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 1240
INTRODUCER:	Senator Sobel
SUBJECT:	Children's Medical Services Eligibility and Enrollment
DATE:	February 8, 2016
REVISED:	

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

I. Summary:

SB 1240 revises the definitions of "children with special health care needs" and "clinical eligibility" for the Children's Medical Services program (program). The bill expands the eligibility criteria to children who have a chronic or serious condition rather than the condition being chronic and serious. The bill specifies minimum requirements for a clinical eligibility assessment tool for the program and requires the program to provide ch. 120, F.S., appeals notices to the parents or guardian of children who are found ineligible under the assessment tool. The Children's Medical Services Managed Care Plan (plan) is also exempted from the regional specialty plan enrollment limits under the Medicaid Managed Care Assistance (MMA) program.

The department estimates an annual fiscal impact of over $100 million.

The bill provides an effective date of upon becoming law.

II. Present Situation:

Children's Medical Services

Children's Medical Services (CMS) is a group of programs that serves children with special health care needs under the supervision of the Department of Health (department). Within CMS, individual services or programs are designed to address specific conditions or family needs such as the newborn screening program, early intervention screenings, or its managed medical assistance plan. CMS is created under Chapter 391 of the Florida Statutes and divided into three parts: Part I (General Provisions), Part II (Children's Medical Services Councils and Panels), and Part III (Developmental Evaluation and Intervention Programs).

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $23.4 billion.[1]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) Program as part IV of ch. 409, F.S.[2] The SMMC has two components: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated, comprehensive, managed care program for Medicaid enrollees that manages the delivery of primary and acute care in 11 regions.

Managed Medical Assistance Program (MMA)

For the MMA component, health care services were bid competitively using 11 regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions.

Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans.

Specialty plans are also held to an enrollment cap in each region. The aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region.

Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services.

Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements, including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

Statewide implementation of SMMC started May 1, 2014, and was completed by August 1, 2014.

[1] Office of Economic and Demographic Research, *Social Services Estimating Conference* (August 4, 2015) *available at* http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Dec. 11, 2015).
[2] *See* Chapter Laws, 2011-134 and 2011-135.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[3]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

The MMA program is authorized by a section 1115 demonstration waiver by federal CMS. It was approved in 2005 and is currently operating as an expansion of the managed care pilot program and was renewed on July 31, 2014, for a second 3-year period through June 30, 2017.[4]

CMS MMA Plan

The CMS MMA plan serves children with special health care needs who meet both financial and clinical eligibility. The CMS plan determines clinical eligibility using an assessment instrument.

Children are referred to the CMS Plan in several ways:

- Medicaid counselors;
- Screening questions on the application; and
- Medical professionals.[5]

When a child is referred to CMS, a care coordinator contacts the family or caregiver by telephone to determine the child's clinical eligibility for CMS. Care coordinators use a computer based tool to enter the information in the CMS system.[6] Care coordinators re-screen children annually or more often, as determined by a primary care physician.[7]

In 2012, the Legislature amended ch. 391, F.S., to include "serious" in the definition of a child with special health care needs.[8] The department implemented a new assessment tool to comply

[3] Section 409.972, F.S.
[4] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf (last visited Feb. 8, 2016).
[5] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends* (March 4, 2015) (on file with Senate Health Policy Committee).
[6] Id.
[7] Id.
[8] Ch. 2012-184, s.75, Laws of Fla.

with the change in statutory definition that a child's condition needed to be both serious and chronic to be eligible for the CMS specialty plan.[9] The most recent version of the assessment instrument incorporated questions from the Child and Adolescent Health Measurement Initiative's (CAHMI).

The CAHMI Screener is a national based screener based out of The Bloomberg School of Public Health at Johns Hopkins University in Baltimore, Maryland. The model stresses family and consumer empowerment and involvement.[10] The screener is used to identify children and teens with special health care needs uses a survey model that is completed by parents and/or teens and assesses preventive and developmental services including:

- Standardized developmental and behavioral screening;
- Avoidable hospitalizations;
- Whether a child has a medical home, including measures specific to children with special health care needs;
- Whether care is culturally competent; and
- Other topic areas.[11]

The most common CMS diagnoses were asthma, attention deficit disorder, and congenital anomalies for 2009-2010 through 2013-2014 fiscal years.[12] The CMS specialty plan also covers a range of conditions from birth such as heart defects and permanent disabilities.[13]

Title XXI Program

The Florida Kidcare Program (Kidcare) was created in 1998 by the Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who have family incomes under 200 percent of the FPL and meet other eligibility criteria. The state statutory authority for Kidcare is found under part II of ch. 409, F.S., specifically in ss. 409.810 through 409.821, F.S. Children with special health care needs may also enroll in the CMS plan who are Title XXI eligible.

The CHIP-funded components of Florida Kidcare serve distinct populations:

- Medicaid for Children: Children from birth until age 1 for family incomes between 185 percent and 200 percent of the FPL.
- Medikids: Children from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL. Those enrollees above 200 percent FPL may enroll at a non-subsidized rate established by the AHCA.

