under the managed care program.

- If implemented as a state-only-funded program, provider agreements and contracts necessary to provide for the preferred services listed above will remain in effect.

Section 37 creates s. 409.964, F.S., to requires all Medicaid recipients to receive covered services through the Medicaid managed care program unless excluded. Exclusions include:
- Women eligible only for family planning services;
- Women eligible only for breast and cervical cancer services;
- Persons with a developmental disability;
- Persons eligible for the Medicaid Non-poverty Medical Subsidy program;
- Persons receiving emergency Medicaid services for aliens;
- Persons residing in a nursing home facility or are considered a resident under the nursing home's bed-hold policy on or before July 1, 2011;
- Persons who are eligible for and receiving prescribed pediatric extended care;
- Persons who are dependent on a respirator by medical necessity and who meet the definition of a medically dependent or technologically dependent child under s. 400.902;

- Persons who select the Medicaid hospice benefit and are receiving hospice services from a hospice licensed under part IV of chapter 400;
- Children residing in a statewide inpatient psychiatric program; and
- Persons eligible for Medicaid who have access to employer-sponsored health coverage. Medicaid financial assistance is available to pay premiums for such coverage for the eligible and his/her eligible family members. The amount of financial assistance may not exceed the capitations that would be paid to a qualified plan for the recipient and his/her eligible family members. A person is deemed to have access to employer-sponsored coverage only if the financial assistance available is sufficient to pay premiums. Also allows persons with access to other coverage created by state or federal law to opt-out of Medicaid coverage under the same premium-assistance conditions as for employer-sponsored coverage.

Provides for voluntary enrollment for those who are exempt from mandatory enrollment, including:
- Recipients residing in residential commitment facilities operated through DJJ, group care facilities operated by DCF, and treatment facilities funded through the Substance Abuse and Mental Health program of DCF
- Persons eligible for refugee assistance

Provides that Medicaid recipients who are exempt from mandatory participation under this section and who do not choose to enroll in the Medicaid managed care program will be served though Medicaid fee-for-service.

Section 38 creates s. 409.965, F.S.:
- Establishes 19 regions in which qualified plans will provide Medicaid services;
- Provides that AHCA will conduct a competitive bid process and that separate invitations to negotiate (ITNs) will be issued for the managed medical assistance program and the managed long-term care program. Establishes selection criteria and process;
- Specifies a preference for plans providing evidence that primary care physicians in the plan's network will be compensated for primary care services equivalent to or greater than 100 percent of Medicare rates;
- Specifies a preference for plans that are based in Florida and have specified operational functions performed in Florida by Florida-employed staff. This preference applies only to an entity whose principal office is in Florida and which is not a subsidiary of or a joint venture with any other entity not located in the state;
- Establishes the CMS network as a qualified plan under statewide contract that is not subject to the procurement requirements;
- Prohibits AHCA from selecting more than one plan per 20,000 Medicaid recipients residing in each region who are subject to mandatory enrollment, with a maximum of 10 plans per region;
- Allows AHCA to issue subsequent ITNs in regions that grow by more than 20,000 Medicaid recipients subject to mandatory enrollment, under certain circumstances, before the end of the contract cycle;
- Requires AHCA to assign FFS Medicaid provider agreements to PSNs in regions containing no PSN or HMO on July 1, 2011, for the first 12 months the PSN operates in the region;

- Requires AHCA to publish a data book containing information plans will need to formulate an ITN response; and
- Provides for negotiation with qualified plans based on the adequacy of GAA funding.

Section 39 creates s. 409.966, F.S., to establish standards for managed care contracts, including 5-year durations, non-renewal of contracts, a primary care physician for each member, prompt pay, required rate of pay for non-contracted providers of emergency services, plan network adequacy, electronic claims and prior authorization processing, adoption of a standard minimum preferred drug list consistent with the process used by the Medicaid Pharmaceutical and Therapeutics Committee, encounter data reporting, quality and performance standards, fraud prevention, grievance resolution, penalties, performance bonds, solvency standards, guaranteed savings, and penalties.

Section 40 creates s. 409.967, F.S., and:

- The AHCA is required to establish a uniform method for annual reporting of premium revenue, medical and administrative costs, and income or losses for all Medicaid prepaid plans across all lines of business in all regions. Qualified plans are required to use the uniform method. Reports are due to the AHCA within 270 days after the conclusion of the reporting period. The AHCA may audit the reports. "Achieved savings rebates" are due within 30 days after a plan's report is submitted. The AHCA is required to calculate achieved savings rebates owed to the state by the plans by determining pretax income as a percentage of revenues and by applying the following parameters:
  - 100 percent of income up to and including 5 percent of revenue will be retained by the plan;
  - 50 percent of income above 5 percent and up to 10 percent will be retained by the plan with the other 50 percent refunded to the state;
  - 100 percent of income above 10 percent of revenue will be refunded to the state;
  - A plan that meets or exceeds AHCA-defined qualify measures may retain an additional 1 percent of revenue;
  - Certain expenses are not to be included in calculating plan income, such as payment of the achieved savings rebate, financial incentive payments made to a plan outside of the capitation, financial disincentive payments levied by the state or federal government, expenses associated with lobbying, and administrative, reinsurance, and outstanding claims expenses in excess of actuarially sound maximums;
  - Qualified plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second year; and
  - Upon failure of a plan to pay the rebate to the state within 30 days, the AHCA must withhold future payments to the plan until the entire rebate amount has been paid.
- Establishes requirements for plans to include providers in their networks. During first year after the initial procurement in a region, plans must offer contracts to FQHCs and (for LTC plans) nursing homes and certain aging network service providers in the region;
- Qualified plans must include the following essential providers in their networks:
  - Faculty plans of state medical schools;
  - Regional perinatal intensive care centers (RPICCs) as defined in s. 383.16, F.S.;
  - Hospitals licensed as a children's specialty hospital as defined in s. 395.002, F.S.

  Qualified plans that have failed to contract with all such essential providers on the first date of recipient enrollment must continue negotiating with those providers in good faith. Such

plans are required to pay physicians on the faculty of non-contracted state medical schools at the applicable Medicaid rate. Services rendered by RPICCs must be paid for at the applicable Medicaid rate as of the first day of the contract between the plan and the AHCA. Payments to non-contracted specialty children's hospitals must equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

- Requires plans and providers to negotiate in good faith. Establishes a procedure for dealing with provider contracting impasses in areas containing no capitated plans prior to July 1, 2011. Requires AHCA to examine the negotiation process to determine good faith, under certain parameters, and based on the findings, a provider may be deemed part of a plan's network for the purpose of network adequacy and the plan must pay the provider rates determined by AHCA to be the average of rates for corresponding services paid in the region and similar counties under similar circumstances;
- Allows AHCA to continue calculating fee-for-service rates for Medicaid hospital inpatient and outpatient services, but specifies that these rates may not be the basis for contract negotiations between plans and hospitals;
- Requires plans to monitor the quality and performance of network providers based on metrics established by AHCA;
- Provides that qualified plans are not required to conduct surveys of health care facilities that the AHCA surveys periodically for licensure or certification purposes. Requires qualified plans to accept the results of such AHCA surveys;
- Requires qualified plans to compensate primary care physicians with payments equivalent to or greater than the Medicare rate for primary care services no later than January 1, 2013;
- Requires non-LTC plans to establish specific programs and procedures to improve pregnancy outcomes and infant health;
- Requires non-LTC plans to achieve an 80-percent EPSDT rate for recipients continuously enrolled for at least 8 months; and
- Requires that unresolved disputes between a qualified plan and a provider shall proceed in accordance with s. 408.7057, which is the existing statewide provider and health plan claim dispute resolution program.

Section 41 creates s. 409.968, F.S., to provide that plans will be paid per-member, per-month payments based on an assessment of each member's acuity level and that payment for LTC plans will be combined with rates for medical assistance plans. The AHCA is required to develop a methodology and request federal approval that ensures the availability of intergovernmental transfers and certified public expenditures in the MMCP to support providers that have historically served Medicaid recipients, including safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed or under contract with a state medical school. The AHCA is directed to develop supplemental payments to qualified plans under certain parameters in order to ensure the providers are paid the exact amounts of the enhanced provider rates, under specified conditions.

The bill separately directs the AHCA to develop a methodology and request federal approval that ensures the availability of certified public expenditures in the MMCP to support non-institutional teaching faculty providers that have historically served Medicaid recipients, including allopathic and osteopathic physicians employed or under contract with a state medical school. The AHCA is directed to make direct supplemental payments to teaching faculty providers or to a statewide

entity acting on behalf of state medical schools and teaching faculty providers that contract with qualified plans and provide care to Medicaid recipients in recognition of costs associated with graduate medical education, educating medical school students, and access to primary and specialty care provided to Medicaid recipients, under specified conditions.

Section 42 creates s. 409.969, F.S.

- Provides that recipients may choose from plans available in their region of residence. Recipients who have not chosen within 30 days of becoming eligible will be automatically assigned to a plan.
- Provides guidelines for auto-assignment based on certain criteria, including Medicare Advantage plan membership, family continuity, adherence to quality standards, network capacity, prior enrollment, and geographic accessibility of providers. Requires that recipients residing in region 11, 15, or 16 who are diagnosed with HIV/AIDS be auto-assigned to an HIV/AIDS specialty plan if those recipients do not choose a plan within 30 days.
- Requires enrollment for 12-month period, except for a 90-day window at the outset of enrollment and "good cause" as determined by the AHCA. Members of managed LTC plans are given an additional window in which to change plans, notwithstanding the 12-month requirement, that lasts for 30 days after being referred for nursing home or assisted living facility services.

