HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1871 PCB FFF 05-03 Medicaid
SPONSOR(S): Future of Florida's Families Committee; Galvano
TIED BILLS: None. **IDEN./SIM. BILLS:** HB 1869, HB 1873, and HB 1875

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Future of Florida's Families Committee	5 Y, 1 N	Collins	Collins
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SUMMARY ANALYSIS

Under a complex framework of federal and state laws and regulations, Medicaid funds health care services to people who meet certain categorical and income eligibility criteria. These populations are primarily low-income children, certain low-income families, certain disabled persons, and certain low-income elderly.

The Medicaid program funds health care benefits to approximately 2.15 million Floridians annually through a diverse network of approximately 80,000 providers. In the 1990s, Medicaid expenditures represented about 15% of the total state budget. At over $14 billion in FY 2004-05, Medicaid now represents approximately 25% of the state budget. If the current rate of growth continues (approximately 13.5 percent a year), future expenditures in Florida's Medicaid program are projected to exceed $52 billion in ten years. This rate of growth has been characterized as unsustainable. The potential cost and complexities of administering the program has led many, including Florida's Governor, to call for reform.

The bill proposes a framework to temper the rate of growth in Medicaid, reduce the complexities of the program, provide greater choices for the recipient, promote a competitive health care market, and promote personal responsibility for health care. The bill accomplishes the following:

- Provides waiver authority for the Agency for Health Care Administration (agency) to seek an experimental pilot or demonstration waiver, pursuant to Section 1115 of the Social Security Act to reform Florida's Medicaid program. Implementation of the waiver is contingent on federal approval to preserve the upper-payment-limit funding method and the disproportionate share program pursuant to chapter 409, F.S.
- Specifies that the following categorical groups shall be included in the waiver: Temporary Assistance for Needy Families; certain groups within the Supplemental Security Income population; and all children covered by Title XIX and Title XXI of the Social Security Act.
- Requires a recipient to be temporarily placed in a plan at the time of application and within 30 days of such application, choose to either remain in the plan to receive health care coverage through Medicaid benefits or choose to receive coverage through the private insurance market.
- Requires choice counseling to be provided before the recipient chooses a plan and the agency shall ensure that there is a record acknowledging such counseling was provided.
- Requires the entity performing choice counseling to determine whether a plan was selected because of unlawful influence by a third party.
- Requires the agency to include behavioral health care benefits as part of the capitation structure for a plan to enable management of all aspects of patient care.

The bill provides a sunset provision that takes effect July 1, 2010 and requires the agency to seek authority from the Legislature before the agency can implement the waiver.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility - The bill allows Medicaid recipients to assume responsibility for their health care by providing greater incentives through Flexible Spending Accounts or Individual Development Accounts.

Empower families – The bill supports Medicaid recipient efforts to take responsibility for their health care.

Limited Government – The bill allows Medicaid recipients to choose health care services from the private insurance market.

B. EFFECT OF PROPOSED CHANGES:

Federal Medicaid Framework
Medicaid was enacted in 1965, in the same legislation that created the Medicare program, under amendments to the Social Security Act (P.L. 89-97). The act created Title XIX of the Social Security Act of 1965. The creation of Medicaid and Medicare replaced two earlier programs of federal grants to States that provided medical care to welfare recipients and the aged.

Medicaid is a means-tested entitlement program. It is jointly financed by federal and state funds. Federal contributions to each state are based on a state's willingness to finance covered medical services and a matching formula. Each state designs and administers its own program under broad federal rules. The Centers for Medicare and Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for Federal oversight of the program.

Federal and State Laws and Regulations
The Medicaid program operates under a very complex and detailed regulatory framework. This framework includes:

- Title XIX of the Social Security Act
- Code of Federal Regulations 42 CFR 430 - 42 CFR 455
- State Plan – The state plan acts as a contract between the State and the Federal government and contains polices regarding the administration, eligibility, coverage and reimbursement structure of the Medicaid program.
- State Medicaid Director's Letter
- Sections 409.905 - 409.9201, F.S.
- Laws of Florida
- Florida Administrative Code Chapters 59G-1 - Chapters 59G-13
- Medicaid Handbooks
- Policy Transmittals

Florida Medicaid
Florida implemented its Medicaid program on January 1, 1970, to fund medical services for indigent people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

The Agency for Health Care Administration
Federal law requires that a state's Medicaid program must be administered by a "single state agency." The Florida Legislature created the Agency for Health Care Administration as part of the Health Care Reform Act of 1992 (Ch. 92-33, Laws of Florida) to reduce administrative costs and improve the state's efficiency in addressing health care issues. The Governor nominates and the Senate confirms the Secretary of the agency.