[9] Florida Dept. of Health, *Senate Bill 1240 Analysis,* p .2, (January 4, 2016) (on file with the Senate Committee on Health Policy).
[10] The Child & Adolescent Health Measurement Initiative, *Who We Are* http://www.cahmi.org/about-us/ (last visited Feb. 8, 2016).
[11] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends* (March 4, 2015) (on file with the Senate Committee on Health Policy).
[12] OPPAGA Research Memorandum, *Children's Medical Services Screening Tool and Enrollment Trends,* p. 6 (March 4, 2015) (on file with Senate Committee on Health Policy).
[13] Id.

- Healthy Kids: Children from age 5 through age 18 for family incomes between 133 and 200 percent of the FPL. Those above 200 percent FPL may enroll at a non-subsidized rate established by the FHKC.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs.

Kidcare is funded by Medicaid funds under Title XIX of the Social Security Act, state funds from General Revenue and the Tobacco Settlement Trust Fund, and family contributions.[14] CHIP has an enhanced federal matching rate that is more favorable than Medicaid. For the period of October 2014 through June 2015, the federal match rate is 71.80 percent.[15]

Title XXI is a non-entitlement program, so families contribute monthly premiums. Family contributions are based on family size, household income, and other eligibility factors. Families above the income limits for premium assistance or who are not otherwise eligible for premium assistance are offered the opportunity to participate in Kidcare at a non-subsidized rate (full-pay) in Healthy Kids or the Medikids program components. The non-subsidized rates are established by the individual program and are based on the actual costs of the program, both premiums and an administrative fee. The income limit for premium assistance is 200 percent of the FPL.

Total enrollment for the CMS plan, both Medicaid and CHIP for January 2016 is provided below:

Children's Medical Services Plan Enrollment[16,17]			
	Title XIX Medicaid MMA	**Title XXI CHIP**	**Total**
January 2016	53,592	9,504	63,096

Revised Screening Tool

The CMS plan implemented the revised screening tool with new enrollees and began the re-evaluation of existing enrollees in May 2015.[18] CMS plan enrollees who were found no longer clinically eligible, but still financially eligible for an MMA plan were transitioned to another MMA plan. The child's new MMA plan was required to honor any ongoing treatment that was authorized or scheduled prior to the child's enrollment into the new health plan for up to 60 days after the child enrolled in the plan.[19]

[14] Florida Kidcare Coordinating Council, *2014 Annual Report and Recommendations,* p. 14, http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last reviewed Feb. 8, 2016).
[15] Office of Economic and Demographic Research, *Social Services Estimating Conference - Kidcare Program (February 12, 2015 Conference Results)* http://edr.state.fl.us/Content/conferences/kidcare/kidcaredetail.pdf (last viewed Feb. 8, 2016).
[16] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report (January 2016)* *http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml* (last visited: Feb. 8, 2016).
[17] Florida Healthy Kids Corporation, *Enrollment - January 2016, https://www.healthykids.org/resources/enrollment/,* (last visited: Feb. 8, 2016).
[18] E-Mail correspondence from Bryan Wendel, Department of Health (July 17, 2015) (on file with the Senate Health Policy Committee).
[19] Id.

In June 2015, an administrative petition was filed against the department seeking a ruling that the CMSN Clinical Eligibility Screening Guide was an unadopted rule whose existence violated s. 120.54(1)(a), F.S.[20] On September 22, the administrative law judge agreed and found the Screening Guide constituted an unadopted rule because it had not been adopted through a formal rulemaking process and ordered the department to immediately cease using the screening tool as a method of determining eligibility.[21]

The department subsequently began the formal rulemaking process and noticed its first proposed rule and rule workshops for October 16, 2015. An interim, time-limited eligibility process was also developed between the department and the AHCA to allow for enrollment to continue into the CMS plan during rule development.[22] The interim process permitted a child's physician to attest to the child's diagnosis as meeting one of the qualifying diagnosis as serious and chronic for enrollment.[23] Serious and chronic under the SMMC contract is defined as one or a combination of some the following conditions:

- Acute or chronic lymphoid leukemia;
- Acute or chronic myeloid leukemia;
- Congenital or acquired quadriplegia;
- Congenital diplegia or hemiplegia;
- Spina bifida;
- Malignant neoplasm of the esophagus, stomach, small intestine, pancreas, ovary, kidney, brain, unspecified part of the nervous system, or lung; or
- HIV.[24]

After several workshops, rulemaking concluded in December and the final rule went into effect January 11, 2016.[25] The final rule creates two pathways to CMS clinical eligibility. A child's clinical eligibility may be established through completion of the CMS Clinical Eligibility Screening Form with an authorized representative of the department. A child with a diagnosis of one or more health conditions listed on the CMS Eligibility Attestation form may also be determined clinically eligibility for the plan through attestation by a physician.[26] The physician-determined automatic eligibility conditions are specific and inclusive to over 2,418 diagnoses.[27] Both the screening tool and the attestation form are adopted by reference in the administrative rule.