Section 43 creates s. 409.970, F.S., to require the AHCA to maintain and operate the Medicaid Encounter Data System. Provides guidelines for data reporting, validation, and analysis. Requires qualified plans to submit encounter data according to deadlines established by the AHCA.

Section 44 creates s. 409.971, F.S., to require the AHCA to begin implementing the new managed care medical assistance component as of December 31, 2011, and finish implementing the component in all regions no later than December 31, 2012. Applies ss. 409.961-409.970 to the medical assistance component.

Section 45 creates s. 409.972, F.S., to establish minimum services that plans must provide in the medical assistance component. Allows for additional services as specified in the GAA. Allows plans to customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services, subject to standards of sufficiency and actuarial equivalence. Requires services provided to be medically necessary. Authorizes the AHCA to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA or s. 409.9022, F.S.

Section 46 creates s. 409.973, F.S., to establish the managed long-term care program. Requires the AHCA to begin implementing the managed long-term care program by March 31, 2012, with full implementation in all regions by March 31, 2013. Applies the provisions of ss. 409.961-409.970 to the managed long-term care program. Requires the AHCA to make payments for long-term care, including home and community-based services, using a capitated managed care model. Requires DOEA to assist the AHCA develop specifications for ITNs and the model contract, determine clinical eligibility for enrollment in managed long-term care plans, monitor plan performance and measure quality of service delivery, assist clients and families to address

complaints with the plans, facilitate working relationships between plans and providers serving elders and disabled adults, and perform other functions specified in a memorandum of agreement.

Section 47 creates s. 409.974, F.S., to require Medicaid recipients to receive covered long-term care services through the managed long-term care program unless excluded pursuant to s. 409.964. Recipients who meet all of the following criteria may participate in the managed long-term care program. Recipients must be:

- Sixty-five years of age or older or eligible for Medicaid by reason of a disability
- Determined by the CARES Program to meet the requirements for nursing facility care

The bill allows recipients already residing in a nursing home or enrolled in certain LTC waiver programs to remain eligible for those programs. Specifies that this part does not create an entitlement for any home and community based services provided under the program.

Section 48 creates s. 409.975, F.S., to establish minimum benefits that managed LTC plans must provide, including all services provided by medical assistance plans, plus nursing facility services and home and community-based services, including but not limited to ALF services. Requires services provided to be medically necessary. Authorizes the AHCA to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA, ch. 216, or s. 409.9022, F.S.

Section 49 creates s. 409.976, F.S., and adds the following plans to the list of qualified plans for managed LTC coverage: Medicare Advantage PPOs, Medicare Advantage PSOs, and Medicare Advantage special needs plans. Specifies that the PACE program is a qualified plan and is not subject to procurement requirements. Requires the AHCA to issue an ITN by November 14, 2011. Establishes selection criteria and process.

Section 50 creates s. 409.977, F.S., to establish requirements for managed LTC plans for including providers in their networks, in addition to the requirements for MAC plans.

Section 51 creates s. 409.978, F.S., to provide for an assessment of an enrollee's level of care by the CARES program.

Section 52 transfers and renumbers s. 409.91207, F.S., relating to medical home pilot program, as s. 409.985.

Section 53 transfers and renumbers s. 409.91211, F.S., relating to the existing Medicaid Reform pilot program, as s. 409.986, F.S.

Section 54 transfers and renumbers s. 409.9122, F.S., relating to managed care mandatory enrollment, to s. 409.987. Makes technical amendments within the statute.

Section 55 transfers and renumbers s. 409.9123, F.S., relating to quality of care reporting, to s. 409.988.

Section 56 transfers and renumbers s. 409.9124, F.S., relating to manage care reimbursement, to s. 409.989.

Section 57 amends s. 430.04, F.S., to require the DOEA to transition persons from existing waivers to qualified managed care plans as they become available.

Section 58 amends s. 430.2053, F.S., to delete obsolete language. Provides that additional duties of Aging Resource Centers (ARCs) are to:

- Assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid managed long-term care component as qualified plans become available.
- Provide enrollment and coverage information for the Medicaid managed long-term care component as qualified plans become available.
- Assist Medicaid recipients enrolled in the Medicaid managed long-term care component with informally resolving grievances with a managed care network and in accessing the managed care network's formal grievance process as qualified plans become available.

Section 59 amends s. 39.407, F.S., to:

- Provide that for any child 10 years of age or younger in an out-of-home placement, any administration of a psychotropic medication must be reviewed by a child psychiatrist;
- Specify criteria to be included in the review and requires that the results of the review be provided to the child and a parent or legal guardian before consent is given; and
- Provide that absent a compelling governmental interest, psychotropic medication may not be court-authorized for any child 10 years of age or younger in an out-of-home placement.

Section 60 amends s. 216.262, F.S., to exempt FTEs in the DOH that are funded by the County Health Dept. Trust Fund from the requirement that the total number of authorized positions at a state agency may not exceed the total provided in the GAA and allows county health departments the flexibility to establish and delete positions without Legislative approval.

Section 61 amends s. 381.06014, F.S., to:

- Redefine "blood establishment" to clarify that a person, entity, or organization that uses a mobile unit and performs any of the activities under the definition of "blood establishment" is also a blood establishment.
- Define a "volunteer donor" for purposes of blood donations.
- Prohibit local governments from restricting access to public facilities or infrastructure for volunteer blood drives based on the tax status of a blood establishment conducting the blood drive.
- Prohibit a blood establishment from considering the tax status of certain customers when determining the price at which to sell blood or a blood component that was obtained from volunteer donors.
- Require a blood establishment that collects blood or blood components from volunteer donors, except a hospital that uses the blood or blood components that the hospital collects only within its own business entity, to disclose information on its Internet web site concerning: a description of the activities of the blood establishment related to collecting, processing, and distributing volunteer blood donations; the number of units that are

produced, obtained from other sources, and distributed; policies related to corporate conduct and executive compensation; and financial-related data. Hospitals are exempt from disclosing financial-related data. Failing to disclose this information subjects the blood establishment to a civil penalty.

Section 62 amends s. 393.063, F.S., to change the definition of "developmental disability" to specifically include "Down Syndrome." Provides a definition of "Down Syndrome."

Section 63 amends s. 400.023, F.S., to revise nursing home civil liability. Additional requirements are specified for suing an officer, director, or owner of a nursing home, including an owner designated as having a controlling interest, or an agent of a nursing home or the nursing home's management company unless at an evidentiary hearing the court determines that there is sufficient evidence in the record or proffered by the claimant. The evidence must establish that a reasonable basis exists for a finding that the person or entity (officer, director, owner, or agent) has breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent. Additionally the evidence must establish that a reasonable basis exists for finding that the breach, failure to perform, or action outside the scope of duties is the legal cause of the actual loss, injury, death, or damage to the nursing home resident.

In wrongful death actions brought against a nursing home, the noneconomic damages may not exceed $250,000, regardless of the number of claimants.

Section 64 amends s. 400.0237, F.S., to revise requirements for obtaining punitive damages from nursing homes.

The requirements and procedures for bringing a punitive damages claim against a nursing home are revised. In a pretrial evidentiary hearing, the claimant would have to demonstrate that a reasonable basis exists for the recovery of punitive damages based on criteria outlined in the section to ensure the sufficiency of punitive damage claims alleged against a nursing home or other liable legal entity. The defendant is allowed to actively refute the claimant's proffered evidence to recover punitive damages. The trial judge must weigh admissible evidence from both defendant and claimant to ensure that a reasonable basis exists to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted.

The bill requires the claimant to produce evidence so that the trier of fact may find, based on clear and convincing evidence, that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant. "Intentional misconduct" is revised to mean that the defendant against whom a claim for punitive damages is sought had actual knowledge of the wrongful conduct and the high probability that injury or damage to the claimant would result and, despite the knowledge, intentionally pursued that conduct, resulting in injury or damage. Under subsection (2), the evidence in a punitive damages claim must show that the defendant (nursing home, including its management company, if applicable) *against whom the punitive damages claim is sought* had actual knowledge of the wrongfulness of the conduct and the probability that the claimant would get injured but intentionally pursued the conduct that resulted in injury or damage to the claimant.

The ability to seek a claim for punitive damages is limited in the context of the vicarious liability of an employer, principal, corporation, or other legal entity against whom the punitive damages claim is sought. In lieu of current requirements for asserting a claim on punitive damages based on the vicarious liability of an employer, principal, corporation, or other legal entity, the claimant may not impose punitive damages for the conduct of an identified employee or agent unless the conduct meets the criteria specified in subsection (2). The claimant must additionally demonstrate that the officers, directors, or managers of the actual employer corporation, or legal entity condoned, ratified, or consented to the specific conduct which resulted in the claimant's injury as alleged by the claimant under subsection (2) of the section. Currently, to impose a punitive damages claim against an employer, principal, corporation, or other legal entity, the claimant must show that employer, principal, corporation, or other legal entity actively and knowingly participated in the conduct, condoned, ratified or consented to the conduct, or that the employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that conduct contributed to the claimant's loss, damages, or injury.