The Medicaid program is administered primarily by the Florida Agency for Health Care Administration under Chapter 409, Florida Statutes. However, other state agencies have certain responsibilities. For example, the Department of Children and Families determines eligibility; the Department of Legal Affairs, Medicaid Fraud Control Unit prosecutes Medicaid fraud; the Department of Health contracts with and monitors medical providers; and the Department of Elder Affairs (DOEA) has responsibility for determining eligibility for nursing home care and other long-term care programs through its CARES (Comprehensive, Assessment, Review and Evaluation Services) program. DOEA also has responsibility for implementing several home and community based waiver programs designed to keep Medicaid recipients at home in the community instead of more costly nursing homes.

Medicaid Eligibility
Medicaid is a program that is targeted at individuals with low-income, but not all of the poor are eligible, and not all those covered are poor. Medicaid is a means-tested program. To qualify, applicants' income and resources must be within certain limits. The specific income and resource limitations that apply to each eligibility group are set through a combination of Federal parameters and State definitions.

Florida's Medicaid program covers all individuals required by federal law and has expanded eligibility to certain populations deemed particularly vulnerable. The average monthly caseload for FY 2004-05 is estimated to be over 2.15 million persons. The following categorical groups that meet financial eligibility requirements are served by Florida Medicaid:

- Elderly or disabled individuals of low-income who are determined eligible for supplemental security income (SSI) as determined by the Social Security Administration.

- Individuals in single-parent low-income families who meet the AFDC (Aid to Families with Dependent Children) eligibility standards effective in September 1996 or meet Temporary Assistance to Needy Families (TANF) eligibility guidelines.

- Unemployed parents and children under 18, children under 21 in intact families, or children born after 9/83 living with non-relatives, where family income meets AFDC standards.

- Individuals who meet SSI or TANF eligibility after expenses for medical care are deducted. This category is 100% federally funded and covers the first eight months in the U.S. for individuals who generally meet the TANF and SSI eligibility requirements.

- Elderly and disabled individuals with income above the criteria for supplemental security income, but less than 90% of the Federal Poverty Level.

- Elderly and disabled individuals between 90-120% of the Federal Poverty Level, Medicaid covers certain Medicare-related expenses.

- Pregnant women under 100% of the Federal Poverty Level and children age 6 and older in families under 100% of the Federal Poverty Level.

- Children age 1 to 6 under 133% of the Federal Poverty Level; pregnant women and infants less than one year old with incomes less than 185% of the Federal Poverty Level.

- Children born after 10/93 who have not reached age 19 and are under 100% of the Federal Poverty Level.

2005 Health & Human Services Poverty Guidelines

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,570	$11,950	$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260
5	22,610	28,270	26,010
6	25,870	32,350	29,760
7	29,130	36,430	33,510
8	32,390	40,510	37,260
For each additional person	3,260	4,080	3,750

Source: Federal Register, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

Choice Counseling

Legislation was passed in 1996 requiring Medicaid recipients be enrolled into MediPass or Managed Care. Choice Counseling was established as part of the legislation. The impetus behind the inclusion of Choice Counseling as part of the required enrollment into managed care was wide spread allegations of enrollment fraud by managed care organizations with Medicaid recipients. A competitive bid process resulted in Benova, now Affiliated Computer Services (ACS), becoming Florida's first Enrollment Broker and providing Choice Counseling to Medicaid recipients. The program was named Medicaid Options.

The goal of the program was to assure each recipient had the opportunity to receive unbiased information and education about the health plans in his or her area, the benefits provided by each plan, and to make a voluntary and informed choice of a health plan, including the provider.

The program was implemented in September of 1998 with disenrollments only. In December 1998, Benova began taking voluntary enrollments as well as disenrollments. Recipients who did not make a voluntary choice were assigned to a health plan according to an algorithm established by AHCA.

The original program was comprehensive. Access to information was provided in person through face-to-face meetings at DCF offices, One Stop Centers, Health Fairs, etc., by mail, and by telephone. Posters advertising the program were displayed in large physician practices and in government buildings. Brochures were widely distributed at Publix, Walmart, pharmacies, and other places with good visibility to the public. Enrollments were performed by mail, by telephone, and in the field. Three offices were opened around the state with Choice Counselors traveling to every county that had an HMO every month to provide scheduled choice counseling sessions to recipients.

In 2000, the Open Enrollment portion of the program was implemented. This required recipients to stay in the plan of their choice or the plan to which they were assigned for one year. For new recipients, the program allowed 90 days to make a selection of a plan or be assigned. Following the selection or assignment, the recipient had an additional 90 days to change their mind without cause. After that, they were locked into the program for the remainder of the year. At the end of the year, they are

notified they have 60 days to change plans if they wish or to stay in the plan. After the first year, the open enrollment period was only for 60 days.

