STORAGE NAME: h1709s1.lt
DATE: April 7, 1999

HOUSE OF REPRESENTATIVES
COMMITTEE ON
Elder Affairs & Long Term Care
ANALYSIS

BILL #: CS/HB 1709

RELATING TO: The Long-term Care Community Diversion Projects

SPONSOR(S): Representative Jacobs & others

COMPANION BILL(S): SB1864

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) Elder Affairs & Long Term Care YEAS 9 NAYS 1
(2) Health & Human Services Appropriations
(3)
(4)
(5)

I. SUMMARY:

The bill directs the Department of Elder Affairs (DOEA), in consultation with the Agency for Health Care Administration (Agency), to select and contract with “other qualified providers” to provide long-term care within community diversion pilot project areas. “Other qualified provider” is defined to mean an entity licensed under chapter 400, F.S., that meets all the financial and quality assurance requirements established by the Agency for provider service networks (PSNs) as authorized in section 409.912, F.S., and can demonstrate a long-term care continuum. Any “other qualified providers” are exempted from regulation as a health maintenance organization (HMO) pursuant to chapter 641, F.S.

The following entities are licensed under chapter 400, F.S.:

nursing homes;
ALFs;
home health agencies;
adult day care centers;
hospices;
adult family-care homes; and
intermediate, special services, and transitional living facilities.

DOEA reports a minimum fiscal impact of $160,000 for fiscal year 1999-2000. AHCA did not report a fiscal impact.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Legislative Commission on Long-term Care

The Florida Legislature's Commission on Long-term Care was created in proviso language during the 1994 Legislative Session to comprehensively address the programming and financing of long-term care services in the state. Its mission was to develop a framework for long-term care planning that would assure the highest possible quality care in the most appropriate setting at the lowest reasonable cost, without unduly restricting the recipient's choice of providers and service settings.

Included in the Commission's recommendations were two fundamental reforms:

1. integration of acute and long-term care; and,

2. creation of a managed care system to achieve the integration of acute and long-term care.

The Commission found that people in need of long-term care commonly cycle in and out of both acute and long-term care providers and environments. It concluded that an integral part of creating an effective and cost-efficient long-term care system lies in coordination and integration of acute and long-term care services. With public expenditures for such services dominated by Medicare and Medicaid, the Commission recommended the pursuit of appropriate federal waivers necessary to achieve integration of acute and long-term care services.

The Commission also found that the present long-term care system is fragmented, uncoordinated, and inconsistent in its ability to provide recipients the array of services they need at a cost affordable to the state. Based on its review of other state efforts, including the federal Social HMO and Program of All-Inclusive Care for the Elderly (PACE) demonstrations, the Commission recommended the Legislature implement a managed care system which integrates acute and long-term care.

Long-Term Care Community Diversion Pilot Projects

In 1995, DOEA was awarded a grant from the Robert Wood Johnson (RWJ) Foundation to develop a managed long-term care service delivery model designed to promote the integration of acute and long-term care services. In 1996, Legislative funding and proviso language was provided for DOEA, in consultation with the Agency, to implement, in the form of pilot projects, a managed long-term care service delivery model to provide individuals with a feasible alternative to institutional care. A Medicaid waiver from the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, which is required to operate the project, was approved in March of 1997.

In 1997, the Florida Legislature enacted the Long-Term Care Community Diversion Pilot Project Act (ss. 430.701 - 430.710, F.S.), providing authority and guidance for the implementation of the Pilot Projects. Section 430.703, F.S., states the Legislature's intent that the Pilot Projects "test the effectiveness of managed care and outcome-based reimbursement principles when applied to long-term care."

Services

The Pilot Projects provide acute care services covered by Medicaid, home and community-based long-term care services, and when necessary, nursing home care through managed care organizations. Section 430.703, F.S., defines the Pilot Project as a service delivery system that places participants in the most appropriate care settings and provides comprehensive home and community-based services of sufficient quantity, type, and duration to prevent or delay the need for long-term placement in a nursing facility. In addition to providing home and community-based services, section 430.705, F.S., requires Pilot Projects to provide skilled and intermediate nursing facility care for participants who cannot be adequately cared for in noninstitutional settings.