Specialty Plan Enrollment Cap

The CMS plan's enrollment is counted as part of the 10 percent enrollment cap placed on aggregate specialty plan enrollment. The chart provided below shows the breakdown of specialty plan enrollment compared to MMA enrollment for January 2016.[28]

[20] A.R., et al v. Dept. of Health, Case No. 15-3737RU (Fla. DOAH 2015).
[21] *See* Final Order, A.R., et al v. Dept. of Health, Case No. 15-3737RU (Fla. DOAH 2015)
[22] Agency for Health Care Administration, *Florida Medicaid - Interim Process to Qualify Children for Enrollment in the Children's Medical Services Plan* (November 2015) (on file with the Senate Committee on Health Policy).
[23] Id.
[24] Id.
[25] Fla. Admin. Code R. 64C-2.002, F.A.C. (2016).
[26] Id.
[27] *Supra* note 9, at 2.
[28] *Supra* note 21.

Specialty Plan Enrollment						
Region	**MMA Enrollment**	**10% of MMA Enrollment**	**Other Specialty Plans**	**CMS Specialty Plan**	**Child Welfare Plan**	**Total Specialty Plan Enrollment**
1	102,355	10,235	216	1,368	1,054	2,638
2	112,592	11,259	2,555	3,983	1,004	7,542
3	259,389	25,940	530	5,486	3,245	9,261
4	307,647	30,765	6,558	4,489	4,059	15,106
5	182,994	18,299	4,753	3,662	2,066	10,481
6	419,797	42,980	7,875	7,209	4,206	29,771
7	409,097	40,910	8,717	7,034	3,334	19,085
8	210,760	21,076	448	3,246	1,827	5,518
9	272,695	27,270	5,452	4,939	2,592	12,983
10	267,695	26,770	5,309	6,406	3,006	14,721
11	548,272	54,827	10,700	5,770	2,750	19,220

III. Effect of Proposed Changes:

Section 1 amends s. 391.021, F.S., to revise the definition of children with special health care needs to allow the physical, developmental, behavioral, or emotional condition to be chronic or serious, rather than both chronic and serious. A definition for *clinical eligibility* is added to mean a determination based on an assessment instrument and a clinical evaluation that a child has special health needs and is eligible to receive services through the CMS program.

Section 2 amends s. 391.029, F.S., to remove repetitive language that is included in the definitions and is based on a diagnosis of one or more chronic and serious medical conditions and the family's need for specialized services.

The bill requires the department to use an assessment instrument to determine a child's clinical eligibility for the CMS program. At a minimum, the instrument must:

- Identify chronic or serious physical, developmental, behavioral, or emotional conditions in the child which require health and care and related services of a type or to an extent greater than that generally required by children; or
- When used as part of a clinical evaluation by a licensed health care professional, indicate the child meets the definition of a child with special health care needs under s. 391.021, F.S.

Section 3 amends s. 391.081, F.S., to require the department to notify the parent or guardian of a child who has been determined clinically ineligible for the program of the right to appeal such determination on behalf of his or her child, in accordance with the requirements of ch. 120, F.S.

Section 4 amends 409.974, F.S., to exempt the CMS plan from the aggregate enrollment limits that are applicable to the MMA specialty plans.

Section 5 provides the bill is effective upon becoming law.

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:

Changing the eligibility requirements for the CMS plan may increase the number of eligible children, leading to an increased enrollment. Children that may be enrolled in private sector plans who may not have been previously eligible for the CMS plan may seek enrollment in the plan as a result of this change.

C. Government Sector Impact:

Using the 2009-2010 National Survey of Children with Special Health Care Needs, the department reports that Florida has an estimated 606,215 children with special health care needs.[29] This translates to potentially an additional 303,107 children who would be eligible for the program and enrolled through either Medicaid or CHIP with the changes in SB 1240.[30] In order to meet this increased enrollment, the department estimates a need for an additional 971 FTEs to provide care coordination services for the increased caseload. The estimated annual total cost for the additional FTEs would be $91,374,984.[31]

In addition to the care coordinators for the program, the department estimates that 169 new nurses would be needed to collect and complete the information needed to determine clinical eligibility on the additional screenings. The estimated annual cost for the additional nurses is $15,903,576.

SB 1240 applies ch. 120, F.S., appeal rights for all children determined clinically ineligible for the program. Historically according to the department, there have been

[29] *Supra* note 6, at 4.
[30] Id.
[31] Id.

7,000 new referrals.[32] To handle the expected volume of appeals, the department requests two additional attorneys at an estimated annual cost of $182,784.

The program's technology and rules need to be updated to reflect the changes to the clinical eligibility process.

Department of Health Estimated Fiscal Impact - Annual	
Issue	**Annualized Amount**
971 FTEs for Care Coordination	$91,374,984
169 FTEs for Eligibility Screenings	$15,903,576
2 FTEs for Appeals Hearings	$182,784
	$107,461,344

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 391.021, 391.029, 391.081, and 409.974.

IX. Additional Information:

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

None.

B. Amendments:

None.

[32] Id at 4.