At the end of the first three years of the contract (2001), a shortfall in Medicaid funds resulted in the redesign and down size of the program. With the redesign, enrollments and Choice Counseling are provided only by telephone. Outbound calls were implemented partially to offset the elimination of other outreach efforts. Recipients no longer have the option of enrolling by mail or of talking with a counselor in their community about the health plans available in their area. Recipients receive materials that explain the choices and encourage the recipient to make a telephone call to the toll free 800 number and make a voluntary choice and enroll in the health plan of their choice.

In 2004, an informational website was added for the convenience of recipients. All materials are posted on the website along with the toll free 800 number.

Legislation that became effective July 2004, reduced the number of days recipients have to make a choice from 90 days to 30 days. The result is the same number of recipients trying to access enrollment and information in one-third the time. This change has created a barrier to access.

In order to receive health coverage through Medicaid, **the bill** requires a recipient to be temporarily placed in a plan at the time of application and within 30 days of such application choose to either remain in the plan or choose to receive coverage through the private insurance market.

The bill requires choice counseling to be provided before the recipient chooses a plan and the agency shall ensure that there is a record acknowledging such counseling was provided.

Additionally, the bill requires the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, or payment to the recipient, or incentives promised by a third party. Provides for reporting of such violation to the Agency for Health Care Administration.

Mental Health and Substance Abuse

The Substance Abuse and Mental Health Programs provide prevention, treatment, and support services to more than 400,000 individuals and their families each year. Many of the services are provided via contracts with community-based providers throughout the state. The Department of Children and Families (DCF) also operates, directly or through contract, seven facilities for persons with mental illnesses or mental abnormalities requiring hospital level care.

The mission of the Mental Health Program Office is to “provide a system of care, in partnership with families in the community that enables children and adults with mental health problems or emotional disturbances to successfully live in the community, to be self-sufficient, or to attain self sufficiency at adulthood, and realize their full potential.” In response to the department’s statutory mandate to provide mental health services to persons living with mental disorders, an array of services is available. Target population groups served include:

- Adults with severe and persistent mental illnesses;
- Adults in mental health crisis;
- Adults with forensic involvement;
- Children with serious emotional disturbances;
- Children with emotional disturbances; and
- Children at-risk of emotional disturbances.

Mental health services are therapeutic interventions and activities that help to eliminate, reduce or manage symptoms or distress for persons who have severe emotional distress or a mental illness. These services help individuals effectively manage the disability that often accompanies a mental

illness so that they can recover, become self-sufficient to the extent possible and live in a stable family or in the community.

Florida law requires that the state manage a system of care for persons with or at-risk for developing substance abuse problems. Section 397.305(2), F. S., directs the development of a system of care to "prevent and remediate the consequences of substance abuse to persons with substance abuse problems through the provision of a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care." Section 20.19(4), F. S., creates within the Department of Children and Family Services a "Substance Abuse Program Office." The responsibilities of this office encompass all substance abuse programs funded and/or regulated by the department.

The Substance Abuse Program Office, pursuant to mandates in Chapters 394 and 397, F.S., is appropriated funding by the Legislature in three (3) primary program areas: Children's Substance Abuse (CSA); Adult Substance Abuse (ASA); and Program Management/Compliance. The CSA and ASA funding is used primarily to contract with community-based providers for direct provision of prevention, detoxification, treatment, aftercare, and support services for children and adults. Program Management and Compliance funding supports state and district/region program offices, staff that are responsible for administrative, fiscal, and regulatory oversight of substance abuse services.

Behavioral Health Services
Behavioral health services include both mental health and substance abuse services. Medicaid behavioral health services include:

- Inpatient psychiatric hospitalization services;
- Community mental health and substance abuse services (i.e., group therapy, individual therapy, day treatment; therapeutic on-site services, rehabilitative and recovery-based services);
- Targeted mental health case management;
- Therapeutic group care services for children;
- Therapeutic foster care services for children;
- Statewide Inpatient Psychiatric Program; and
- Behavioral health overlay services

The bill requires the Agency for Health Care Administration to include behavioral health care benefits for managed care plans and health insurance plans participating in the Medicaid opt-out option. This will enable a plan to coordinate and fully manage of all aspects of patient care.

Prepaid Mental Health Plan
Covered services include: inpatient psychiatric services; outpatient hospital services for covered diagnosis; community mental health services; mental health targeted case management; psychiatrist physician services; and substance abuse services are not included in the prepaid mental health plan. There are existing programs in Areas One and Six (Panhandle and Hillsborough County), with staggered implementation in remainder of state. The first "request for proposal" (RFP) was released on January 14, 2005, to select contractors for Areas Five and Seven. Anticipated start date of June 2005. The proposed schedule of implementation is through March, 2006.

