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 Committee on Health Policy

BILL:	SB 898
INTRODUCER:	Senator Joyner
SUBJECT:	Health Care Coverage
DATE:	April 1, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Pre-meeting**
2.			BI	
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

SB 898 requires health insurers, corporations and health maintenance organizations (HMOs) to provide coverage for telemedicine services under certain types of policies, contracts or plans. The bill prohibits the insurer, corporation or HMO from excluding coverage for a service solely because the service was delivered through telemedicine services rather than face to face. Reimbursement for services through telemedicine must be on the same basis as if treated face to face.

The bill also authorizes the application of a deductible, copayment or coinsurance for services through telemedicine so long as it does not exceed the amounts that would have been applicable under a face to face diagnosis, consultation or treatment, and a separate lifetime or annual benefit maximum is also not permitted for telemedicine services. These provisions are applied to policies, contracts or plans that are delivered, re-issued, or extended in this state on or after July 1, 2013.

The bill requires coverage for telemedicine services under Medicaid plans if the health care services would have been covered through an in-person consultation, including those services delivered in the patient's home.

Certain policy types are excluded from the telemedicine services requirement including short term coverage and limited benefit coverage and coverage under state or federal governmental plans. In the case of adverse decisions, SB 898 requires the insurer, corporation or HMO to notify the covered individual and their health plan to conduct a utilization review.

The bill creates a medical assistance program for eligible individuals with chronic conditions and provides health home services under a Medicaid waiver or state plan amendment. The program is created through provisions authorized under 42 U.S.C. s. 1396w-4.

The bill includes an interagency study led by the Department of Health. The study focuses on options for inclusion of telemedicine in a comprehensive state plan that includes multi-payor coverage and reimbursement for stroke diagnosis, high-risk pregnancies, premature births and emergency services. A final report is due to the Legislature by July 1, 2014.

The Department of Health is provided rulemaking authority with the appropriate medical boards to implement the provisions relating to telemedicine services and the coverage of those services by the applicable health care practitioners.

The act has an effective date of July 1, 2013.

This bill creates undesignated sections of the Florida Statutes:

II. Present Situation:

Telemedicine utilizes various advances in communication technology to provide healthcare services through a variety of electronic mediums. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. According to the American Telemedicine Association, services provided through telemedicine include:[1]

- **Primary Care and Specialist Referral Services** – involves a primary care or allied health professional providing consultation with a patient or a specialist assisting the primary care physician with a diagnosis. The process may involve live interactive video or the use of store and forward transmission of diagnostic images, vital signs and/or video clips with patient data for later review.
- **Remote patient monitoring** – includes home telehealth, uses devices to remotely collect and send data to home health agencies or remote diagnostic testing facilities.
- **Consumer medical and health information** – offers consumers specialized health information and on-line discussions groups for peer to peer support
- **Medical education** - provides continuing medical education credits.

Telemedicine Services in Florida

Since 2006, the Children's Medical Services Network (CMS Network) has provided specified telemedicine services under Florida's 1915(b) Medicaid Managed Care Waiver in compliance with federal and state regulations. Authorized CMS Network telemedicine services include certain evaluation and consultation services already covered by the Medicaid state plan.

The Child Protection Team (CPT) program under Children's Medical Services also utilizes a telemedicine network. The CPT is a medically directed multi-disciplinary program that works

[1] American Telemedicine Association, *What is Telemedicine*, http://www.americantelemed.org/learn/what-is-telemedicine (last visited Mar. 26, 2013).

with local Sheriffs offices and the Department of Children and Family Services in cases of child abuse and neglect to supplement investigative activities.[2] The telemedicine network works by connecting the child in one location ("remote site") where a Registered Nurse greets the child and assists with the examination by the health care professionals in another location ("hub site").[3] The hub site is a comprehensive medical facility with a wide range of medical and interdisciplinary staff that can assist with the exam and review. Special equipment allows for live assessments between the remote and hub sites in telemedicine, including permitting professional participation from multiple locations.[4]

The use of telemedicine for the CPTs is further defined under rule at Rule 64C-8.001, F.A.C. Rule 64C-8.003, F.A.C, allows medical diagnosis and evaluation to be conducted in person or through telemedicine. However, the use of telemedicine specifically requires the presence of a CMS approved physician or Advanced Registered Nurse Practitioner at the hub site and a Registered Nurse at the remote site.