Acute and Long-Term Integration

Integration of acute and long-term care services is an important strategy to preventing or delaying permanent placement in a nursing facility, and is an integral component of the Pilot Project service delivery model. Fragmentation of care, care decisions based on coverage not need, and a lack of accountability for outcomes contribute to unnecessarily high rates of hospitalizations and to nursing facility admissions.

Pilot Project enrollees are dually eligible for Medicare and Medicaid and are an especially vulnerable population, often requiring substantial acute and chronic medical care and long-term care services. Dual eligible beneficiaries rely on Medicare as their primary payer for medical acute and chronic care, and on Medicaid as a Medigap policy to pay pharmacy and cost-sharing expenses and as the payer of long-term care services. Medicare and Medicaid may initially appear to provide distinguishable but complementary services to the dual eligible population. However, due to differences in administration, eligibility, financing, and overlapping coverages, as well as the overall failure to coordinate medical and long-term care throughout the health care system, the two programs do not provide the continuum of care required by the dual eligible population.

Section 430.705, F.S., requires Pilot Projects to integrate acute and long-term care services, and the funding sources for such services, as feasible. The model contract for Pilot Projects requires providers to have the capacity to integrate the delivery of acute and long-term services to Project enrollees. To facilitate integration, DOEA is developing contracts with HMOs that also have Medicare managed care plans. The goal is to provide Pilot Project enrollees with a choice of joining the contractor's Medicare plan, thus making the HMO responsible for managing both the medical and long care of the enrollees.

Pilot Project Area

Section 430.705., F.S., provides for DOEA to select Pilot Project areas based on a variety of factors. The Palm Beach (Palm Beach, Indian River, Okeechobee, Martin and St. Lucie) and Orange County (Orange, Seminole, Brevard, and Osceola) areas were selected as the initial sites for the projects.

Participant Eligibility

Section 403.704, F.S., directs DOEA to evaluate criteria for participant eligibility. As established in the Medicaid waiver, project participants must be age 65 or older, must meet Medicaid financial eligibility requirements up to the Institutional Care Program level, must meet special clinical eligibility criteria, and must be eligible for Medicare benefits.

Enrollment

Consistent with sections 430.704 and 430.705, F.S., the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit staff of DOEA determine clinical eligibility for the program and serve as choice counselors, providing prospective Project participants with information regarding their long-term care options, including enrollment in the Pilot Projects. Financial and technical eligibility for Medicaid is completed by the Department of Children and Families. The managed care organization may not disenroll a person due to a change in health status or to placement in a nursing facility.

Project Providers

Section 430.707, F.S., directs DOEA to select and contract with managed care organizations to provide long-term care within Pilot Project areas. Section 430.703(6), F.S., defines "managed care organization" to mean an entity that meets the requirements of the Department of Insurance for operation as a HMO and meets the qualifications for participation as a managed care organization established by the Agency and DOEA. In addition, the Medicaid waiver from HCFA requires managed care organizations to have, or have applied for, a health care provider certificate from the Agency and a certificate of authority from the Department of Insurance (HMO licensure).

Section 403.704, F.S., directs DOEA to evaluate criteria for selecting managed care organizations, including, but not limited to, quality assurance processes, grievance procedures, service costs, accessibility, adequacy of provider networks, and administrative costs. DOEA relies on the HMO licensure process and standards to ensure financial soundness and minimum quality of care standards. These standards are supplemented by Medicaid prepaid plan requirements in Chapter 409, F.S. The model contract requires all HMOs to meet all state and federal requirements to enroll as a Medicaid prepaid health services provider, as provided in chapter 409, F.S. HMOs also must have, or have a subcontractor that has, prior experience in providing home and community-based long-term care services in the Project service area.