Child Welfare Prepaid Mental Health Plan
Joint development of RFP by AHCA and DCF for statewide management of children registered in the HomeSafenet database. A single plan for statewide coverage will be awarded to one or a group of Lead Community Based Care (CBC) Agencies. The awarded Lead CBC must have a managed care organization as a contracted partner to meet managed care licensing requirements. Services in the prepaid plan include:

- Inpatient psychiatric services;

- Outpatient hospital services for covered diagnosis;
- Community mental health services;
- Mental health targeted case management;
- Psychiatrist physician services;
- Therapeutic foster care services; and
- Substance abuse services, behavioral health overlay services, therapeutic group care, the Statewide Inpatient Psychiatric Program and psychotropic medications are not included.

The Florida KidCare Program

The Florida KidCare Program was created by the 1998 Legislature to make affordable health insurance to low and moderate income Florida children. The program is primarily targeted to uninsured children under age 19 whose family income is at or below 200 percent of the federal poverty level (FPL) ($38,700 for a family of four in 2005). The KidCare Program is designed to maximize coverage for eligible children and federal funding participation for Florida, while avoiding the creation of an additional entitlement program under Medicaid. The KidCare Program is outlined in ss. 409.810 through 409.821, F.S. The KidCare Coordinating Council, located in the Department of Health, is charged with responsibility for making recommendations concerning the implementation and operation of the program.

Enrollment was initiated on October 1, 1998, and 1,465,083 children are enrolled in the various components of the KidCare Program as of March 2005. Of this total, 226,016 children are Title XXI eligible, 20,425 children are non-Title XXI eligible, and 1,218,642 children are eligible under the Medicaid Title XIX Program.

KidCare is an "umbrella" program that currently includes the following four components: Medicaid for children; Medikids; the Florida Healthy Kids Program; and the Children's Medical Services (CMS) Network, which includes a behavioral health component.

KidCare Eligibility

The eligibility requirements for the four KidCare components are as follows:

- Medicaid - for children who qualify for Title XIX (of the Social Security Act) under the following limitations: birth to age 1, up to 200 percent of the FPL (185% - 200% Title XXI); ages 1 through 5, up to 133 percent of the FPL; and ages 6 through 19, up to 100 percent of the FPL.

- Medikids - for children ages 1 through 4 who qualify for Title XXI (of the Social Security Act) with incomes up to 200 percent of the FPL.

- Healthy Kids - for children ages 5 through 18 who qualify for Title XXI up to 200 percent of the FPL. A limited number of non-Title XXI non-qualified alien children are enrolled in the non-federally funded program and are funded with state and local funds. A limited number of children who have family incomes over 200 percent of the FPL and a limited number of children age 19 are enrolled in the unsubsidized full pay category in which the family pays the entire cost of the premium, including administrative costs.

- CMS Network - for children ages birth through age 18 who have serious health care problems.

The Department of Health (DOH) contracts with the Department of Children and Family Services (DCF) to provide behavioral health services to non-Medicaid eligible children with special health care needs.

KidCare Administration

The Florida Healthy Kids Program component of KidCare is administered by the non-profit Florida Healthy Kids Corporation, established in s. 624.91, F.S. The Florida Healthy Kids program existed prior to the implementation of the federal Title XXI SCHIP. Florida was one of three states to have the benefit package of an existing child health insurance program grandfathered in as part of the Balanced Budget Act of 1997, which created SCHIP.

The Florida Healthy Kids Corporation contracts with managed care plans throughout the state for the provision of health care coverage. The Healthy Kids Corporation contracts with a fiscal agent to perform initial eligibility screening for the program and final eligibility determination for children who are not Medicaid eligible.

The fiscal agent refers children who appear to be eligible for Medicaid to DCF for Medicaid eligibility determination, and children who appear to have a special health care need to the CMS Network within DOH for evaluation. If eligible for Medicaid, the child is enrolled immediately into that program. If the child is not eligible for Medicaid, the application is processed for Title XXI and if the child is eligible under Title XXI, the child is enrolled into the appropriate KidCare component.

Medicaid for children and Medikids are administered by the Agency for Health Care Administration. Medikids uses the Medicaid infrastructure, offering the same provider choices and package of benefits.

The KidCare Program requires a two tiered family premium for program participation. Families under 150 percent of the FPL pay $15 per month and families between 150 percent and 200 percent of the FPL pay $20 per month. The fiscal agent generates bills for co-payments for those participants who are required to pay a portion of the premium for their coverage.

Program Funding

Florida KidCare is financed with a combination of federal, state, and local funds, as well as family contributions. Federal funds come from two sources: the SCHIP, Title XXI of the Social Security Act (requires 29 percent state match), and Medicaid, Title XIX of the Social Security Act (requires 41 percent state match).