In December 2010, Florida Medicaid submitted a state plan amendment to the federal Centers for Medicare and Medicaid Services (CMS) to allow for the provision of specified physician, dental, mental health, and substance abuse treatment telemedicine services. The amendment had been requested because Medicaid had been only reimbursing the physician rendering services using telemedicine, not the provider who is with the patient. The state plan amendment specifies that covered telemedicine services under Medicaid must include, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the Medicaid recipient and the health care practitioner.[5] Telephone conversations, chart review, electronic mail messages or facsimile transmissions are not considered telemedicine.[6]

Only a specific list of provider types are eligible for Medicaid reimbursement for telemedicine services and such providers or entities must be licensed under chs. 394, 397, 458, 459, 464, 466, 490, or 491, F.S.[7] The state plan amendment was approved in March 2011 and was retroactively effective to October 1, 2010. The 2012-2015 Model Contracts with the Medicaid Managed Care Organizations, however, limit telemedicine services to behavioral health care and dental services.[8,9]

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[2] Florida Department of Health, *Child Protection Teams*, http://www.cms-kids.com/families/child_protection_safety/child_protection_teams.html (last visited Mar. 26, 2013).
[3] Florida Department of Health, *CPT Telemedicine and Telehealth Network*, http://www.cms-kids.com/families/child_protection_safety/cpt_telemedicine.html (last visited Mar. 26, 2013).
[4] Florida Department of Health, *Child Protection Team Telemedicine Network Fact Sheet*, http://www.cms-kids.com/families/child_protection_safety/documents/cpt_telemedicine_fact_sheet.pdf (last visited Mar. 26. 2013).
[5] Florida Medicaid State Plan, Attachment 3.1-B, Page 11.
[6] Ibid.
[7] The eligible provider types are: physicians, dentists, psychiatric nurses, registered nurses, advanced registered nurse practitioners, physician's assistants, clinical social workers, mental health counselors, marriage and family therapists, masters level certified addiction professionals (CAP) and psychologists.
[8] According to the February 17, 2010 minutes of a Medicaid Medical Advisory Committee meeting, Medicaid reimburses telemedicine dental services for oral prophylaxis, topical fluoride application, oral hygiene instructions when a dental hygienists performs these services via video teleconferencing with a supervising licensed dentist.
[9] Agency for Health Care Administration, *House Bill 499/Senate Bill 898 Bill Analysis and Economic Impact Statement*, p. 2, (Mar. 27, 2013) (on file with the Senate Health Policy Committee).

The contract language specifically excludes reimbursement for telephone conversations, video cell phone interactions, electronic mail messages, facsimile transmission, telecommunications with the enrollee at a location other than the spoke site; and, "store and forward" visits and consultations that are transmitted after the Medicaid recipient is no longer available.[10] Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide the services. The spoke site is the provider office location where an approved service is being furnished.[11]

Fee for service (FFS) Medicaid providers may provide telemedicine services within the requirements of the current Medicaid Services Coverage and Limitations Handbook.[12] Currently, the approved FFS providers are physicians, dental and behavioral health care providers.[13] The managed care contracts are currently being amended to include the provision of telemedicine services by physicians.[14]

Florida law allows the Florida Board of Medicine (Board) to establish by rule standards of practice and standards of care for particular practice settings, including, but not limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedures manuals. In 2003, the Board adopted rule 64B8-9.014 "Standards for Telemedicine Prescribing Practice." The rule prohibits prescribing based solely on an electronic questionnaire. The rule permits a doctor to provide treatment recommendations, include issuing a prescription if they do so based on a documented patient evaluation, discussion between the patient and physician regarding treatment and treatment options and maintenance of appropriate medical records.