The 1998 Legislature amended section 430.707, F.S., to authorize DOEA to contract with entities which have submitted an application as a community nursing home diversion project as of July 1, 1998, to provide benefits pursuant to the "Program of All-Inclusive Care for the Elderly" as established in Pub. L. No. 105-33. The 1998 act exempts such entities from the requirements of chapter 641, F.S., if the entity is a private, nonprofit, superior-rated nursing home with at least 50 percent of its residents eligible for Medicaid.

Services/Reimbursement

The HMO is paid a capitation payment with two components: 1) a component for the acute care services (prescription drugs, dental, hearing, visual, home health, and community mental health services) and for the supplementary costs paid by Medicaid for services covered under Medicare (cross-over payment) and 2) a component for the long-term care. The acute care component is based on Medicaid's historical costs for the covered services under fee-for-service reimbursement. Section 430.704, F.S., requires DOEA to develop a capitation rate-setting methodology for the projects that assures sufficient savings from the Medicaid nursing home budget to fund the projects and assures expenditures do not exceed the average nursing home costs in the project areas. For persons who join the HMOs Medicare plan, the managed care organization also will receive a capitation payment from HCFA covering Medicare benefits.

Quality Assurance and Improvement

The complex health care needs of the individuals served in the Pilot Projects require a coordinated quality assurance system to ensure that individuals are safely served. Section 430.706, F.S., requires DOEA, in consultation with the Agency, to develop quality of care standards for Pilot Projects, including outcome measures, utilization review, grievance and conflict resolution, patient satisfaction, and care and service standards. As licenced HMOs, Pilot Project providers must meet quality of care standards included in Chapter 641, F.S., as well as Medicaid managed care standards included in chapter 409, F.S. Additional quality of care standards are included in the contract with each HMO.

Pilot Project Implementation

Implementation of the Pilot Projects has been delayed by a lack of actuarial data HMOs depend on to measure financial risk and by concerns with Medicare capitated payment rates. Experience with managing and taking risk for long-term care is limited, and this has meant the time-line for typical new business development activities has been extended. The Medicare rate for persons who are chronically ill and very frail also has been a major problem for HMOs from the beginning of the Department's efforts to implement the Pilot Projects.

The passage of the Balanced Budget Act of 1997 (BBA) compounded the problem. Before the BBA changes, HMOs were expressing concern about the Medicare reimbursement rate for the very frail. The BBA changes, which limit the growth in HMO reimbursement rates and increase administrative costs, have compounded the problem by leading to a series of industry retractions from several geographic areas in the Medicare market.

The Pilot Projects Operations

Pilot Project operations began in the Orlando area in December 1998. United Health Care, under contract with DOEA and the Agency, initiated enrollment and program operations in their Pilot Project, "Health and Home Connection," in Orange, Seminole and Osceola counties. Project enrollment has been modest during the initial two months, but a mass marketing campaign in March should lead to significant enrollment growth.

As noted above, to facilitate integration, DOEA is developing contracts with HMOs that also have Medicare plans. The goal is to provide Pilot Project enrollees with a choice of joining the contractor's Medicare plan, thus making the HMO responsible for managing both the acute and long care of the enrollees. However, as part the industry retractions from the Medicare market, United HealthCare withdrew from the Medicare market in the Orlando area. For now, therefore, Pilot Project enrollees in the Orlando area will be Medicare fee-for-service, which places additional barriers to the integration of their care. To address this barrier, DOEA is pursuing a Medicare 222 waiver to allow a Medicare payment methodology that provides appropriate Medicare payment for the very frail.

DOEA reports that four organizations, all of whom have Medicare plans, are interested in implementing the Pilot Project in the Palm Beach area. Beacon Health Plan, Inc., submitted an application in February 1999 for the Palm Beach area. Physicians HealthCare Plan, a Tampa-based HMO, has expressed an intent to submit an application, and ElderHealth, a managed care company operating a similar program in Baltimore, is entering into discussions with an HMO in Florida to implement the Pilot Project. Both are interested in the Palm Beach area. United Health Care also has expressed an interest in expanding their program to the Palm Beach area.

HMO Licensure Requirements

HMOs are regulated by parts I and III of chapter 641, F.S., and are exempt from all other provisions of the Florida Insurance Code. Part 1 of chapter 641, F.S., entitled the Health Maintenance Organization Act, requires an entity to obtain a certificate of authority from the Department of Insurance (DOI) prior to operating as an HMO, and authorizes DOI to regulate finances, contracting, and marketing of HMOs. Section 641.21. F.S., specifies information that must be submitted with an entity's application for a certificate of authority, including, but not limited to, the following financial information: an audited financial statement and a comprehensive feasibility study performed by a certified actuary in conjunction with a certified public accountant. Section 641.22, F.S., directs DOI to issue a certificate of authority to any entity filing a completed application in conformity with section 641.21, F.S., upon payment of prescribed fees, and upon DOI's satisfaction that the entity has met specified standards and has obtained a health care provider certificate issued by the Agency for Health Care Administration (Agency) pursuant to part III of chapter 641, F.S.

The purpose of the health care provider certificate is to ensure that HMOs deliver high quality health care to their subscribers. Provisions in part III of chapter 641, F.S., allow for the Agency to:

1. require all HMOs to obtain and maintain accreditation with a nationally recognized accreditation organization having expertise in HMO quality of care issues;
2. conduct follow-up examinations in those instances when the external accreditation reviews indicate that the HMO is out of compliance with accreditation standards;
3. have full access to medical records of HMOs; and
4. levy administrative fines in cases of continued non-compliance.

Part III of chapter 641, F.S., also includes provisions governing HMO quality assurance programs, subscriber grievance reporting and resolution, provision of emergency services and care, and internal risk management programs.

Medicaid Prepaid Plan Requirements

Section 409.912, F.S., authorizes the Agency to contract with HMOs for the provision of Medicaid services to recipients, and establishes financial and quality assurance requirements for entities contracting with the Agency on a prepaid or fixed-sum basis. Subsection (4) of section 409.912, F.S.,

establishes quality and financial standards for Medicaid prepaid plans. Subsection (14) of section 409.912, F.S., establishes surplus fund requirements in addition to those provided under HMO licensure requirements (641.225, F.S.), and subsection (15) of section 409.912, F.S., authorizes the Agency to require entities to establish restricted insolvency protection accounts. Subsection (24) of section 409.912, F.S., provides for the Agency to establish a health care quality improvement system for entities contracting with the Agency pursuant to this section, incorporating all the standards and guidelines developed by the Medicaid Bureau of HCFA as part of the quality reform initiative.

Provider Service Networks

Section 409.912, F.S. authorizes the Medicaid program to "engage in cost-effective" purchasing. It further provides that the Medicaid agency may enter into contracts with the following entities among others:

1. Other state agencies or the federal government

2. HMOs certified pursuant to chapter 641, F.S.

3. A prepaid health plan owned and operated by a county, county health department, or a county-owned and operated hospital that provides only Medicaid prepaid services. **These plans were exempt from licensure by the Department of Insurance until January 1, 1998.** After January 1, 1998, only those entities that demonstrated to the satisfaction of the Insurance Commissioner that it is backed by the full faith and credit of the county in which it is located may be exempted from s. 641.225, F.S.

4. An entity that is providing comprehensive inpatient and outpatient mental health care services to certain recipients living in Hillsborough, Highlands, Hardee, Manatee, and Polk counties (the mental health carve-out project). That entity was exempted from licensure under chapters 624 (Insurance Code), 630 (Alien Insurers: Trusteed Assets; Domestication), or 641 (HMO) until December 31, 1998. However, if that ***entity assumes financial risk, DOI is required to develop regulatory requirements by rule under the Insurance Code before the entity becomes operational.***

5. A federally qualified health center or an entity owned by one or more FQHCs or an entity owned by other migrant and community health centers receiving non-Medicaid federal government financial support to provide services on either a prepaid basis or fixed sum basis. These entities must be licensed under parts I and III of chapter 641, F.S., by January 1, 1998. If it meets certain conditions, the entity can be exempted from 641.225 (Surplus Requirements), F.S.

6. No more than **four provider service networks for demonstration projects to test Medicaid direct contracting.** One demonstration project must be located in Orange County. The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. **A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care.** ***A demonstration project awarded pursuant to this paragraph shall be for 2 years from the date of implementation.***

Statewide Provider and Subscriber Assistance Program

As noted, HMOs and Medicaid prepaid health plans are required to have internal grievance procedures for subscribers to protest a denial of services or payment for services. Under section 408.7056, F.S., subscribers have a right to appeal any unresolved grievance to the Statewide Provider and Subscriber Assistance Panel, which was created to review enrollment/disenrollment, financial, contractual, and quality of care complaints against HMOs. The panel may review and consider subscriber and provider grievances and make recommendations to the Agency and the DOI as to any action that should be taken concerning such grievances.

Other Home & Community-Based Services Provided Through DOEA

In addition to the Pilot Projects, DOEA operates several non-HMO based home and community-based services programs. These include:

Community Care for the Elderly

The Community Care for the Elderly (CCE) program provides community-based services organized in a continuum of care to assist functionally-impaired older people to live in the least restrictive environment suitable to their needs. Individuals must be 60 years of age and be functionally impaired as determined by a standardized functional assessment instrument. Priority is given to individuals at risk of entering an institution, or those who have been abused, neglected or exploited and referred by Adult Protective Services. Services are provided by 54 lead agencies (43 non-profit and 11 county/local government agencies) and their subcontractors.

Home Care for the Elderly

The Home Care for the Elderly (HCE) program encourages the provision of care for older persons 60 plus in family living arrangements in private homes, as an alternative to nursing home or other institutional care. In addition to case management, a basic subsidy is provided for support and maintenance of the older person, including medical costs. A special subsidy may also be provided for needed services/supplies. An individual must be 60 plus, have income less than the Medicaid Institutional Care Program standard, meet the asset limitation, be at risk of nursing home placement, and have an approved adult caregiver living with them who is willing and able to provide or assist in arranging for services.

Medicaid Aged/Disabled Adult Services Waiver

Medicaid Aged/Adult Services Waiver services are for older persons and disabled individuals assessed as frail, functionally impaired, and at risk of nursing home placement. Services which help a person remain at home are arranged by a case manager. DOEA has an interagency agreement with the Agency for administration of the waiver program. Individuals must be 60 years old or disabled, Medicaid eligible, and certified by a health professional to be in need of nursing home placement or in need of community care in lieu of nursing home placement, and meet additional clinical criteria.

Assisted Living for the Elderly Medicaid Waiver

Assisted Living for the Elderly Medicaid Waiver Services are for clients age 60 plus who meet specific functional criteria and are in need of additional support and services to remain in an Assisted Living Facility (ALF) setting, avoiding their being placed in more costly, less preferred, institutional care. Individuals must be Medicaid eligible, age 60 plus, and meet clinical eligibility criteria. The maximum amount allocated for services per individual is $850/month. Clients may have a patient responsibility depending on income. For each participant, case managers receive a capitated rate of $100 per month. Facilities also are able to bill up to $125 per month per person for incontinence supplies.

B. EFFECT OF PROPOSED CHANGES:

The bill would direct DOEA, in consultation with the Agency for Health Care Administration (AHCA) to select and contract with “other qualified providers” in addition to managed care organizations to provide long term care services in the community diversion project areas.

The bill specifies that DOEA is to contract with “other qualified providers” on a capitated basis.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No

(3) any entitlement to a government service or benefit?

No

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      No.

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      No.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs? Does the bill prohibit, or create new government interference with, any presently lawful activity?

      N/A

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

          N/A

      (2) Who makes the decisions?

          N/A

      (3) Are private alternatives permitted?

          N/A

      (4) Are families required to participate in a program?

          N/A

      (5) Are families penalized for not participating in a program?

          N/A

   b. Does the bill directly affect the legal rights and obligations between family members?

      N/A

   c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

      (1) parents and guardians?

          N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

430.703, 430.707, F.S.

E. SECTION-BY-SECTION ANALYSIS:

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

2. Recurring Effects:

3. Long Run Effects Other Than Normal Growth:

4. Total Revenues and Expenditures:

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

N/A

2. Recurring Effects:

N/A

3. Long Run Effects Other Than Normal Growth:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

N/A

2. Direct Private Sector Benefits:

   N/A

3. Effects on Competition, Private Enterprise and Employment Markets:

   N/A

D. FISCAL COMMENTS:

This bill addresses the concept of allowing entities that are not licensed as HMOs to contract under a risk-based capitated payment model. This concept is not new and should be considered in light of past discussions and actions. Although the Legislature has allowed non-HMOs to provide health services to Medicaid recipients under risk-based capitated payment, in recent years, after instances of financial mismanagement were investigated, the Legislature has acted to eliminate such exemptions from HMO licensure.

During the 1997 Legislative Session, The Florida Commission on Integrated Health Care Delivery Systems was established and directed to evaluate the business arrangements between health care providers, insurers, HMOs, and other health care purchasers for the provision of health care goods and services and recommend requirements, including whether, and to what extent, various arrangements should be regulated and what quality of care standards should be met. Included in the Commission's recommendations was that in all direct contracting arrangements, when a provider sponsored organization (PSO) is a risk-bearing entity in the business of insurance, it is an insurer, and when it is the primary risk-taker, it should be regulated under the Insurance Code. Regarding Medicaid provider sponsored organizations (PSOs), the Commission noted that the legislature recently has authorized a demonstration program to test the viability and workability of PSOs as full risk-takers under Medicaid managed care, and as a result recommended no change to current law for full-risk takers under Medicaid. Although several bills addressing the Commission's recommendations were filed and considered by the 1998 Legislature, no legislation was enacted.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The mandates provision does not apply.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

DOEA reports that contracting with "other qualified providers" on a capitated basis would preserve the existing incentive created by placing providers at-risk of nursing home costs, but would frustrate attempts to achieve integration of acute and long-term care.

By expanding the pool of eligible providers for the Pilot Projects, the bill could increase opportunities to prevent or delay permanent institutional placement. However, the bill also might have the opposite effect if the expansion discourages existing eligible providers from participating in the project. Some health maintenance organizations have expressed reservations and concerns about multiple providers in one

area attempting to implement the project because the appropriation associated with the diversion projects is only sufficient to support about 800 people.

One of the ways that an HMO "manages" the risk associated with a capitated arrangement is to enroll the largest possible group of participants. That larger enrollment has the effect of "distributing" the risk across a larger group of persons, diminishing the per enrollee "risk ."

In addition, under a capitated payment methodology, "other qualified providers" will face the same uncertainties and risks that have concerned HMOs and delayed program implementation. "Other qualified providers" would face the additional challenge of developing the capacity to provide covered acute care services (prescription drugs, dental, hearing, visual, home health, and community mental health services) and pay the supplementary costs paid by Medicaid for services covered under Medicare (cross-over payments).

It appears that the Agency for Health Care Administration is limited to a total of four demonstration projects statewide (with one required in Orange county) to test direct contracting with "Provider Service Networks". The statute appears to limit the length of any one of these contracts to two years [409.912 (3)(d)].

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The Committee Substitute for HB 1709 differs from the original bill in the following ways:

- Requires DOEA, in consultation with AHCA, to select and contract with "other qualified providers" as well as managed care organizations for the Community Diversion Pilot Projects.
- "Other qualified providers" must be paid a capitated rate as established under the provisions of section 430.704, F.S.
- "Other qualified providers" are exempt from the requirements of chapter 641, F.S., related to licensure of HMOs, Prepaid Health Clinics, and Health Care Services.
- "Other qualified providers" are required to meet all of the financial and quality assurance requirements for a provider service network as specified in section 409.912, F.S.

VII. SIGNATURES:

COMMITTEE ON Elder Affairs & Long Term Care:

Prepared by:	Staff Director:
Melanie Meyer	Tom Batchelor, Ph.D.