The amount of the federal funds available for Title XXI programs is limited for each fiscal year nationally and at the state level. State allotments for a fiscal year are determined in accordance with a statutory formula that is based on two factors: the “Number of Children” and the “State Cost Factor.” The variability of state allotments over time is constrained by the application of federal statutorily prescribed floors and ceilings, which limit the amount that allotments fluctuate from year-to-year and over the life of the SCHIP program. In general, state allotments for a fiscal year remain available for expenditure by that state for a 3-year period; the fiscal year of the award and the two subsequent fiscal years. However, any allotment amounts for a fiscal year, which remain available after the three fiscal years, are subject to reallocation to another state. In 2005, Florida will receive $38,256,995 in redistributed dollars from unspent funds from other states for FY 2002.

2004 Legislative Changes (SB 2000, chapter 2004-270, L.O.F.)

Because the Legislature funded a “no growth” enrollment policy in fiscal year 2003-2004, waiting lists for enrollment were established for the KidCare program. By January 30, 2004, the cumulative Title XXI waiting list had grown to over 90,000 children. To address this waiting list, the 2004 Legislature passed SB 2000 (ch. 2004-270, Laws of Florida) which provided funding to eliminate the waiting list. Among this and other changes, the law also eliminated continuous enrollment and replaced it with no more than two 30-day open enrollment periods per fiscal year (September 1 – 30 and January 1 – 30) on a first-come, first-served basis using the date the new open enrollment application is received. Each open enrollment period is only allowable if the Social Services Estimating Conference estimates that KidCare caseloads are at a level that an open enrollment would not exhaust the state’s allotment of federal

funds through the remainder of the program's authorization (2007). As a result of these changes, eligible children on the waiting list were enrolled in their respective programs in early 2004.

January 2005 Open Enrollment for KidCare

The Social Services Estimating Conference convened on November 1 and 10, 2004 to adopt a caseload and expenditure forecast for the Kidcare Program through October 2007. The conference reviewed recent program experience, with particular attention to caseload levels in light of the freeze on new enrollments into the program. The Conference found that, in general, caseloads are on a downward trend as children leaving the program are not being replaced by new enrollees, with caseloads for November 2004 at about 85 percent of the average appropriated monthly level for the fiscal year.

Discussion at the conference centered on the attrition in the caseload and its consequences over the period through September 2007 when authorization for federal funding participation ends, and on the effect an open enrollment period in January 2005 would have on the sufficiency of Florida's allotment of federal funds over that time period. The conference agreed that considering the rate of attrition being experienced in the program and the fact that current caseload levels were less than appropriated, it would be extremely unlikely that holding an open enrollment in January 2005 (as allowed by statute) would result in caseload levels that would exhaust the state's allotment of federal funds through the remainder of the program's authorization.

As a result, an open enrollment was approved for January 2005, under the condition that the number of new enrollees did not surpass the appropriated Title XXI level of 389,515 enrollees. Based on the Title XXI caseload as of November 2004, 72,000 open enrollment slots were deemed available.

Between January 1 and January 31, 2005, the Florida KidCare program conducted an open enrollment. The program received 96,561 applications representing an estimated 175,000 children. These applications are still being processed at this time, so it is unclear how many of the available slots will be filled from the January open enrollment. Historically, 35 percent of applicants are enrolled in Medicaid, 20 percent do not complete the process (e.g., they fail to return required paperwork, etc.), and seven percent are deemed ineligible. Based on these statistics, Healthy Kids Corporation administrators believe that the open enrollment process will not fill all available slots and, at the current rate of attrition, that the state will not exhaust its federal resources for this fiscal year which may result in Florida having to return a portion of its allocation back to the federal government.

MediKids

MediKids, serving children ages 1 through 4, is also funded with SCHIP funds and family contributions. Families pay a monthly premium of either $15 or $20 per month, based on household size and monthly income, regardless of how many children are enrolled.

The MediKids program uses the same providers as Medicaid. Depending on the county of residence, a family selects either a managed care plan or a Medipass provider to direct a child's care. MediKids enrollees do not pay co-payments. This program is administered by the Agency for Health Care Administration.

Children's Medical Services Network

The Children's Medical Services Network, administered by the Department of Health, serves children from birth through 18 years of age who have special health care needs, chronic medical conditions, or special behavior problems. It is partially funded by Medicaid and SCHIP federal funds, as well as by family contributions from those enrolled under Title XXI. The CMS Network handles children's physical health needs and partners with the Behavioral Health Network, a program of the Department of Children and Families, to provide comprehensive behavioral health services to children with serious mental or substance abuse problems. Children enrolled in the CMS Network receive their care from a network of specialized providers that meet specific Network standards.

The bill includes the Children's Medical Services network under chapter 391, F.S., in the definition of "managed care plan" for purposes of this act. Additionally, the agency is authorized to reform Medicaid for certain categorical groups including "all children covered pursuant to Title XIX and Title XXI of the Social Security Act."