Patient Protection and Affordable Care Act

In March 2010, the Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[15] Under PPACA, qualified health plans (QHP) would be available from the state or federal Exchange beginning January 1, 2014. The PPACA required the Secretary of Health and Human Services to establish a minimum package of essential health benefits (EHB) for individual and small group health insurance.[16] The EHB package must cover benefits across ten general categories from preventive services, maternity care, hospital services to prescription drugs.[17]

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[10] Agency for Health Care Administration, 2012-2015 Health Plan Model Contract Attachment II – Core Contract Provisions, Paragraph 22, http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/contract/1215_Contract/2012-2015/Jan2013/2012-15_HP-ContractAtt-II_GEN-AMEND1-JAN-2013-CLEAN.pdf (last visited Mar. 26, 2013).
[11] Ibid.
[12] Agency for Health Care Administration, *supra*, note 9, at 2.
[13] Ibid.
[14] Agency for Health Care Administration, *supra*, note 9, at 2.
[15] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[16] Ibid.
[17] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Coverage Bulletin*, (1), Dec. 16, 2011, available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (last visited: Mar. 26, 2013).

Section 1311(d)(3)(B) of the PPACA allows a state to require QHPs to cover additional benefits above those required under the EHB; however, the law also directs the state or the issuer to offset the costs of those supplemental benefits to the enrollee.[18] The exchange is charged with making the determination as to whether a benefit constitutes a mandate thus requiring a state to fund the additional costs.

In addition to these provisions, certain plans under the PPACA received "grandfather status." A grandfathered health plan is a plan that existed on March 23, 2010, the date that the PPACA was enacted, and that at least one person had been continuously covered for one year.[19] Some consumer protection elements do not apply to grandfathered plans that were part of the PPACA but others are applicable, regardless of the type of plan. Providing the essential health benefits are also not required of grandfathered health plans.[20] A grandfathered plan can lose its status if significant changes to benefits or cost sharing changes are made to the plan since attaining its grandfathered status.[21] Grandfathered plans are required to disclose their status to their enrollees every time plan materials are distributed and to identify the consumer protections that are not available as a grandfathered plan.[22] Even though exempt from the EHB, a grandfathered plan could still be required to meet a new a requirement under state law if otherwise required under state requirements.[23]

The provisions of the PPACA include annual limitations on cost sharing in section 1302(c)(1) and an annual limitation on deductibles on small group plan deductibles in section 1302(c)(2) of the Affordable Care Act effective January 1, 2014. The type of plan an individual is enrolled in and the level of benefits selected will determine the amount of out of pocket costs that an individual may incur; however, out of pocket costs must still remain within certain guidelines.

The federal law further prohibits the imposition of annual and lifetime benefit limits, except for certain grandfathered plans, effective January 1, 2014. These protections went into effect for children earlier, September 23, 2010, and apply to grandfathered group health insurance plans.

Florida Mandates

A "mandate" is usually defined as required health coverage for specific type of treatments, benefits, providers or categories of dependants.[24] In Florida, health insurance coverage mandates are spread throughout the insurance statutes depending on the coverage type and insurance product. In addition, some types of health insurance coverage are exempt from state mandates,

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[18] 78 Fed. Reg. 12838, 12865 (February 25, 2013), available at: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf (last visited Mar. 26, 2013).
[19] Healthcare.gov, *Grandfathered Health Plans, http://www.healthcare.gov/law/features/rights/grandfathered-plans/* (last visited Mar. 26, 2013).
[20] Healthcare.gov, *Essential Health Benefits, Actuarial Value, and Accreditation Standards: Ensuring Meaningful, Affordable Coverage,* http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html (last visited: Mar. 26, 2013).
[21] Sarah Barr, *FAQ: Grandfathered Health Plans¸http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx* (last visited: Mar. 26, 2013).
[22] Ibid.
[23] 75 Fed. Reg. 34, 538, 34,540 (June 17, 2010).
[24] National Conference of State Legislatures, *Mandated Health Insurance Benefits and State Laws, http://www.ncsl.org/issues-research/health/mandated-health-insurance-benefits-and-state-laws.aspx* (last visited: Mar. 26, 2013).

such as self-funded or ERISA plans.[25,26] As a result, specific mandates may not be applicable to all insured persons as not all benefits are applicable to all insurance coverage types.[27] Florida has at least 52 different "mandates" falling across the small group, individual or large group health insurance market, including health maintenance organizations (HMOs).[28]

Required Study by Advocates

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal that would mandate specific health coverage to submit to the Agency for Health Care Administration (AHCA) and the appropriate legislative committee a report reviewing the social and financial impacts of the proposed coverage. The statute lists twelve components for assessment, if available:

- To what extent is the treatment or service generally used by a significant portion of the population?
- To what extent is the insurance coverage generally available?
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment?
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship?
- The level of public demand for the treatment or service.
- The level of public demand for insurance coverage of the treatment or service.
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- To what extent will the coverage increase or decrease the cost of the treatment or service?
- To what extent will the coverage increase the appropriate uses of the treatment or service?
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders?
- The impact of this coverage on the total cost of health care.

SB 898 requires coverage of a specific health care service, telemedicine. No study on the impact of this potential mandate has been received on the bill.

Statewide Medicaid Managed Care (SMMC)

In 2011, the Legislature also passed HB 7107 creating the SMMC program as part IV of ch. 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care. Under s. 409.966(c)(2), F.S., the Agency is required to give preference to plans that have

[25] Florida Department of Financial Services, *Insurance Library,* *http://www.myfloridacfo.com/consumers/insuranceLibrary/Insurance/L_and_H/Health_Care/Self-Funded_Medical_Plans/Self-Funded_-_Regulation.htm* (last visited: Mar. 26, 2013).
[26] Federal Employee Retirement Income Act of 1974 (ERISA) governs self insured health plans.
[27] Florida Department of Financial Services, *Insurance Library, available at:* *http://www.myfloridacfo.com/consumers/insuranceLibrary/Insurance/L_and_H/Health_General/MandatedHealthInsAndHMOBenefits.pdf* (last visited: Mar. 26, 2013).
[28] Ibid.

well designed programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes.

The AHCA began implementing the SMMC in January 2012 and recently released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis. Plans can supplement the minimum benefits in their bids and offer enhanced options.[29] Statewide implementation of SMMC is expected to be completed by October 1, 2014. Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however on February 20, 2013, the AHCA and the Centers for Medicare and Medicaid Services reached an "Agreement in Principle" on the proposed plan.[30]

Health Homes for Enrollees with Chronic Conditions

Under the PPACA, a new option under the Medicaid state plan was made available to states for the provision of health homes to individuals with chronic conditions.[31] States electing this option under Section 1945 of the Social Security Act would receive 90 percent federal medical assistance (FMAP) for the first eight fiscal quarters that the state plan amendment is in place.

The health home model seeks to integrate medical, behavioral and social support services for individuals with chronic conditions through an expanded medical home model. The chronic conditions that have been identified include: a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25.[32] To be eligible, a recipient must meet the following requirements:[33]

- Have at least two chronic conditions;
- Have at least one chronic condition and is at risk of having a second chronic condition; or,
- Have at least one serious and persistent mental health condition.

States may elect to provide health homes services to individuals eligible for all of the chronic conditions listed in statute or provide services only to a select few conditions.[34] The population, however, must include all categorically eligible individuals who meet the criteria and may include the medically needy population.[35] Planning grants are available to the states for purposes of drafting and submitting state plan amendments.