Section 65 amends s. 408.7057, F.S., to alter provisions relating to the existing statewide provider and health plan claim dispute resolution program and establish that this section of statute creates a procedure for dispute resolution, not an independent right of recovery. The conclusions of law contained in the written recommendation of the resolution organization must identify the provisions of law or contract which, under the peculiar facts and circumstances of the case, entitle the provider or health plan to the amount awarded, if any.

Section 66 creates s. 458.3167, F.S., to specify requirements for a medical physician licensed in another state or Canada to obtain a certificate from the Board of Medicine to provide expert medical testimony concerning the prevailing professional standard of care for medical negligence litigation pending in Florida against a Florida-licensed medical physician or osteopathic physician in a medical malpractice action. An application for an expert witness certificate must be approved or denied within 5 business days after receipt of a completed application; if not, the application is deemed approved. An applicant seeking to claim certification by default must notify the Board of Medicine, in writing, of the intent to rely on the default certification provision of this section. In such case, the criminal penalties for violations of the medical practice act, ch. 458, F.S., do not apply, and the applicant may provide expert testimony. All licensure fees, other than the initial certificate application fee, are waived for those persons obtaining an expert witness certificate. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of medicine as defined in ch. 458, F.S.[133] The board is granted rulemaking authority to implement the requirements to issue the certificate, including rules setting the amount of the certificate application fee, which may not exceed $50. An expert witness certificate expires 2 years after the date of issuance.

Section 67 amends s. 458.331, F.S., to establish grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of medicine.

Section 68 creates s. 459.0078, F.S., to specify requirements for an osteopathic physician licensed in another state or Canada to obtain a certificate from the Board of Osteopathic

[133] *See Section 458.305, F.S.*

Medicine to provide expert medical testimony concerning the prevailing professional standard of care for medical negligence litigation pending in Florida against a Florida-licensed medical physician or osteopathic physician in a medical malpractice action. An application for an expert witness certificate must be approved or denied within 5 business days after receipt of a completed application; if not, the application is deemed approved. An applicant seeking to claim certification by default must notify the Board of Osteopathic Medicine, in writing, of the intent to rely on the default certification provision of this section. In such case, the criminal penalties for violations of the osteopathic medicine practice act, ch. 459, F.S., do not apply, and the applicant may provide expert testimony. All licensure fees, other than the initial certificate application fee, are waived for those persons obtaining an expert witness certificate. The possession of an expert witness certificate alone does not entitle the physician to engage in the practice of osteopathic medicine as defined in ch. 459, F.S.[134] The board is granted rulemaking authority to implement the requirements to issue the certificate, including rules setting the amount of the certificate application fee, which may not exceed $50. An expert witness certificate expires 2 years after the date of issuance.

Section 69 amends s. 459.015, F.S., to establish grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of osteopathic medicine.

Section 70 amends s. 499.003, F.S., to clarify that a blood establishment is a health care entity that may engage in the wholesale distribution of certain prescription drugs.

Section 71 amends s. 499.005, F.S., to exempt a blood establishment that manufactures blood and blood components from the requirement to be permitted as a prescription drug manufacturer and register products.

Section 72 to amends s. 499.01, F.S., and authorizes certain blood establishments to obtain a restricted prescription drug distributor permit to engage in the wholesale distribution of certain prescription drugs to health care entities, and authorizes DOH to adopt rules related to the distribution of prescription drugs by blood establishments.

Section 73 amends s. 626.9541, F.S., to allow insurers issuing group or individual health benefit plans to offer a voluntary wellness or health improvement program and to encourage or reward participation in the program by authorizing rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts or rebates, contributions to a member's health savings account, or modifications to copayment, deductible, or coinsurance amounts. Allows insurers to require a health benefit plan member to provide verification, such as an affirming statement from the member's physician, that the member's medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program.

The bill declares that a reward or incentive described above is neither an insurance benefit nor a violation of the prohibition against unfair methods of competition and unfair or deceptive acts or practices, if it is disclosed in the policy or certificate.

[134] *See* s. 459.003, F.S.

Section 74 amends s. 627.4147, F.S., to delete a statutory requirement that a medical malpractice insurance contract include a clause authorizing an insurer to admit liability and make a settlement offer or offer of judgment on behalf of the insured physician if the offer is within the policy limits without the insured physician's permission.

Section 75 amends s. 766.102, F.S., to establish that if a medical or osteopathic physician is a party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must otherwise meet the requirements of this section and be licensed as a medical or osteopathic physician, or must possess a valid expert witness certificate.

Section 76 amends s. 766.104, F.S., to provide that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure specified damages, the presuit investigation and certification required by attorneys must demonstrate grounds for a good-faith belief that the requirement is met.

Section 77 amends s. 766.106, F.S., to specify that immunity from civil liability arising from participation in the presuit screening process does not prohibit a physician or osteopathic physician licensed under ch. 458 or ch. 459, F.S., respectively, or an expert witness licensed under ch. 458, F.S., or ch. 459, F.S., from being subject to disciplinary action by the Board of Medicine or the Board of Osteopathic Medicine.

Section 78 amends s. 766.1115, F.S., to conform this section of statute to sovereign immunity provisions for the nonprofit independent college or university located and chartered in Florida that owns or operates a medical school which appear in section 82 of the bill.

Section 79 creates s. 766.1183, F.S., relating to standard of care for Medicaid providers:

- Modified Recovery of Civil Damages – Specifies that the liability of health care providers who provide covered medical services to Medicaid recipients is limited to $200,000 per claimant or $300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, medical services to a Medicaid recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of $200,000/$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature;
- However, a provider may still be liable for amounts in excess of $200,000 or $300,000 if a claimant proves that the provider acted in a wrongful manner;
- The existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render medical services to a Medicaid recipient;
- Standard of care for imposing liability on provider greater than $200,000 ($300,000) is modified – Medical malpractice claimant who is a Medicaid recipient must prove that the provider acted in a wrongful manner. "Wrongful manner" is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of humans rights, safety, or property. The modified

standard of care conforms to the standard of care used when the limited waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.;

- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of $200,000 per claimant ($300,000 per occurrence). Plaintiffs can still recover damages from the provider up to $200,000 ($300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions;
- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are Medicaid recipients; and
- Provider – means a health care provider as defined in s. 766.202, F.S., an ambulance provider licensed under ch. 401, F.S., or an entity that qualifies for an exemption under the health care clinic act.[135] The term includes any person or entity for whom a provider is vicariously liable; and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of the provider.

At the time an application for medical assistance is submitted, the Department of Children and Family Services must furnish the applicant with written notice of the provisions of this section. This section does not apply to any claim for damages to which s. 768.28, F.S., relating to the limited waiver of sovereign immunity, applies.

Section 80 creates s. 766.1184, F.S., to provide that:

- "Low income pool recipient" is defined as a low income individual who is uninsured or underinsured and who receives primary care services from a provider which are delivered exclusively using funding received by that provider under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured;
- "Provider" is defined as a health care provider under the Medical Malpractice Act which received funding under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured. The term includes persons or entities for whom the provider is vicariously liable, and persons or entities whose liability is based solely on such persons or entities being vicariously liable for the actions of the provider;
- Modified Recovery of Civil Damages – Specifies that the liability of health care providers who provide covered medical services to low income recipients is limited to $200,000 per claimant or $300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, primary care services to a low income pool recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of $200,000/$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature;

[135] Section 400.9905(4)(e), F.S. (An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. s. 409 that has a board of trustees not less than two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof).

- However, a provider may still be liable for amounts in excess of $200,000 or $300,000 if a claimant proves that the provider acted in a wrongful manner;
- The existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render primary care services to a low income recipient;
- For the limitations on civil damages to apply, the provider must develop, implement, and maintain policies and procedures to: ensure that the appropriated funds (Specific appropriation 191) are used exclusively to serve low income persons who are uninsured or underinsured; determine whether funds (Specific appropriation 191) are being used to provide primary care services to a particular person; and identify whether an individual receiving primary care services is a low income recipient to whom the limitations apply. The provider also must provide notice of the statutory provisions prior to providing services to the recipient. Additionally, the provider must be in compliance with the agreement between the provider and the AHCA governing the receipt of the funds;
- Standard of care for imposing liability on provider greater than $200,000 ($300,000) is modified – Medical malpractice claimant who is a low income pool recipient must prove that the provider acted in a wrongful manner. "Wrongful manner" is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of humans rights, safety, or property. The modified standard of care conforms to the standard of care used when the limited waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.;
- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of $200,000 per claimant ($300,000 per occurrence). Plaintiffs can still recover from the provider damages up to $200,000 ($300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions; and
- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are low income pool recipients.

Section 81 amends s. 766.203, F.S., to provide that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure specified damages, then the presuit investigation and certification required for the claimant and the defendant must ascertain that reasonable grounds exist to believe that the requirement is met.

Section 82 amends s. 768.28, F.S., to extend the limited waiver of sovereign immunity to a not-for-profit independent college or university located in Florida which owns or operates an accredited medical school and its employees and agents when the employees or agents of the medical school are providing patient services at a teaching hospital that has an affiliation agreement or other contract with the medical school. The not-for-profit independent college or university located in Florida which owns or operates a medical school and its employees or agents when providing patient services to patients at the teaching hospital would be considered an agent of the teaching hospital for purposes of sovereign immunity while acting within the scope and pursuant to guidelines in the contract.