Mandatory Services
Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans; however, a state's Medicaid program must offer certain mandatory medical benefits to most categorically needy populations if federal matching funds are to be received. Medicaid is also unable to disqualify eligibles based on pre-existing medical conditions. Mandatory Medicaid benefits include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

Optional Services
Florida's Medicaid program provides all of the mandatory medical benefits under its state plan but it may also receive federal matching funds to provide certain optional services. The following optional benefits are provided under Florida's Medicaid program:

- Adult Health Screening
- Ambulatory Surgical Centers
- Assistive Care
- Birth Center Services
- Children's Dental Services
- Children's Hearing Services
- Children's Vision Services
- Chiropractic Services
- Community Mental Health
- County Health Department
- Clinic Services
- Dialysis Facility Services
- Durable Medical Equipment
- Early Intervention Services
- Emergency Dental for Adults
- Healthy Start Services
- Home & Community-Based Services
- Occupational Therapy
- Optometric Services
- Orthodontia for Children
- Personal Care Services
- Physical Therapy
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Mgmt – (MediPass)
- Private Duty Nursing
- Registered Nurse First Assistant Services
- Respiratory Therapy
- School-Based Services
- Speech Therapy
- State Mental Hospital Service
- Subacute Inpatient Psychiatri

- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Program for Children
- Targeted Case Management

Service Delivery System for Medicaid Services

Florida law requires that, to the extent possible, Medicaid recipients enroll in a managed care delivery system. Depending on geographic availability, recipients have several managed care arrangements from which to choose. As of January 2004, over 1.4 million (or 67%) of the state's Medicaid recipients were enrolled in one of these managed care options, including 697,694 recipients enrolled in MediPass, 697,453 in Medicaid health maintenance organizations (HMOs), and 18,144 in provider service networks (PSNs). All other recipients are considered fee-for-service. This group includes dual eligibles (individuals who receive both Medicare and Medicaid), institutionalized and hospice recipients, new recipients, recipients for whom Medicaid is supplemental insurance, and the Medically Needy.

- Medicaid Provider Access System (MediPass). The MediPass system is available statewide and is a primary care case management program. MediPass recipients select or are assigned a primary care physician (PCP) who is responsible for providing primary care and referring patients for specialized services. The state pays PCPs a $3 monthly case management fee for each recipient in addition to fee-for-service reimbursement for each service they provide to recipients. The MediPass program also is currently implementing two pilot projects, Children's Provider Networks (also known as the Pediatric ER Diversion Program) and Minority Physician Networks. These pilot projects target specific utilization and cost concerns related to children and minorities and have the flexibility to develop their own networks and to outsource many administrative functions.

- Medicaid Health Maintenance Organizations (HMOs). Medicaid HMOs, available in 41 of the state's 67 counties, provide medical services to Medicaid recipients on a prepaid basis. For each enrolled recipient, the state pays HMOs a monthly fee that is set at 92% of the expected cost to provide services to equivalent groups of fee-for-service recipients. Besides the approved Medicaid services, HMOs are required to provide additional services, including smoking cessation, pregnancy prevention, and domestic violence intervention services.

- Provider Service Networks (PSNs). PSNs are currently available in only two counties, Broward and Miami-Dade. PSNs provide medical services through an integrated health care delivery system owned and operated by Florida hospitals and physician groups.

Waivers

Waivers are instruments under which the federal Centers for Medicare and Medicaid Services (CMS) allows states to try innovative programs that are cost neutral to the federal government. States may request waivers of certain federal regulations. In general, federal regulations require services to be provided on a statewide basis, comparable across the state, and must be sufficient in amount, duration, and scope to reasonably achieve its purpose. In addition, the recipient must have freedom of choice.

Waivers allow the reform of Medicaid services for certain populations and benefits. For example, Medicaid's home and community–based services waiver program affords states the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. This waiver program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care.

Medicaid waivers fall into one of four major categories: 1115, 1915(b), 1915(b/c), and 1915(c). Under Florida law [s.409.912 (11), F.S.], the Agency for Health Care Administration may apply for any federal waiver believed necessary to more efficiently or effectively manage the state's Medicaid program;

however, the same law specifically requires the Legislature to approve the waiver before it can be implemented by the agency.

States may apply to CMS for a section 1915(b) Freedom of Choice waiver, which allows a state to provide services in only specific areas of the state, allows states to provide a subset of services that may not be in the state plan, and allows states to waive freedom of choice requirements. By waiving freedom of choice, this means that individuals are constrained to receive waiver services from select providers rather than choosing their own provider. The 1915(b) waivers are limited in that they apply to existing Medicaid-eligible beneficiaries; authority under this waiver cannot be used for eligibility expansions to individuals not covered under the traditional Medicaid program.