The statute also prescribes the services to be covered under health homes and include:

- Comprehensive care management;

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[29] Agency for Health Care Administration, *Senate Bill 896 Bill Analysis and Economic Impact Statement*,(Mar. 11, 2013) (on file with the Senate Health Policy Committee).
[30] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (last visited Mar. 27, 2013).
[31] 42 U.S.C. 1396w-4.
[32] Centers for Medicare and Medicaid Services, *Dear State Medicaid Director and Dear State Health Official Letter, ACA #12 (Health Homes for Enrollees with Chronic Conditions), November 16, 2010, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf* (last visited: Mar. 26, 2013).
[33] Ibid.
[34] Ibid.
[35] Ibid.

- Care coordination and health promotion;
- Comprehensive transitional care, including appropriate follow up;
- Referral to community and social support services, if needed; and,
- Use of health information technology, as feasible and appropriate.

As of November 2012, eight states had approved Health Home State Plan Amendments and three more states had pending amendment requests.[36] Several more states had draft amendments under review or had received planning grants from CMS to draft their state plan amendments.[37] Florida Medicaid has not pursued this option.[38]

III. Effect of Proposed Changes:

Section 1 of the SB 898 creates an undesignated statutory section requiring insurers, HMOs, and corporations issuing health care policies, contracts or plans that provide hospital, medical, surgical or major medical coverage to provide coverage for the cost of health care services provided through telemedicine services.

Telemedicine services are defined as the delivery of health care services through synchronous video conferencing, remote patient monitoring, asynchronous health images or other health transmissions supported by mobile devices or other technology for the purposes of diagnosis, consultation or treatment. Telemedicine does not mean audio-only telephone, e-mail messages or facsimile transmission.

An "adverse decision" is defined as a determination that the use of a telemedicine service or a proposed use is not covered under the plan, policy or contract. The bill also defines "utilization review" to mean the review for the determination of the appropriateness of telemedicine services or if the coverage of proposed telemedicine services is required. Utilization review for coverage for telemedicine must be made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered under the policy, contract, or plan. The bill permits the insurer, corporation, or HMO to conduct utilization reviews. If an adverse decision is made, the bill requires the insurer, corporation, or HMO to notify the covered individual and the health care provider and if a written request is received from either the individual or the provider, utilization review must be conducted.

Medical services rendered using telemedicine cannot be excluded from coverage solely because the service is provided through telemedicine rather than through a face to face consultation or face to face contact between the provider and patient. An insurer, corporation, or HMO is not required to reimburse the telemedicine provider for any technology fees or costs related to the provision of telemedicine services.

Telemedicine services may not be subject to a different deductible, copayment, or coinsurance requirement than applies to the same service if it had been provided through face to face

[36] Center for Medicare and Medicaid Services, *State Health Home CMS Proposal Status (November 2012),* *http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HHMap_v15_2.pdf* (last visited: Mar. 26, 2013).
[37] Ibid.
[38] Agency for Health Care Administration, *supra* note 9, at 2.

diagnosis, consultation, or treatment. Additionally, the health insurance or contract cannot impose different annual, calendar year, or lifetime dollar maximum limits to telemedicine services than are equally imposed upon all terms and services covered under the health care policy or contract, or plan.

Telemedicine applies to any insurance policy, contract, or plan that is delivered, issued for delivery, reissued or extended in this state on or after July 1, 2013. For Medicaid plans, if the health care service would be covered through an in-person consultation between the Medicaid recipient and the provider, including services from the recipient's home, then the telemedicine services would be covered.

The bill does not require telemedicine coverage for short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts. Coverage is also not required under Medicare coverage or any other similar coverage under state or federal governmental plans.

Section 2 of the bill refers to an optional Medicaid program that creates "health homes" for Medicaid beneficiaries with chronic conditions under 42 U.S.C. 1396w-4. A state plan or waiver of the Medicaid state plan would be required to implement the program along with approval of that amendment or waiver by the federal Centers for Medicare and Medicaid Services before such services could be available under Florida Medicaid.

Section 3 of the bill requires the Department of Health to lead and conduct an interagency study on options for a comprehensive telemedicine services and coverage state plan that would address multi-payer coverage and reimbursement for stroke diagnosis, high-risk pregnancies, premature births, and emergency services. The final report is due to the Legislature by July 1, 2014.

Section 4 of the bill permits the Department of Health to adopt rules in consultation with the appropriate boards relating to health care practitioners to address the provision of telemedicine services and the coverage of those services.

Section 5 of the bill provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals with an individual, group accident or sickness insurance policy, or a health plan provided by an HMO, may see an increase in the cost of their health insurance coverage related to the telemedicine coverage requirement. The amount of any increase is not known. Self-insured or ERISA plans would not be subject to the provisions of this bill as they are regulated by the federal government. Approximately 60 percent of employees are in ERISA plans.

C. Government Sector Impact:

SB 898 excludes the application of the telemedicine coverage requirement from policies or contracts under state or governmental plans. State and governmental plans are not defined in the bill so it is unclear which governmental plans have been excluded.

The AHCA indicates that implementation of the health homes option would have no fiscal impact the first year as the time to receive approval of a state plan amendment would put implementation in the last part of state fiscal year 2014-2015.[39] Because states are eligible for 90 percent federal match for the first 8 fiscal quarters, AHCA reports that there would be little fiscal year in the second fiscal year 2014-2015.[40]

VI. Technical Deficiencies:

The Office of Insurance Regulation (OIR) notes that "Corporation" is not a type of insurance product.[41] This term needs to be defined in the bill. It is unclear whether this refers to self insured plans, employer group policies, Employment Retirement Income Security Act (ERISA) plans, etc.[42]

The OIR also notes that the bill refers to the applicability of policies that are "extended." OIR suggests that if "extended" means renewed, then the same terminology should be used throughout the bill.[43]

Subsection (7)(b) of the bill refers to "Medicaid plans" but does not define a Medicaid plan. Additionally, the following paragraph, (8), appears to contradict the Medicaid requirement by excluding application of the section to "any coverage under state or federal governmental plans." Medicaid is already covering some telemedicine services currently according to the bill analysis submitted by the AHCA.

[39] Agency for Health Care Administration, *supra* note 9, at 5.
[40] Ibid.
[41] Office of Insurance Regulation, *SB 898 Bill Analysis (February 18, 2013)*(on file with Senate Health Policy Committee).
[42] Ibid.
[43] Ibid.

Section 2 of the bill cites a Medicaid option for health homes and coverage for eligible individuals under a state plan amendment or waiver. This optional service is not currently available in Florida Medicaid. The bill does not provide any direction or authority to the AHCA or any agency to seek approval of a state plan amendment or waiver that would accomplish implementation of the option.

Section 4 of the bill authorizes the Department of Health to adopt rules relating to health care practitioners and the implementation of this act relating to the provision of telemedicine services and coverage by such practitioners. The AHCA notes in their bill analysis that as the single state agency for Medicaid, the AHCA has the authority for determining coverage requirements for Medicaid services and the bill appears to delegate some of its rulemaking authority to the Department of Health.[44]

VII. Related Issues:

The AHCA has released an ITN covering all Medicaid services as part of the Statewide Medicaid Managed Care program (SMMC). This ITN includes health home services as part of those comprehensive medical services and requires the managed care organizations to cover all benefits. Creating a separate health home project through a Medicaid waiver or state plan amendment may be contrary to integrated care model of the SMMC program and the services already incorporated in the ITN.

Section 409.961, F.S., provides that if any conflict exists between provisions contained in the Medicaid Managed Care Part (Part IV) and in other parts of the Chapter, the provisions of Part IV would control.

VIII. Additional Information:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[44] Agency for Health Care Administration, *supra*, note 9, at 4.