"Employee or agent" means an officer, employee, agent, or servant of a nonprofit independent college or university located and chartered in Florida which owns or operates an accredited medical school, including, but not limited to, the faculty of the medical school, health care practitioners for which the college or university are vicariously liable, and the staff or administrator of the medical school.

"Patient services" mean comprehensive health care services as defined in s. 641.19, F.S., including related administrative services, provided to patients in a teaching hospital or in a health care facility that is a part of a nonprofit independent college or university located and chartered in Florida which owns or operates an accredited medical school pursuant to an affiliation agreement with a teaching hospital. The term also includes training and supervision of interns, residents, and fellows providing patient services in a teaching hospital or a health care facility that is a part of a nonprofit independent college or university located and chartered in Florida which owns or operates an accredited medical school pursuant to an affiliation agreement with a teaching hospital. "Patient services" also includes participation in medical research protocols or training and supervision of medical students.

"Teaching hospital" means a teaching hospital as defined in s. 408.07, F.S., which is owned and operated by the state, and other specified governmental entities as outlined in the section.

The teaching hospital or the medical school, or its employees or agents, must provide patients notice, which must be acknowledged in writing, that the college or university that owns or operates the medical schools and the employees or agents of the college or university are acting as agents of the teaching hospital and that the exclusive remedy for injury or damage suffered as a result of acts or omissions of the teaching hospital, the college or university, or employees or agents while acting within the scope of duties under the affiliation agreement with the teaching hospital is by action under the sovereign immunity provisions.

The bill extends the limited waiver of sovereign immunity to providers or vendors, 75 percent of whose client population consists of individuals with a developmental disability as defined in ss. 393.063 and 400.960, F.S., individuals who are blind or severely handicapped individuals as defined in s. 413.033, F.S., individuals who have a mental illness as defined under s. 394.455, F.S., or individuals who have any combination of these conditions, which have contractually agreed to act on behalf of the APD, the AHCA, the Division of Blind Services in the Department of Education, or the Mental Health Program Office of the DCF to provide services to these individuals. For purposes of extending the limited waiver of sovereign immunity, the employees or agents of these providers or vendors are considered agents of the state, solely with respect to the provision of services while acting within the scope of and pursuant to guidelines established by contract, a Medicaid waiver agreement, or rule. The contracts for the services must provide for the indemnification of the state by the agent for any liabilities incurred up to the $100,000 per person ($200,000 per occurrence) limits specified in s. 768.28, F.S.[136]

[136] $100,000 ($200,000 effective October 1, 2011) per claim or judgment by any one person and $200,000 ($300,000 effective October 1, 2011) when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence.

Section 83 creates a non-statutory provision of law providing legislative findings regarding role of and need for teaching hospitals and graduate medical education for Florida residents. Specifies that "employee or agent," patient services," and "teaching hospital" used in this section has the same meaning as the terms defined in s. 768.28, F.S., as amended by the bill. Establishes a legislative declaration that there is an overpowering public necessity for extending the state's sovereign immunity to a nonprofit independent college or university chartered and located in Florida that owns and operates a medical school when providing patient services in teaching hospitals and that there is no alternative method of meeting such public necessity.

Section 84 amends s. 1004.41, F.S., to extend the limited waiver of sovereign immunity to Shands Teaching Hospital and related entities. The bill provides that the University of Florida Board of Trustees shall lease the hospital facilities on the Gainesville campus of the University of Florida to Shands Teaching Hospital and Clinics, Inc., for the primary purpose of supporting the University of Florida Board of Trustees' health affairs mission of community service and patient care, education and training of health professionals, and clinical research. Shands Teaching Hospital and Clinics, Inc., may, in support of the health affairs mission of the University of Florida Board of Trustees and with its prior approval, create for-profit or not-for-profit corporate subsidiaries and affiliates, or both. The bill provides that Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center, Inc., Shands Jacksonville Healthcare, Inc., and not-for-profit subsidiaries of Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., are instrumentalities of the state for purposes of sovereign immunity. The University of Florida Board of Trustees has the right to control Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center, Inc., and Shands Jacksonville Healthcare, Inc.

Section 85 provides that, effective October 1, 2013, the following sections of Florida Statutes are repealed: 409.9121, 409.919, and 624.915.

Section 86 transfers and renumbers s. 409.942, F.S., relating to the electronic benefit transfer program, to s. 414.29, F.S.

Section 87 amends s. 443.111, F.S., to make a technical statutory reference change.

Section 88 provides that ss. 409.944, 409.945, and 409.946, F.S., are transferred and renumbered as ss. 163.464, 163.465, and 163.466, F.S., respectively.

Section 89 provides that ss. 409.953 and 409.9531, F.S., are transferred and renumbered as ss. 402.81 and 402.82, F.S., respectively.

Section 90 creates a non-statutory provision of law to require the AHCA to submit a reorganizational plan to the Governor, the Speaker of the House of Representative, and the President of the Senate by January 1, 2012, which converts the AHCA from a check-writing and fraud-chasing agency into a contract compliance and monitoring agency.

Section 91 creates a non-statutory provision of law providing that, effective December 1, 2011, if the Legislature has not received a letter from the Governor stating that the federal CMS has approved the waivers necessary to implement the Medicaid managed care reforms contained in

the bill, the State of Florida will withdraw from the Medicaid program effective December 31, 2011.

Section 92 creates a non-statutory provision of law providing that if any provision of this bill or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the bill which can be given effect without the invalid provision or application, and to this end the provisions of this bill are severable.

Section 93 provides that the bill will take effect upon becoming a law.

Other Potential Implications:
The bill specifies requirements for a medical physician or an osteopathic physician licensed in another state or Canada to obtain a certificate from the Board of Medicine or the Board of Osteopathic Medicine to provide expert medical testimony concerning the prevailing professional standard of care for medical negligence litigation pending in Florida against a Florida-licensed medical physician or osteopathic physician. There is a balance between enactments of the Legislature and the Florida Supreme Court on matters relating to evidence. The Legislature has enacted and continues to revise ch. 90, F.S., and other relevant provisions of law relating to medical negligence. The Florida Supreme Court regularly adopts amendments to the Evidence Code as rules of court when it is determined that the matter is procedural rather than substantive. If the Florida Supreme Court views the changes in this bill for expert witnesses, to first obtain certification from a regulatory board as a condition precedent to offering testimony in a medical negligence action, as an infringement upon the Court's authority over practice and procedure, it may refuse to follow or adopt the changes in the bill as a rule.[137]

The bill extends the limited waiver of sovereign immunity to a provider or vendor if 75 percent of its client population consists of individuals with a developmental disability as defined in ss. 393.063 and 400.960, F.S., individuals who are blind or severely handicapped individuals as defined in s. 413.033, F.S., individuals who have a mental illness as defined under s. 394.455, F.S., or individuals who have any combination of these conditions, and the provider or vendor is contractually agreed to act on behalf of specified governmental agencies to provide services to such individuals, with respect to the provision of such services while acting within the scope of and pursuant to guidelines established by contract, a Medicaid waiver agreement, or rule. The provisions extending the limited waiver of sovereign immunity do not require that any notice be provided to individuals served by an affected provider or vendor regarding that provider's or vendor's status for purposes of sovereign immunity. And, it is unclear what rights to sue are afforded to a client in the other 25 percent of the client population who is not be covered by the guidelines established by contract, Medicaid waiver agreement, or rule, if injured by acts or omissions of the provider or vendor.

[137] *See, e.g., In re Florida Evidence Code*, 782 So. 2d 339 (Fla. 2000) (Florida Supreme Court adopting Evidence Code to the extent it is procedural and rejecting hearsay exception as a rule of court), and *compare with In re Florida Evidence Code*, 372 So.2d 1369 (Fla. 1979) (Florida Supreme Court adopting Florida Evidence Code to the extent it is procedural), *clarified, In re Florida Evidence Code*, 376 So. 2d 1161 (Fla. 1979).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

By designating certain not-for-profit entities and subsidiaries as instrumentalities of the state, the bill could render those entities subject to the provisions of Article I, Section 24, of the Florida Constitution relating to access to public records and meetings. Some of those entities and subsidiaries might qualify for the exemptions provided under s. 395.3036, F.S.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

D. Other Constitutional Issues:

The bill provides that Shands Teaching Hospital and Clinics, Inc. and certain Shands entities shall be conclusively deemed corporations primarily acting as instrumentalities of the state, pursuant to s. 768.28(2), F.S., for purposes of the state's limited waiver of sovereign immunity. The bill includes similar provisions for Shands Jacksonville Medical Center, Inc., and its parent Shands Jacksonville Healthcare, Inc., and any not-for-profit subsidiaries of Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc. The bill extends the limited waiver of sovereign immunity to a nonprofit independent college or university located and chartered in Florida which owns or operates an accredited medical school and its employees and agents when the employees or agents of the medical school are providing patient services at a teaching hospital that has an affiliation agreement or other contract with the medical school.

Additionally, the bill extends the limited waiver of sovereign immunity to providers or vendors meeting certain criteria and their employees or agents solely with respect to the provision of services to individuals with a developmental disability as defined in ss. 393.063 and 400.960, F.S., individuals who are blind or severely handicapped individuals as defined in s. 413.033, F.S., individuals who have a mental illness as defined under s. 394.455, F.S., or individuals who have any combination of these conditions, while acting within the scope of and pursuant to guidelines established by contract, a Medicaid waiver agreement, or rule.

If sovereign immunity from liability is legislatively accorded to a private entity, a potential constitutional challenge would be that the law violates the right of access to the courts. Section 21, Article I of the State Constitution, provides that the courts shall be open to all for redress for an injury. To impose a barrier or limitation on a litigant's right to file certain actions, an extension of immunity from liability would have to meet the test

announced by the Florida Supreme Court in *Kluger v. White*.[138] Under the test, the Legislature would have to provide a reasonable alternative remedy or commensurate benefit, or make a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity. A substitute remedy does not need to be supplied by legislation that reduces but does not destroy a cause of action. When the Legislature extends sovereign immunity to a private entity, the cause of action is not constitutionally suspect as a violation of the access to courts provision of the State Constitution because the cause of action is not completely destroyed, although recovery for negligence may be more difficult.[139]

The bill also provides modified recovery of civil damages and restructures the cause of action for Medicaid recipients and certain low income pool recipients seeking damages in a cause of action arising out of the rendering of, or the failure to render, medical services to Medicaid or low income pool recipients, as applicable, unless the claimant proves that the provider acted in a wrongful manner. Again, a potential constitutional challenge would be that the law violates the right of access to the courts. Under the *Kluger v. White* test, the cause of action is not destroyed. The Legislature has granted the potential litigants with a substitute remedy and has not totally abolished the cause of action, as the claimants may still obtain a judgment in excess of $200,000/$300,000, and the claimant has the option of reporting the judgment to and seeking the excess amount from the Legislature. Similarly, if the claimant seeks to recover damages in excess of $200,000/$300,000 by proving that the provider acted in a wrongful manner when rendering or failing to render medical services to a Medicaid or low income pool recipient, the cause of action has been restructured to require a higher burden of proof but not abolished.[140] The Florida Supreme Court in *Iglesia v. Floran*[141] held that although a 1978 amendment to a workers' compensation statute[142] precluded liability for simple negligence, the statute did not implicate the access to courts provision in the State Constitution.[143]

The Florida Supreme Court has repeatedly held that a statute that merely alters the standard of care owed by one party to another or increases the degree of negligence necessary to maintain a successful tort action does not abolish a preexisting right of access and does not, therefore, implicate Article I, Section 21 of the State Constitution. In

[138] See *Kluger v. White*, 281 So. 2d 1 (Fla. 1973).
[139] *Id.* at 4.
[140] See *Amorin v. Gordon*, 996 So. 2d 913, 917-18 (Fla. 4th DCA 2008) ("'[t]he Constitution does not require a substitute remedy unless legislative action has abolished or totally eliminated a previously recognized cause of action. As discussed in *Kluger* and borne out in later decisions, no substitute remedy need be supplied by legislation which reduces but does not destroy a cause of action.'" (quoting *Jetton v. Jacksonville Electric Auth.*, 399 So. 2d 396, 398 (Fla. 1st DCA 1981))).
[141] *Iglesia v. Floran*, 394 So. 2d 994 (Fla. 1981).
[142] Section 440.11(1), F.S., as amended by s. 2 of ch. 78-300, Laws of Florida, "grants immunity from tort liability to co-employees who, while in the course of their employment, negligently injure other employees of the same employer, unless the employees act with willful and wanton disregard or unprovoked physical aggression or with gross negligence." (cited in *Iglesia*, 394 So. 2d at 995).
[143] *Iglesia*, 394 So. 2d at 995-96 (citing *McMillan v. Nelson*, 5 So. 2d 867 (Fla. 1942)). The Court described its rationale that "[s]ection 440.11[(1), F.S., as amended] still provides a cause of action for gross negligence just as the court-sustained 'guest statute' did. The Florida Legislature has broad powers in enacting legislation. The acts that it passes are to be sustained unless they run afoul of a limitation placed upon them by the Florida Constitution or violate a provision of the U.S. Constitution."

Abdin v. Fischer, the Court upheld a statute that exempted property owners from liability for injuries occurring on private property set aside for public recreation, unless the owner inflicted "deliberate, willful, or malicious injury to persons or property."[144] The Court explained that "[w]hat *Kluger* and *McMillan* make clear is that legislative action that alters standards of care need only be *reasonable* to be upheld" (emphasis added).[145]

In *Sontay v. Avis Rent-A-Car Systems, Inc.*,[146] s. 324.021(9), F.S., was challenged on various grounds that it violated the appellant's rights under access to courts, equal protection, due process, and the right to jury trial under the Florida Constitution. The court found that the challenged provision limits the vicarious liability of motor vehicle owners and lessors but did not equate to a denial of access to court because the court reasoned that the operator of the vehicle was still available to be sued for excess liability.[147] In the *Smith v. Department of Insurance*, however, the Florida Supreme Court held that a $450,000 cap on noneconomic damages that tort victims could recover for noneconomic losses violated their constitutional right to access to courts in conjunction with right to trial by jury and rejected arguments that exceptions to *Kluger* were applicable where there was not any showing of reasonable alternative remedy or commensurate benefit or a legislative showing of overpowering necessity for the abolishment of the right and no alternative method of meeting such public necessity.[148] If potential challenges to access to courts for the bill's provisions are linked and read in conjunction with other constitutional rights, it is unclear how the Florida Supreme Court may rule on such challenges.

On lines 3445-3465, the bill specifies a mechanism for the award of contracts to qualified plans in the Medicaid Managed Care Program that may favor Florida-based companies. The Commerce clause states that "Congress shall have Power… To regulate Commerce…among the several States…"[149] Courts have used a two-tiered analysis to determine whether a statutory scheme violated the dormant Commerce clause: (1) "If a statute 'directly regulates or discriminates against interstate commerce, or [if] its effect is to favor in-state economic interests over out-of-state interests,' the court may declare it unconstitutional as applied, without further inquiry."[150] (2) "However, if the statute regulates evenhandedly and if it has only an indirect effect on interstate commerce, the court must determine whether the state's interest is legitimate and, if so, whether the burden on interstate commerce exceeds the local benefits."[151] However, actions of a state

[144] *Abdin v. Fischer*, 374 So. 2d 1379, 1380-81 (Fla. 1979) (holding that to the extent the "statute alters the standard of care owed to plaintiff by defendants, this type of modification by the legislature is not prohibited by the constitution." The Florida Supreme Court noted in *Kluger* that there is a "distinction between abolishing a cause of action and merely changing a standard of care.").
[145] *Id.* at 1381. See also, *Eller v. Shova*, 630 So. 2d 537, 542 (Fla. 1993).
[146] *Sontay v. Avis Rent-A-Car, Systems, Inc.*, 872 So. 2d 316, 318 (Fla. 4th DCA 2004).
[147] *Id.*
[148] *Smith v. Department of Insurance*, 507 So. 2d 1080, 1088 (Fla. 1987).
[149] *Bainbridge v. Turner*, 311 F.3d 1104, 1108 (citing U.S. CONST. art. I, s. 8, cl. 3.).
[150] *National Collegiate Athletic Ass'n v. Associated Press*, 18 So.3d 1201, 1211-1212 (Fla. 1st DCA 2009) (citing *Brown-Forman Distillers Corp. v. New York State Liquor Authority*, 476 U.S. 573, 578-579).
[151] *Id.* (internal citations omitted). *See Bainbridge v. Turner*, 311 F.3d 1104, 1108-1109.

as a market participant are not subject to the limitations of the Commerce clause when the state is acting like an economic actor such as a purchaser of goods and services.[152]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill requires the AHCA, upon being granted a federal waiver, to assess a fee against the parents of a child who is being served by a waiver program for home and community-based services if the adjusted household income is greater than 100 percent of the federal poverty level. The fee will be calculated using a sliding scale based on family size, the amount of the parent's adjusted gross income, and the federal poverty guidelines.

The bill requires that, upon being granted a federal waiver, the AHCA must implement a $10 monthly premium on Medicaid applicants to cover all Medicaid-eligible recipients in the applicant's family, effective December 31, 2011. However, an individual who is eligible for the Supplemental Security Income-related Medicaid and is receiving institutional care payments is exempt from this premium.

The bill increases the allowable Medicaid copayment for each visit with a specialty care physician from up to $2 (under current law) to up to $3.

The bill requires the AHCA to seek a federal waiver of the requirement that Medicaid cost-sharing amounts for non-emergency services and care furnished in a hospital emergency department be nominal. Upon waiver approval, a Medicaid recipient who requests such services and care must pay a $100 copayment to the hospital for the nonemergency services and care provided in the hospital emergency department. (Under current law, such a copayment may not exceed $15.)

Medical and osteopathic physicians who otherwise qualify to testify as medical witnesses who are licensed in another state or Canada will be liable for an expert witness certification application fee which may not exceed $50. The fee may recur because the expert witness certificate expires two years after its issuance.

B. Private Sector Impact:

There are various private-sector fiscal impacts, including:

- The fees and copayments for Medicaid recipients described above;
- The reduction of funds available to participants in the MNMS program. Total expenditures in that program are expected to be reduced by $230.2 million in state fiscal year 2011-12, which annualizes to $865.3 million;
- Medicaid providers that currently participate under the program's fee-for-service payment system will face a new financial system of negotiating payments with qualified plans under the Medicaid Managed Care Program, which is likely to change the reimbursements those providers are paid by an indeterminate amount;

[152] See *White v. Massachusetts Council of Constr. Employers*, 460 U.S. 204 (1983) (providing that a state may grant and enforce a preference to local residents); s. 287.0874, F.S. (providing a preference to Florida businesses).

- The bill's provisions regarding payments and fiscal accountability for qualified plans participating in the Medicaid Managed Care Program (guaranteed savings, penalties, surety bond, etc.) and Healthy Kids health plans, are likely to present some indeterminate amount of fiscal challenges for the health plans;
- Primary care physicians participating in Medicaid are likely to experience a substantial increase in Medicaid reimbursement on January 1, 2013, when Medicaid payments to those physicians for primary care services will be required to equal or exceed the payments for comparable services under the Medicare program; and
- The DOEA advises that Florida's elders, including approximately 32,000 currently served by Medicaid long-term care waivers as well as those served in Medicaid-funded nursing facility beds, will be impacted by this proposal. The impact to the population is indeterminate. However, the specified population will be required to participate in a managed care system for their health care needs and depending on the number of plans available in their region, their choice may be increased or limited. Both elders and the nursing facility industry would be impacted if level of care criteria is narrowed or remove existing levels of care as individuals who currently qualify for nursing facility care may no longer be eligible. Although the bill provides specific contracting requirements aimed at supporting the state's Aging Resource Centers, there will be impacts on ARCs and aging network providers as a result of this legislation. ARCs will be impacted as choice counselors under the new system, and based on the regions proposed, the state's network of ARCs and aging service providers will no longer correspond to the Medicaid regional structure for long-term care. This may create administrative challenges and may allow for existing aging network providers or ARCs to be awarded contracts for areas of the state that do not correspond to their federally approved planning and service areas.

C. Government Sector Impact:

Section 1 of the bill will have a negative fiscal impact on community redevelopment trust funds because hospital districts and other specified taxing authorities will no longer be required to appropriate dollars into such community redevelopment trust funds. Hospital districts and other taxing authorities will experience a corresponding positive fiscal impact.

Sections 8 and 15 of the bill relating to the Kidcare program and school breakfast and lunch programs would impact government expenditures in both Kidcare and Medicaid. See the charts below for fiscal estimates provided by the AHCA and the FHKC:

Additional Children in Medicaid: 17,984	First 12 Months	Next 12 Months
Federal Funds	$32,568,650	$32,568,650
General Revenue Fund	$25,652,033	$25,652,033
Total Medicaid Funds	$58,220,682	$58,220,682

Additional Children in Kidcare: 20,280	First 12 Months	Next 12 Months
Federal Funds	$25,359,212	$25,359,212
General Revenue Fund	$11,435,930	$11,435,930
Grants & Donations Trust Fund	$2,501,066	$2,501,066
FHKC Technology Upgrade, federal	$172,050	$0
FHKC Technology Upgrade, GR	$77,950	$0
Total Kidcare Funds	$39,546,208	$39,296,208

Total General Revenue Required	**$37,165,913**	**$37,087,963**

The AHCA further advises as follows on the bill's fiscal impact:

Managed Care Medical Assistance Component
Based on January 2011 Medicaid enrollment data, an additional 794,618 Medicaid eligibles could be transitioned into managed care plans. This population is assumed to shift into managed care over a period of 12 months, beginning March 1, 2012, and ending March 31, 2013. A statewide managed care discount factor of 6.12 percent (93.88 percent of Fee for Service) is assumed in the analysis, and all expenditures utilized were based on the February 2011 Social Services Estimating Conference.

This estimate does not adjust for the level of future intergovernmental transfers (IGTs) that are currently provided today for inpatient and outpatient hospital utilization. If future IGT contributions are reduced and there are additional funding needs for general revenue, then savings may be reduced. The savings reflected in this analysis assume $12,124,969 in IGT for Fiscal Year 2011-2012 and $140,648,714 in IGT for Fiscal Year 2012-2013.

Managed Long-Term Care Component
Current caseload is 80,660; it is assumed that new eligibles seeking nursing home or HCBS will be 3,436 per month. New eligibles will be transitioning to the waiver starting in June 2012. By the end of June 2013, it is estimated that 44,668 will be enrolled in the managed LTC program. There is an assumed savings of 7 percent as specified in the bill resulting in a reduction of $886,992 for State Fiscal Year 2011-12, and for State Fiscal Year 2012-13 of $83,207,269. Federal regulations require that capitation rates must be actuarially sound and as such the savings amount may be adjusted to reflect this requirement.

Increase to Primary Care Physician Reimbursement
Based on the February 2011 SSEC, if the physician fees are increased to the Medicare rates, for State Fiscal Year 2011-12, there is no fiscal impact since the effective date provided in the bill is January 1, 2013. For State Fiscal Year 2012-13, the total fiscal impact is $441,842,581. This fiscal is assuming the PPACA is still law and the increase will be 100% federally funded until the end of CY 2015. If the PPACA is invalidated by court order, then the state would need to fund the state share of the costs. In this latter case, the general revenue need would be $192,068,970 with the federal funds being $249,773,611.

Reductions to the Medically Needy/MNMS Program
This bill revises the Medically Needy/MNMS program to provide physician services only for non-pregnant adults effective April 1, 2012. The Senate Budget reflects a total reduction of $230,193,780 of which $96,157,486 is general revenue funds and $134,036,294 is from trust funds. The remaining annualization realized in Fiscal Year 2012-2013 is an additional reduction of $635,153,319 of which $264,706,814 is general revenue funds and $370,446,505 from trust funds. These amounts are based on February 2011 Social Services Estimating Conference data.

$3.00 Copayment for Specialty Care
Physician services for adults billed by specialists will be charged a $3 copayment instead of the current $2.00 copayment. The copayment is deducted from the amount paid to the provider. The net result is a decrease to SFY 2011-12 expenditures by $14,911,169.

$100.00 Copayment for Non-Emergency Services in the ER
All non-emergency room services in an outpatient hospital setting that have revenue code 510 and will be charged a $100.00 co-pay. The copayment exceeds the maximum co-payment permitted under federal regulations and as a result the state will need to seek a waiver from the federal CMS. The Agency is unaware of CMS authorizing a co-payment this large that applies to all populations for the waiver including children, pregnant women and disabled adults. As a result, it is anticipated that the negotiations will take over a year. If approved by CMS, the net result is a decrease to Fiscal Year 2012-2013 expenditures by $9,612,700, but no impact for Fiscal Year 2011-2012. Furthermore, this amount may be adjusted as it is anticipated that CMS will continue apply current cost sharing protections for children, pregnant women and low-income families, which either exempt individuals from cost sharing or limit cost sharing amounts.

$10.00 Monthly Family Premium Payment
Federal regulations preclude premiums at this level for groups earning less that 150 percent of the federal poverty level and would require a waiver. It is anticipated that it would be one year or greater to negotiate a waiver. Therefore, no impact is included.

AHCA Resource Needs
Additional resources will be needed to accomplish the tasks in the time periods allotted:

- Requesting 27 FTE at 20 percent above minimum of pay grade and 13 OPS positions in order to implement the language in the proposed bill;

- Requesting $375,000 in total non-recurring contract funds for development of procurement documents, scope of services, plan requirements and contracts for acute care managed care program. ITN for 19 regions must be posted by August 15, 2011;
- Requesting $375,000 in total non-recurring contract funds for development procurement documents, scope of services, plan requirements and contracts for long term care managed care program. ITN for 19 regions must be posted by November 14, 2011;
- Requesting $30,000 in total non-recurring contract funds for development and submission of waiver to achieve bill components relating to acute care managed care, long term care managed care, and other requirements. The waiver must be submitted by August 1, 2011;
- Requesting $120,000 in total non-recurring contract funds to contract for specialized professional review of ITN response component relating to network requirements. Review of ITN responses due by October 12, 2011 and January 13, 2011 respectively for acute care and long term care managed care procurements;
- Requesting $1,066,816 in total additional contract funds for Medicaid Options Enrollment Broker services for the first year and $3,764,870 for year 2; and
- Requesting $1,028,958 in total additional Actuary contract funds for additional rate setting duties due to regional nature of program and addition of long term care.

AHCA FISCAL IMPACT	Year 1 FY 2011-12 Costs (Savings)	Year 2 FY 2012-13 Costs (Savings)
Program Impacts		
Medically Needy/MNMS	($230,193,780)	($635,153,319)
Title XXI (sections 8 and 15 of the bill)	$39,546,208	$39,296,207
Title XIX (sections 8 and 15 of the bill)	$58,220,682	$58,220,682
Physician Fee Increase	$0	$441,842,581
Addition of Dental, Vision, Hearing and Podiatric Services to Nursing Home Direct Care Subcomponent	$279,966	$0
Managed Care Transition	($10,551,255)	($122,393,755)
$3 Co-Pay for Specialty Care	($14,911,169)	($14,911,169)
Managed Long-term Care	($886,992)	($83,207,269)
$100 Co-Pay for Non-Emergency ER (OP)	$0	($9,612,700)
Total Recurring Expenditures (Savings)	**($158,776,306)**	**($325,918,742)**
General Revenue Fund	($70,436,981)	($327,865,334)
Medical Care Trust Fund (federal)	($72,842,873)	$50,640,523
Grants and Donations Trust Fund	($15,123,903)	($48,127,155)
Refugee Assistance Trust Fund	($92,583)	($566,776)
Total	**($158,496,340)**	**($325,918,742)**

Administrative Expenditure Impacts		
Total Nonrecurring Expenditures	$1,055,920	
Total Recurring Expenditures (27 FTE)	$4,973,061	$7,671,115
Total Expenditures	**$6,028,981**	**$7,671,115**
General Revenue Fund	$2,993,268	$3,816,948
Medical Care Trust Fund (federal)	$2,578,870	$3,421,375
Health Care Trust Fund	$456,843	$432,792
Total Expenditures	**$6,028,981**	**$7,671,115**

Total Impact Break-out		
General Revenue Fund	($67,443,713)	($324,048,386)
Medical Care Trust Fund (federal)	($70,264,003)	$54,061,898
Grants and Donations Trust Fund	($15,123,903)	($48,127,155)
Refugee Assistance Trust Fund	($92,583)	($566,776)
Health Care Trust Fund	$456,843	$432,792
TOTAL AHCA IMPACT (Savings)	**($152,467,359)**	**($318,247,627)**

The DOEA advises that there will be a direct fiscal impact related to enrollment and choice counseling functions for the proposed managed long term care system. In terms of enrollment broker transactions and choice counseling materials, addition of the currently exempt dually-eligible population as well as all Medicaid Institutional Care Program recipients into a managed care system will result in increased costs for enrollment broker services. In terms of choice counseling, ARCs have a limited amount of funding to complete Medicaid administrative activities at a 50 percent federal financial participation. To provide for effective choice counseling of elders, additional ARC Medicaid funded staff will be needed. When Florida Senior Care was originally proposed (2005), an ARC that covers a four-county area in an urban setting estimated that a contract for them to provide choice counseling services would cost approximately $200,000 a year. ARCs are determining whether a similar cost structure will apply to implementation of the choice counseling provisions of this legislation.

The DOH advises that it will need additional resources to implement the two new regulatory programs relating to expert witness certifications. The DOH estimates a recurring fiscal impact of $113,988 per fiscal year.

The APD advises that if Down Syndrome is added to the definition of developmental disability, an increase in the number of consumers requesting services is anticipated, particularly through general revenue funds. The fiscal impact is indeterminate.

VI. Technical Deficiencies:

The language in section 2 of the bill relating to hospital districts that currently reads:

> Notwithstanding any special act or other law governing the expenditure of ad valorem revenues, ad valorem revenues raised pursuant to a special act establishing a hospital district, by a county hospital pursuant to chapter 155, or a public health trust established pursuant to s. 154.07, and disbursed by the district, county hospital, or trust to municipalities or other organizations, may be used only to pay for health care services.

would be clearer by reading as follows (note verbiage in italics):

> Notwithstanding any special act or other law governing the expenditure of ad valorem revenues, ad valorem revenues raised pursuant to a special act establishing a hospital district, by a county hospital pursuant to chapter 155, or *by* a public health trust established pursuant to s. 154.07, and disbursed by the district, county hospital, or trust to municipalities or other organizations, may be used only to pay for health care services.

The language in lines 3990-3993 that currently reads:

> The amount paid to the plans to make supplemental payments or to enhance provider rates pursuant to this subsection must be reconciled to the exact amounts the plans are required to pay providers.

should instead read as follows (note verbiage in italics):

> The amount paid to the plans to make supplemental payments *pursuant to subsection (1)* or to enhance provider rates *pursuant to subsection (2)* must be reconciled to the exact amounts the plans are required to pay providers.

The language on lines 6038-6053 that currently reads:

> Providers or vendors, 75 percent of whose client population consists of individuals with a developmental disability as defined in ss. 393.063 and 400.960, individuals who are blind or severely handicapped individuals as defined in s. 413.033, individuals who have a mental illness as defined under s. 394.455, or individuals who have any combination of these conditions, which have contractually agreed. . .

indicates the percentage must be 75 percent, with no allowance for having a percentage greater than 75 percent. The language could be clearer by reading as follows (note verbiage in italics):

> Providers or vendors, 75 percent *or more* of whose client population consists of individuals with a developmental disability as defined in ss. 393.063 and 400.960, individuals who are blind or severely handicapped individuals as defined in s. 413.033, individuals who have a mental illness as defined under s. 394.455, or individuals who have any combination of these conditions, which have contractually agreed. . .

The effect of lines 3622-3626 is unclear, since the language providing that:

> . . . this section does not preclude a plan from contracting with a provider that is approved via a final order, has commenced construction, and will be licensed and operational within 18 months after the effective date of this act;

could be interpreted to require a qualified plan to *know*, in advance, that the provider will be licensed and operational within 18 months after the effective date of this act before the plan can contract with such a provider under this provision in the bill. The language could be clearer by reading as follows (note verbiage in italics):

> . . . this section does not preclude a plan from contracting with a provider that is approved via a final order, has commenced construction, and *is scheduled to be* licensed and operational within 18 months after the effective date of this act;

VII. Related Issues:

In section 2 of the bill, ch. 200, F.S., contains no definition of "health care services," leaving the intent and effect of the bill's new language in s. 200.186, F.S., unclear as to what might or might not constitute allowable expenditures for the ad valorem revenues raised by hospital districts, county hospitals, and public health trusts. In light of the fact that these types of revenues are often used to draw down federal Medicaid matching dollars, the AHCA advises it is not possible to tell how this new language in section 2 of the bill might potentially impact the collection of such revenue.

Also in section 2 of the bill, the Department of Revenue advises that ch. 200, F.S., relates to millage rate compliance by local government taxing authorities and that it is unclear why the language in section 2 of the bill is placed in ch. 200, F.S., because the Truth in Millage[153] (TRIM) process neither monitors revenue spending nor audits the budgets of taxing districts. The effectiveness of the language as placed in this chapter is indeterminate.

The FHKC advises that contracts the FHKC holds with its health and dental plans cycle on October 1st (health) or July 1st (dental) each year. It would be difficult to implement the changes in the medical loss ratio requirements mid-contract cycle, especially for the health plans which have a different medical loss ratio standard than the dental plans. The health plans are also under a rate freeze for the current contract year (October 1, 2010 through September 30, 2011) and another rate freeze is proposed for the following rate cycle (October 1, 2011 through September 30, 2012). Increasing the minimum medical loss ratio while rates are frozen may result in issues of actuarial soundness and could force plans to exit the Healthy Kids program.

The FHKC also advises that if Florida were to exit the Medicaid program, it is unclear whether or not Florida could maintain its Title XXI Children's Health Insurance Program (CHIP) without having the underlying entitlement program under Title XIX. If the state *can* have a Title XXI program without Title XIX, then the CHIP program could see a surge in enrollment since one of the enrollment qualifiers for CHIP is that a child not be eligible for Medicaid.

The OIR notes that section 39 of the bill requires qualified plans to secure a surety bond, a letter or credit, or a trust account and advises that if this requirement is in addition to s. 409.912(18), F.S., which authorizes the AHCA to require a deposit, one or the other should be removed. The OIR advises that a deposit is preferred to a letter of credit or surety bond because a letter of credit expires and a surety bond would likely require litigation before the state would collect.

The OIR also notes that section 39 of the bill requires a qualified plan that reduces enrollment or leaves a region before the end of the contract term to pay penalties. The OIR advises if the departing plan provides commercial or Medicare coverage, the bill's penalties could be significant enough to cause the plan to become impaired or insolvent.

The AHCA advises that, in regard to the language in section 40 of the bill providing that qualified plans are required to accept the results of the periodic licensing and certification surveys of health care facilities and are not required to conduct their own surveys, some health care facilities do not have regular surveys for licensure. The AHCA advises that the language should permit more frequent visits if needed for qualified plans to fulfill the bill's purpose of monitoring provider performance.

In section 40 of the bill, qualified plans are required to submit certain financial reports to the AHCA within 270 days after the conclusion of "the reporting period." It is unclear which

[153] The Truth in Millage (TRIM) process sets forth the legal requirements all local governments must follow in setting tax rates and adopting budgets. While each local government taxing authority uses a slightly different process and timetable, all must follow the basic rules and schedules set forth in TRIM. The timetable, hearing requirements, and advertising specifications must be adhered to precisely. Any local government found in violation faces the loss of state funds. See "TRIM and Property Taxes: A Primer," Florida TaxWatch, available at http://www.floridataxwatch.org/resources/pdf/1006TRIMandPropertyTaxesPrimer.pdf

"reporting period" is being referenced and why reports may be submitted up to 270 days after the conclusion of the reporting period.

In section 40 of the bill, for the purpose of establishing a qualified plan's achieved savings rebate, a list of five "expenses" is specified that may not be included in calculating income to the plan. Four of the five items in the list seem to represent potential payments plans might make while one represents potential income a plan might receive.

Section 40 of the bill requires a qualified plan to include certain essential providers in its network. The bill requires that, in the absence of a contract with a specialty children's hospital, the plan must pay the hospital an amount that equals the highest rate established by contract between that provider and any other Medicaid managed care plan. The bill does not address cases in which the hospital might not have a contract with any other Medicaid managed care plan.

The DOH advises that, through county health departments (CHDs), it provides communicable disease services to all persons regardless of citizenship status. CHDs currently do not verify citizenship or immigration status. CHDs therefore may provide treatment to individuals who do not meet the citizenship or legal status as defined in the bill. The DOH would not be able to bill Medicaid for communicable disease prevention services provided to non-citizens who have no proper documentation. If an alternate funding source is not provided, this could have a negative impact on public health. Preventing the spread of disease is a fundamental public health need. Withholding treatment of communicable diseases would likely spread those diseases in Florida.

The DOH also advises that there are approximately 1,000 HIV patients enrolled in the Medically Needy program. If Medicaid services for HIV/AIDS infected persons are limited to physician services only, these HIV/AIDS infected persons would most likely seek pharmaceutical and laboratory services from the AIDS Drug Assistance Program (ADAP).

The DOH also advises that the Children's Medical Services Network would become a statewide managed care option in the bill. CMS is a state agency and not eligible for the type of accreditation required by the bill. The choice counseling process that is currently in place includes screening questions to identify and refer children with special health care needs to CMS for eligibility determination. Since the bill eliminates choice counseling, it would also eliminate the ability to identify children with special health care needs and for those children to be referred to CMS.

The DOH also advises that the bill would require the Board of Medicine and the Board of Osteopathic Medicine and the DOH to regulate new programs and issue expert witness certificates within five days of receipt of a completed application. It would task the DOH's complaint, investigative, and prosecution resources with handling a new class of medical complaints. Also, s. 120.60, F.S., gives the boards 90 days after receiving a completed application to approve or deny. Under the Sunshine Law, the boards may not make decisions regarding applications except at duly noticed public meetings. Even if the criteria to approve an expert witness certification were clear enough to delegate approvals to DOH staff, the decision to deny an application can only be made by majority vote of the board members at a noticed public meeting. Given the requirements for public meetings under the Sunshine Law, the bill appears to

not give enough time to process applications under the bill's requirements and abide by existing state law at the same time.

The DOH also advises that under the bill, Medicaid applicants must consent to having their medical records released to the Medicaid Fraud Control Unit of the Department of Legal Affairs. This potentially conflicts with federal HIPAA laws that restrict a provider's ability to refuse treatment based on a patient's refusal to consent to various releases of personal health information.[154]

The DOEA advises that Medicaid recipients cannot be automatically assigned to PACE plans because federal Medicare regulations prohibit automatic assignment.

The DOEA also advises that section 51 of the bill outlines three levels of care for CARES to assign recipients into that do not correspond to the existing criteria for the state's three levels of care (Skilled, Intermediate I, and Intermediate II). As a result, the proposed language would significantly change medical eligibility determination for long-term care services in Florida, and may impact existing nursing home and Medicaid waiver recipients' on-going eligibility for enrollment in the proposed system. The intent and impact of new level-of-care criteria is not clear. The proposed "Level of care 2" includes language related to current recipients in home and community-based waiver programs indicating that those who remain financially eligible for Medicaid are not required to meet new level-of-care criteria except for immediate placement in a nursing home. Federal regulations require regular and periodic evaluation of individual eligibility, which conflicts with the bill language, according to the DOEA.

The DOEA also advises that the proposed "Level of care 3" criteria uses the Department's priority score measure as a factor in determining eligibility for nursing facility care. This is not part of the approved eligibility criteria for nursing facility care in Florida. The Department's priority ranking scores are currently only used for wait list prioritization purposes to determine need for community services. The proposed "Level of care 3" specifies that priority ranking scores shall be used to determine level of care. This is an inappropriate use of priority ranking score that will not produce the desired outcome, according to the DOEA.

The DOEA also advises that Level of Care criteria specified in the proposed bill conflicts with current level of care criteria in Rule at 59G-4.290, F.A.C. and 59G-4.180, F.A.C. and authorized under the federally approved Medicaid State Plan. Section 26 of the bill does not appear to include the skilled level of care which would conflict with federal law at 42 U.S.C. 1396d (a)(4)(A) that defines medical assistance required under the Medicaid State Plan to include nursing facility services for individuals 21 years or age or older. See also existing federal regulations at 42 CFR 440.40 and 42 CFR 440.155.

Two private-sector trade associations have raised concerns about the 19 regions contained in section 38 of the bill. The Florida Hospital Association and the Florida Association of Health Plans have each submitted alternative proposals for breaking the state into either 13 or 11 regions based on patterns of referral designed to track where the residents of the various counties actually receive Medicaid services.

[154] *See* Title 45 C.F.R. s. 164.508.

VIII. Additional Information:

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

CS by the Budget Subcommittee on Health and Human Services Appropriations on April 6, 2011:
The CS includes the following changes:

- The AHCA is required to select no fewer than 3 qualified plans per region as a result of the procurement process;
- The AHCA is required to establish a system for limiting the profits of qualified plans through a system of financial reporting and achieved savings rebate payments to the state if profits exceed specified ratios. This replaces provisions in the previous CS for the AHCA to subject qualified plans to a minimum medical loss ratio of 90 percent;
- Qualified plans are required to contract with specified essential providers and, if attempts to contract are unsuccessful, qualified plans are required to continue negotiating in good faith and to pay such providers certain specified payment rates;
- The AHCA is required to develop a methodology and request authority from the federal CMS that ensures the availability of certified public expenditures in the MMCP to support non-institutional teaching faculty providers that have historically served Medicaid recipients. The AHCA is required to make direct supplemental payments to such providers or to a statewide entity on behalf of such providers that contract with qualified plans, under certain parameters;
- Provisions to limit the legal liability of eligible lead community-based providers and their subcontractors relating to foster care services were removed from the bill; and
- Ambulance providers licensed under ch. 401, F.S., were added to the definition of "provider" in section 79 of the CS.

CS by the Committee on Health Regulation on March 30, 2011:
The CS includes the following provisions that were not included in the bill as filed:

- Section 163.387(2)(c), F.S., is amended to provide that hospital districts that are special districts as defined in s. 189.403, F.S., county hospitals that have taxing authority under ch. 155, F.S., and public health trusts established under s. 154.07, F.S., are exempt from s. 163.387(2)(a), F.S., which requires that upon the adoption of an ordinance providing for funding of a community redevelopment trust fund, each taxing authority listed above must make an annual appropriation to the redevelopment trust fund for a duration determined by statutory criteria. Under the bill, the taxing authorities listed above are exempt from annually appropriating funds to the redevelopment trust fund;
- Section 200.186, F.S., is created to provide that, notwithstanding any law governing the expenditures of ad valorem revenues, such revenues raised pursuant to a special act that establishes a hospital district, by a county hospital pursuant to ch. 155, F.S., or by a public health trust established pursuant to s. 154.07, F.S., and disbursed by the district, county hospital, or trust to municipalities or other organizations, may be used only to pay for "health care services;"

- Medically necessary vision and hearing care are added to the direct care subcomponent of the long-term care reimbursement cost reporting system. The bill as filed added dental and podiatric care to the subcomponent;
- The definition of "provider service network" includes entities whose governing bodies are controlled by a health care provider, a group of health care providers, or a public agency or entity that delivers health care services;
- Children residing in a statewide inpatient psychiatric program are excluded from the Medicaid Managed Care Program;
- Qualified plans that are based in Florida and have operational functions performed in Florida are eligible to receive preference during the procurement process;
- Qualified plans are authorized to contract with a provider that is approved via final order, has commenced construction, and will be licensed and operational within 18 months after the effective date of the bill;
- Qualified plans are required to accept prior authorization requests from prescribers and pharmacists for medication exceptions to the plan's preferred drug list or formulary. The criteria for the approval and the reasons for denial of prior authorization must be made "readily available" to the prescribers and pharmacists submitting requests;
- Qualified plans are required to pay non-contracted providers for emergency services at the same fee-for-service rate the AHCA would pay the non-contracted provider for such services, unless the agency has developed an average rate for the non-contracted provider and those services under s. 409.967(3)(c), F.S.;
- Qualified plans must adopt a standard minimum preferred drug list as described in s. 409.912(39), F.S., and must publish an up-do-date listing of its formulary on a publicly available website;
- A qualified plan *and its subcontractors* must spend at least 90 percent of the plan's capitation on medical services and direct care management according to AHCA rules;
- Qualified plans are not required to conduct surveys of health care facilities that are periodically surveyed by the AHCA and are required to accept the results of such AHCA surveys;
- The AHCA is required to develop a methodology and request a federal waiver that ensures the availability of intergovernmental transfers *and certified public expenditures* in the Medicaid Managed Care Program;
- Requires the AHCA to automatically assign a Medicaid Managed Care Program recipient who is a member of a Medicare Advantage managed care plan that is under contract with the AHCA for Medicaid services, into that Medicare Advantage managed care plan for the provision of applicable Medicaid services if the recipient has not made a choice of plans within his or her 30-day choice period;
- Allows recipients in the managed LTC component to change plans within 30 days after being referred for nursing home or ALF services; and
- The limited waiver of sovereign immunity is extended to certain providers or vendors, 75 percent of whose client population consists of individuals with developmental disabilities, individuals who are blind or severely handicapped, or individuals with mental illness, which have contractually agreed to act on behalf of certain state agencies to provide services to such individuals. Those providers or

vendors and their employees or agents are considered agents of the state under certain parameters.

B. Amendments:

None.