States may also apply to CMS for a section 1915(c) waiver to provide home and community-based services as an alternative to institutional care in a hospital, nursing home, or intermediate care facility for the mentally retarded. If approved, the waivers allow states to limit the availability of services geographically, to target services to specific populations or medical/disease conditions, or to limit the number of persons served; actions not allowed under Medicaid state plan services. Under a 1915(c) waiver, states determine the types of long-term care services they wish to offer and any provider who is interested and meets application requirements can provide services. Waivers may offer a variety of skilled services to only a few individuals with a particular condition, such as persons with traumatic brain injury, or they may offer only a few unskilled services to a large number of people, such as the aged or disabled

Section 1115 of the Social Security Act allows states to pursue "an experimental, pilot, or demonstration project which, in the judgment of the Secretary of Health and Human Services, is likely to assist in promoting the objectives" of Title XIX. The objectives of the Act are set forth in section 1901, and provide in part that funds are appropriated by the federal government:

> *For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.*

While 1115 waivers allow states some flexibility regarding coverage eligibility, provider choice, provider reimbursement, managed care and other provisions, states must adhere to certain requirements. For example, any waiver initiative must be budget neutral to the federal government, must contain adequate evaluation components, and must maintain service to specific categories of beneficiaries. Section 1115 waivers are initially approved for 5 years and can be extended for 3 years.

Florida has numerous waivers:

1115	*1915(b)*	*1915(c)*
❖ *Cash and Counseling (Consumer Directed Care)*	*(1) – (4) Managed Care*	❖ *MR/DD (Developmental Disabilities)*
❖ *Pharmacy Plus*	❖ *MSPSI under 21 (Statewide Inpatient Psychiatric Program SIPP)*	❖ *MR/CLSA (Family & Supported Living)*
❖ *Family Planning*	*(4) Non-emergent Transportation*	❖ *Aged and Disabled*
		❖ *Channeling*

		❖ *Nursing Home Diversion*
		❖ *Assisted Living (Assisted Living for the Elderly)*
		❖ *AIDS/ARC (Project Aids Care)*
		❖ *TBI (Traumatic Brain/Spinal Cord Injury)*
		❖ *Spinocerebellar (Model or Katie Beckett*
		❖ *Adult Cystic Fibrosis*
(b)/(c) Comprehensive Adult Day Health - (b)/(c) Alzheimer Waiver		

The bill provides waiver authority for the Agency for Health Care Administration (agency) to seek an experimental, pilot, or demonstration waiver, pursuant to Section 1115 of the Social Security Act to reform Florida's Medicaid program. Implementation of the waiver is contingent on federal approval to preserve the upper-payment-limit funding method and the disproportionate share program pursuant to chapter 409, F.S.

Disproportionate Share Hospital (DSH) Payments
States may make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. These funds account for a significant proportion of Medicaid funding in many of Florida's "safety-net" facilities.

Upper Payment Level (UPL) Payments
This supplemental payment mechanism is a complex funding arrangement between the state and the federal government where states are allowed to make special Medicaid payments to compensate certain hospitals and providers to make up the difference between Medicaid and Medicare fees and their usual and customary charges for certain services.

Funding and Cost
For program administration costs, the federal government contributes 50 percent for each state. For medical services, the federal government contributes at a variable rate called the Federal Medical Assistance Percentage (FMAP). A state's FMAP is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent.

Florida's FMAP is 59 percent, which means that the federal government pays 59 cents of every dollar spent in Florida's Medicaid program. These matching rates provide significant assistance to states in their efforts to provide medical care to low-income individuals; however, if downturns in the economy occur over a long period of time, states may find it difficult to balance their budgets even with this assistance.

Florida's Medicaid expenditures have grown in several distinct surges since its inception in 1970, with the most significant increases over the last 20 years. Florida Medicaid expenditures increased from $795 million in FY 1983-84 to over $12.5 billion in FY 2003-04. Since 1999, Medicaid expenditures have doubled, growing by over 112 percent. Future expenditures in Florida's program are projected to exceed $52 billion in ten years if the current rate of growth continues (approximately 13.5 percent a year).

Why has Medicaid cost increased so much? The factors that have been identified as contributing to the rapid growth of Medicaid are numerous[1]. The more frequently cited factors in the increased cost of Medicaid include:

- Increase in Florida's population. According to the 2000 U.S. Census, Florida's population increased from 12,937,926 in 1990 to 15,982,378 in 2000, a 23.53% increase.
- Increase in the population of very low-income seniors that usually need more prescription drugs and costly long-term care. This area of the Medicaid budget has been growing rapidly as people are living longer and will continue to do so as the "baby-boomer" generation ages, in part because dual-eligibles (eligible for Medicaid and Medicare) tend to be sicker and have higher health care costs than other Medicare recipients.
- Medical inflation has surpassed the yearly growth in state revenues.
- Economic downturns result in more people on Medicaid. When people lose their jobs and employers cut benefits, more people go on Medicaid, which increases state and federal spending on the program.
- Cost of drugs – Prescription drug costs in Medicaid have increased dramatically and there are more and better medications. In 1995, prescription drug cost represented 10% of the Medicaid budget. In 2005, it represents approximately, 18% of the Medicaid budget.
- Advance in medical technology - Better technology but more cost associated with using the technology.

Within Medicaid, certain categories of services are growing more rapidly than others. The categories of services that constitute the greatest amount of expenditures can be grouped into four distinct areas. Hospital inpatient services and nursing home care have traditionally been the largest expenditure categories, however this changed just in the last couple of years with prescription drugs expenditures increases more rapidly than either and actually surpassing both as the single largest expenditure category.

For FY 2004-05, the largest projected expenditures by service category include prescription drugs ($2.6 billion or 17.98% of all expenditures), nursing home care ($2.3 billion or 15.73% of expenditures), hospital inpatient services ($1.76 billion or 11.98% of expenditures), and prepaid health plans/HMOs ($1.6 billion or 11.03% of expenditures).

Estimated Medicaid Spending by Major Service Category, FY 2004-05

Service	Estimated Annual Spending	Percentage of Medicaid Budget
Prescribed Medicine/Drugs	$2,644,054,895	17.98%
Nursing Home Care	2,314,153,880	15.73%
Hospital Inpatient Services	1,762,289,358	11.98%
Prepaid Health Plans/HMOs	1,622,434,059	11.03%
Home & Community-Based Services	769,697,270	5.23%
Physician Services	754,478,058	5.13%
Special Payments to Hospitals	577,333,410	3.92%
Supplemental Medical Insurance	539,444,228	3.67%
Hospital Outpatient Services	533,443,612	3.63%
Disproportionate Share Hospital Payments	310,917,998	2.11%
Hospice Services	219,702,401	1.49%
Intermediate Care Facility/DD	194,819,297	1.32%
Home Health Services	162,861,286	1.11%

[1] "Florida's Medicaid Budget: Why are Costs Going Up?" Policy Brief, Winter Park Health Foundation, July, 2004.

Therapeutic Services for Children	159,329,606	1.08%
Other	2,144,318,352	14.58%
TOTAL	**$14,709,277,810**	**100%**

Source: General Appropriations Act of 2004 and Agency for Health Care Administration.

C. SECTION DIRECTORY:

Section 1. Medicaid Reform; eligibility determination; services.—

(1) Waiver Authority.--Provides authority for AHCA to seek an experimental, pilot, or demonstration waiver, pursuant to Section 1115 of the Social Security Act, to reform Florida's Medicaid program in urban and rural demonstration sites contingent on federal approval to preserve the upper-payment-limit funding method (UPL) and the disproportionate share program (DSH) pursuant to chapter 409, F.S.

(2) Definitions.--Provides definitions for terms used in the section.

(3) Eligibility.--Authorizes waiver for specific categorical groups: Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) population, excluding those dually eligible for Medicaid and Medicare, and all children covered under Title XIX and Title XXI of the Social Security Act.

(4) Choice Counseling.--Requires AHCA or contracted entity to assist recipients in making informed decisions about health coverage within 30 days of eligibility and promotes health literacy.

(5) Plans.--Requires AHCA to develop a capitated system of care that promotes choice and competition. Plans must provide benefits to include mandatory services (s. 409.905, F.S.), behavioral health care (s. 409.906(8), F.S.), and pharmacy benefits (s. 409.906(20), F.S.), and other supplemental care. The bill requires behavioral health care to be a part of a managed care plan (not a carve out) and allows AHCA to set standards.

(6) Applicability of Other Law.--Requires AHCA to apply and enforce laws not referenced in this section to ensure safety, quality, and integrity of the waiver.

(7) Rulemaking.--Authorizes AHCA to adopt rules to implement the waiver.

(8) Implementation.--Requires AHCA to report provisions of approved waiver and deviations from this act. Requires legislative authority prior to implementation of the waiver.

(9) Review and Repeal.--Provides for future review and repeal of this act on July 1, 2010.

Section 2. Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments section.

2. Expenditures:

   See Fiscal Comments section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   See Fiscal Comment section.

2. Expenditures:

   See Fiscal Comment section.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The Opt-out option could provide a stimulus for the private insurance market.

D. FISCAL COMMENTS:

A section 1115 waiver initiative must be budget neutral to the federal government. As a result, the waiver's cost must be comparable to or less than current Medicaid expenditures in the waiver demonstration sites.

The provision of mental health services provided through the Department of Children and Family Services is generally provided through a state and local partnership effort. Section 394.76, F.S., provides 25% for local participation in financing of certain mental health services. This local match may be from county commissions, city commission, special districts, or other community sources. In FY 2001-02, counties and districts/region community-based agencies provided more than $109 million in cash and in-kind matching funds.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the Agency for Health Care Administration authority to promulgate rules to implement the provisions of the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES