HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HCB 6003 CS PHCB HFC 05-01 Medicaid Reform
SPONSOR(S): Health & Families Council, Benson, Elder & Long-Term Care Committee, Future of Florida's Families Committee, Health Care General Committee, Health Care Regulation Committee, and others
TIED BILLS: **IDEN./SIM. BILLS:** HBs 1869, 1871, 1873, 1875

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health & Families Council	8 Y, 3 N	Brown-Barrios, Collins, Liem, Mitchell	Moore
1) Fiscal Council	19 Y, 3 N, w/CS	Massengale	Kelly
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

House Combined Bill 6003 proposes to reduce the rate of growth in the Medicaid program by establishing an actuarially-based, risk-adjusted capitation reimbursement method that promotes choice and competition. Plans must provide basic benefits of Medicaid mandatory services, plus behavioral health care and pharmacy benefits. The bill establishes enhanced benefit coverage, which is additional or alternative health care beyond basic coverage under certain conditions. The bill also establishes catastrophic coverage designed to provide for payment of medically necessary care for recipients who are enrolled in a plan and whose care has exceeded a predetermined monetary threshold.

The bill establishes a regulatory framework that allows the Agency for Health Care Administration to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements. The bill also reduces the agency's burden of administering the complexities of the Medicaid's fee-for-service system for mandatory and optional services by transferring the operational administration of service delivery to managed care plans.

The bill requires AHCA to conduct a feasibility study on a Medicaid Buy-in program, which would help certain working persons with disabilities receive Medicaid coverage.

The bill permits the agency, contingent on federal approval, to expand a Medicaid reform demonstration waiver to integrate state funding for Medicaid services provided to individuals 60 years of age or older. The bill specifies standards the agency and a managed care plan are required to satisfy for integrating such services. The agency is required to offer recipients 60 years of age or older a choice of managed care plans.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government—The bill allows Medicaid recipients to choose health care services from the private insurance market.

Promote personal responsibility—The bill establishes a reward mechanism for compliance with wellness or disease management plans. The bill also provides greater choices for the recipient in the health care market. The bill allows Medicaid recipients greater choice of long-term care service delivery systems. The bill allows Medicaid recipients to assume responsibility for their health care by providing greater incentives through Flexible Spending Accounts or Individual Development Accounts. The bill also establishes the Medicaid Buy-in program that allows certain disabled persons ineligible for Medicaid because of current eligibility standards to participate in Medicaid through cost sharing while continuing to work.

Empower families—The bill supports Medicaid recipient efforts to take responsibility for their health care. The bill allows Medicaid recipients greater choice of long-term care service delivery systems.

B. EFFECT OF PROPOSED CHANGES:

House Combined Bill 6003 proposes a framework for a Medicaid Reform waiver that allows the Agency for Health Care Administration (agency) to temper the rate of growth in Medicaid, reduce the complexities of the program, provide greater choices for the recipient, promote a competitive health market and promote personal responsibility for health care.

Managed Care

The bill requires a recipient to choose a managed care plan within thirty-days of eligibility determination or lose eligibility. Until a plan is chosen, a recipient is eligible for emergency services only. 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.

The bill proposes to reduce the rate of growth in Medicaid by establishing an actuarially based risk - adjusted capitation reimbursement method that promotes choice and competition. Plans must provide basic benefits of Medicaid mandatory services, plus behavioral health care and pharmacy benefits.

The bill establishes a regulatory framework that allows the agency to open competition in the delivery of health care benefits by establishing a certification process, which allows a broad array of entities to become certified managed care plans upon meeting certain financial, programmatic and administrative requirements. It also reduces the agency's burden of administering the complexities of the Medicaid's fee-for-service system for mandatory and optional services by transferring the operational administration of service delivery to managed care plans.

Managed care entities which the agency can certify include, but are not limited to, health maintenance organizations (HMOs), health insurance companies, prepaid health plans, provider service networks (PSNs), Medicaid provider networks, mental health and substance abuse providers and hospitals. The bill specifies that it is the intent of the Legislature, to the extent possible, that certified plans include any federally qualified health center, federally qualified rural health clinic, county health department, or other federal, state, or locally funded entity serving the area of the demonstration project.

The bill requires a certificate of operation from the agency for an entity to operate a managed care plan. Requirements and standards for certification include financial solvency and health care network capacity. The agency is to develop the requirements in consultation with the Office of Insurance Regulation.

The bill establishes a framework for Medicaid recipients to take more responsibility for their wellness and to better manage any disease state they have by providing a reward mechanism for compliance with wellness or disease management plans. The bill establishes Flexible Spending Accounts and Individual Development Accounts where funds can be deposited and used by recipients for the purchase of enhanced benefits when the recipient complies with the objectives of a wellness or disease management plan.

The bill requires managed care plans to implement wellness or disease management programs. Disease management seeks to improve patient care and health outcomes and to reduce health care costs by concentrating services on chronically ill patients who often receive fragmented care, do not follow treatment and medication regimens, experience a high rate of preventable complications, and have high use of costly services.

The bill establishes a catastrophic coverage designed to provide for payment of medically necessary care for recipients who are enrolled in a plan and whose care has exceeded a predetermined monetary threshold. The bill also allows recipients to choose private market alternatives offered by the recipient's employer for health care benefits.

The bill requires AHCA to conduct a feasibility study on a Medicaid Buy-in program, which allows certain disabled persons ineligible for Medicaid with income below 250 percent of federal poverty level to purchase medical coverage through Medicaid. .

Long Term Care

House Combined Bill 6003 permits the agency, contingent on federal approval, to expand a Medicaid reform demonstration waiver to integrate state funding for Medicaid services provided to the elderly into a managed care delivery system.

The bill specifies standards the agency and a managed care plan are required to satisfy for integrating such services. The agency is required to offer recipients 60 years of age or older a choice of managed care plans, which includes both HMOs and other state-certified providers. The agency is to develop additional quality assurance standards specific to the care needs of the elderly in managed care, in consultation with area agencies on aging (AAAs) and the Department of Elderly Affairs. The agency is to contract with AAAs to perform initial and ongoing measurement of quality of care for the elderly in managed care plans. AAAs must collect grievance and complaint information and report on resolution.

The bill creates a "quality reserve fund." This requires the agency to withhold a percentage of the capitation rate, which is to be disbursed to plans that demonstrate high quality of service delivery based on achievement of several indicators such as a low rate of enrollee complaints, successful enrollee outcomes, compliance with quality improvement standards, and other factors determined by the agency as indicators consistent with high quality service delivery. The bill requires that managed care plans rebate, on a sliding scale, excess profits earned on long-term care services to elderly individuals.

The bill imposes additional responsibilities on managed care plans under contract to the agency to serve individuals 60 years of age or older. A managed care plan must allow an enrollee to select any provider with whom the plan has a contract; make a good faith effort to develop contracts with current aging network providers; ensure choice for recipients; and develop and use a service provider qualification system that describes the quality-of-care standards that providers must meet in order to obtain a subcontract with the plan, which does not duplicate other state or federal requirements. A managed care plan must provide enrollees the ability, to the extent possible, to choose nursing home and assisted living facility providers that are affiliated with an individual's religious faith or denomination

or part of a retirement community in which an enrollee resides and geographically located as close as possible to an enrollees family, friends and social support system.

The bill also expresses legislative intent regarding the inclusion of Medicare in an integrated long-term care system. The agency is authorized to begin discussions with the Centers for Medicare and Medicaid Services.

The bill requires the agency to develop a loan program to assist local community care for the elderly agencies and other essential community providers to become managed care organizations. The loan program is subject to appropriations and allows the agency to advance up to $500,000 per network. The terms of repayment may not extend beyond six years and include interest equal to or greater than the federal funds rate. The agency is authorized to develop a grant program to implement the loan program.

Oversight
HCB 6003 employs several oversight mechanisms to ensure that Medicaid recipients receive the services they need and that services are improved and monitored for quality and effect. In addition, the bill requires a constant vigilance against fraud and abuse and establishes requirements to minimize this problem.

Background

Medicaid funds health care services to people who meet certain categorical and income eligibility criteria. These populations are primarily low-income children, families, disabled persons and elderly. The Medicaid program funds health care benefits to approximately 2.15 million Floridians annually. 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.

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, 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 policies regarding the administration, eligibility, coverage and reimbursement structure of the Medicaid program.
- State Medicaid Directors letters.
- Sections 409.901–409.9205, Florida Statutes.
- Laws of Florida.
- Florida Administrative Code Chapters 59G-1 - Chapters 59G-13.
- Florida Administrative Code Chapter 65A-1.
- 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 Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

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 restrictions 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 Fiscal Year (FY) 2004-05 is estimated to be more than 2.15 million persons. The following categorical groups that meet financial eligibility requirements are served by Florida Medicaid:

- SSI eligible elderly or disabled individuals with incomes equal to or less than 88 percent of the federal poverty level (FPL).
- TANF-Families (24 percent of FPL).
- Elderly and disabled individuals with incomes equal to or less than 120 percent of FPL are eligible for payment of certain Medicare-related expenses.
- Pregnant women under 185 percent of FPL.
- Children age 6 and older in families under 100 percent of FPL.
- Children age 1 to 6 under 133 percent of FPL.
- Infants less than one year old with incomes equal to or less than 200 percent of FPL.

2005 Federal 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

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 as part of the Health Care Reform Act of 1992 (ch. 92-33, L.O.F.) to reduce administrative costs and improve the state's efficiency in addressing health care issues.

The Medicaid program is administered primarily by the Florida Agency for Health Care Administration (AHCA) under chapter 409, Florida Statutes. Other state agencies, however, have certain responsibilities. For example, the Department of Children and Family Services (DCF) 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 Comprehensive Assessment, Review and Evaluation Services (CARES) program. DOEA, along with the Agency for Persons with Disabilities, 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 or other institutions.

Mandatory Services
Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans, but a state's Medicaid program must offer mandatory medical benefits to most categorically needy populations. 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.
- Transportation services.

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
- Hospice Care
- Intermediate Care Facilities/ Developmentally Disabled
- Intermediate Nursing Home Care
- Occupational Therapy
- Optometric Services
- Orthodontia for Children
- Personal Care Services
- Physical Therapy
- Physician Assistant Services
- Podiatry Services
- Prescribed Drugs
- Primary Care Case Management –(MediPass)
- Private Duty Nursing
- Registered Nurse First
- Assistant Services
- Respiratory Therapy
- School-Based Services
- Speech Therapy
- State Mental Hospital Services
- Subacute Inpatient Psychiatric Program for Children
- Targeted Case Management

Children's Health Services
Healthy Kids, MediKids, Children's Medical Services Network (CMSN), and Medicaid make up the Florida KidCare program. All four of the KidCare components share the goal of providing comprehensive, high quality health care coverage for Florida's uninsured children. Overall, the Florida KidCare Program is financed by state and federal funds, family contributions and local communities. Federal funds come from the State Children's Health Insurance Program (SCHIP—Title XXI) or Medicaid (Title XIX). While Medicaid is an entitlement program, meaning that all eligible children must be provided coverage, SCHIP is not, allowing states to set enrollment limits.

Healthy Kids
The Healthy Kids component serves children ages 5 through 18 years. The Florida Healthy Kids Corporation contracts with commercial health and dental plans to provide care to enrollees. Families pay a monthly premium depending on their household size and income. Most Healthy Kids families pay either $15 (based on family income up to 150 percent of FPL) or $20 (based on family income from 151 to 200 percent of FPL) per month, regardless of the number of children in the family. Small co-payments are required for most services, including doctor visits, prescriptions, and specialty care.

Healthy Kids allows families who do not qualify for state and federal subsidized health benefits to buy coverage in the program for their children. For the 2003–2004 fiscal year, this full-pay rate was $92 per child per month without a dental benefit, or $109 with it.

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 AHCA.

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 DCF program, 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.

Pharmacy Benefits
Florida's Medicaid program provides prescription drug coverage for its fee-for-service beneficiaries. Medicaid reimburses licensed, Medicaid-participating pharmacies. Medicaid covers prescription drugs, as well as some over-the-counter medicines on an outpatient basis. In Fiscal Year 2004-05, prescription drug expenditures are expected to exceed $2.5 billion, comprising 18 percent of total Medicaid spending. Brand name prescriptions are limited to four per month with some exceptions. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. Based on the treatment needs of the Medicaid recipient, the agency may authorize exceptions to the four-brand-name drug restriction. There is no limitation on the number of prescriptions for recipients under the age of 21.

According to the AHCA[1], since FY 1996-97, growth in pharmacy services has outpaced spending in other areas. Since FY 2001, pharmacy claims have increased by an average of 12 percent annually.

[1] Presentation to the Senate Health and Human Services Appropriations Committee, December 15, 2004 by Thomas W. Arnold, Deputy Secretary for Medicaid.

Total expenditures for pharmacy services have grown annually by an average of about 16 percent. For mandatory populations in FY 2003, $1.77 billion was spent on pharmacy benefits; $529 million was spent on pharmacy benefits for optional populations in FY 2003.

On January 1, 2006, all dual eligibles (eligible for Medicare and Medicaid) will transition from Medicaid pharmacy benefits into Medicare. Medicaid matching funds will no longer be available if a dual eligible could enroll in Medicare Part D benefits. The state will continue to pay a portion of the cost for dual eligibles through a monthly payment to the U.S. Treasury. The amount of each state's payment reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles.

Choice Counseling

Legislation was passed in 1996 requiring Medicaid recipients to be enrolled into MediPass or managed care. Choice counseling was established as part of the legislation. The motivation behind the inclusion of choice counseling as part of the required enrollment into managed care was widespread 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 and 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 the agency.

The original program was comprehensive. Access to information was provided through face-to-face meetings at DCF offices, one stop centers, health fairs, by mail, and telephone. Posters advertising the program were displayed in large physician practices and in government buildings. Brochures were widely distributed at Publix stores, Wal-Marts, 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 every month to every county that had an HMO 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. Subsequently, they were locked into the program for the remainder of the year. At the end of the year, they were notified they had 60 days to change plans if they wished 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 of the program. With the redesign, enrollments and choice counseling are now provided only by telephone. Outbound calls are used 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.

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 April 2005, more than 1.5 million (or 67 percent) of the state's Medicaid recipients were enrolled in one of these managed care options, including 726,044 recipients enrolled in MediPass, 770,266 in Medicaid HMOs, and 18,307 in PSNs. All other recipients are considered fee for service. This group includes dual eligibles, 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. Services for recipients are reimbursed on a fee-for-service basis. 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—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 developed by estimating the cost to provide services to equivalent groups of fee-for-service recipients and then adding cost-savings factors. Besides the approved Medicaid services, HMOs are required to provide smoking cessation and children's programs.

- Provider Service Networks—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.

Disease Management
The Florida Legislature in 1997 directed the AHCA to implement a disease management initiative for Medicaid clients diagnosed with asthma, diabetes, HIV/AIDS, and hemophilia. The Legislature reduced Medicaid appropriations based on anticipated savings that were to be achieved through this initiative. In Fiscal Years 1998-99 and 2000-01, the Legislature directed the agency to expand the initiative and develop programs for hypertension, cancer, congestive heart failure, end-stage renal disease, and sickle cell anemia. The Legislature made further Medicaid budget reductions based on the additional expected savings.

Florida's disease management initiative delivers services to Medicaid clients enrolled in MediPass using disease management organizations (DMOs), which are private companies that specialize in disease management. These companies provide a range of services to both MediPass clients and providers. DMOs concentrate these services through a care manager who coordinates all aspects of patient care by developing individual care plans, monitoring patient compliance of treatment protocols, and informing physicians of patient progress. DMOs also provide services and educational materials to physicians by sharing best practice guidelines.

Disease management seeks to improve patient care and health outcomes and to reduce health care costs by concentrating services on chronically ill patients who often receive fragmented care, do not follow treatment and medication regimens, experience a high rate of preventable complications, and have high use of costly services. Disease management offers an integrated approach to treating chronic disease by providing support to patients and physicians. For example, by using a care manager, disease management helps patients follow appropriate treatments, use less expensive outpatient interventions, and learn how to self-monitor their conditions. Disease management

encourages doctors to use best practice guidelines for optimal treatment and enhances communication between patients and caregivers to prevent duplication or gaps in treatment.

Mental Health and Substance Abuse
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 Family Services also operates, directly or through contract, seven facilities for persons with mental illnesses or mental abnormalities requiring hospital level care.

The mission of the DCF 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.

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), Florida Statutes, 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), Florida Statutes, 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, Florida Statutes, is appropriated funding by the Legislature in three primary program areas: children's substance abuse services; adult substance abuse services; and program management/compliance. The service 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, which are responsible for administrative, fiscal and regulatory oversight of substance abuse 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; a statewide inpatient psychiatric program (SIPP); and behavioral health overlay services.

There are also existing prepaid mental health plans in Areas One and Six (Panhandle and Hillsborough County), with staggered implementation in the remainder of the state. The first request for proposal was released on January 14, 2005, to select contractors for Areas Five and Seven. Anticipated start date of June 2005. The proposed schedule of the remaining implementation is through March 2006.

In addition, AHCA and DCF have a jointly-developed RFP 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, and therapeutic foster care services. Substance abuse services, behavioral health overlay services, therapeutic group care, SIPP and psychotropic medications are not included.

Long Term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. This care is often supportive, rather than curative in nature, and is provided in institutions, home-like institutional settings and to persons living in their own residence. Long-term care may be care provided in a nursing home, in a residential setting such as an assisted living facility, in an adult day care center, or may be delivered to a person as home care. Long-term care in nursing homes is more medically oriented and is often provided by licensed and certified personnel to people with severe limitations and severe cognitive disorders. Much of long-term care provided in the home is supportive in nature, such as assistance with the activities of daily living of eating, toileting, and dressing.

CMS is permitted under section 1915(c) of the Social Security Act to waive certain federal requirements in order to provide home and community-based services (HCBS) to persons who would require institutionalization without community supports. Services vary by waiver, but typical waiver programs include services such as personal care, homemaker, companion, chore, respite care, and adult day health care. Most services are provided directly in a recipient's home. Florida has twelve approved HCBS waivers.

Each waiver has specific eligibility criteria such as age, type and level of disability, and service area covered. All waivers provide case management services to assess individual needs and work with recipients to develop a plan for their care, including which services will be provided, by which provider, and at what frequency. Unlike other long term care services, the state can, and does, limit the number of individuals served in each waiver program. There are waiting lists for most waiver programs due to this limit. Most waivers reimburse providers on a fee-for-service basis. The federal government, through the Medicare program, pays for the majority of health care required by older people, including short-term nursing home care and recuperative home health care.

The federal government also funds long-term community care services through the Older American's Act. States, through their Medicaid programs, finance the majority of nursing home bed days (long-term nursing home care). Medicaid also finances the home and community-based care that serves as an alternative to nursing home placement through the use of Medicaid waivers. A major impediment for states in planning an efficient long-term care system has been the difficulty of managing the interrelationship of incentives between the Medicare and Medicaid financing systems, and the effect that care of acute illnesses has on the eventual need for long-term care. States often have little control over the admission of a patient into a nursing home since the initial portion of a nursing home stay is usually financed by Medicare or other sources.

Many of these Medicare beneficiaries end up converting to Medicaid. Medicaid conversion in nursing homes occurs when a resident spends all of his or her assets to pay for an extended stay in a nursing home and is without private long-term care insurance. When an individual is eligible for Medicaid at the time of nursing home entry and Medicare coverage is also available, Medicare is considered the primary payer although Medicaid might also fund part of the costs of the nursing home stay. Medicaid per diem payments begin only after the Medicare benefit is exhausted. Most Medicaid conversions in Florida happen within the first year of a nursing home stay. Medicaid pays for approximately two-thirds of the patient days in nursing homes in Florida.

<u>Community Based Long Term Care</u>

The Department of Elderly Affairs and AHCA provide a system of home and community-based services to elderly individuals through a variety of programs. Though the stated purpose of these programs is to assist elderly individuals to remain in their homes as they become increasingly frail, the programs differ in the characteristics of their target groups and their payment methodologies and rates. Some of these programs are targeted at elderly people who meet nursing home admission criteria and who are in the

process of entering a nursing home, while others serve people who have lesser levels of disability and who can be assisted in remaining in their homes with the provision of limited supportive services. There are other programs that provide supportive services to lessen isolation, keep elders healthy, or relieve the burdens and stresses placed on families caring for aged family members.

Florida has a long history of providing care and services to elderly individuals through a system of AAAs and local community care for the elderly lead agencies—often referred to as Florida's "Aging Network". Area Agencies on Aging (AAA) are the administrative entities used by DOEA to manage aging services in the state. When DOEA was created, AAAs assumed many of the functions formerly performed by HRS District Aging and Adult Services offices, making the AAAs, in effect, DOEA's district offices. The AAAs perform program oversight for DOEA at the local level; for example, DOEA has contractual agreements with the AAAs to oversee the Medicaid Aged/Disabled Adult Waiver and the Medicaid Assisted Living for the Elderly Waiver. AAAs contract for and monitor service delivery under the state's Community Care for the Elderly, Home Care for the Elderly, and the federal Older Americans Act programs. Florida has long aligned its federal Older Americans Act Planning and Services Areas (PSA) to correspond with the 11 former Department of Health and Rehabilitative Services service districts, which were in existence prior to the formation of the Department of Children and Family Services (DCF).

When DOEA became the state unit on aging in 1992, it continued to use the same service areas for program purposes. The Older Americans Act requires states to establish a AAA in each PSA. Thus, there are 11 AAAs in Florida. Lead agencies are the local community agencies that provide state-funded aging services directly to individuals. Lead agencies have provided case management services to the state's functionally impaired elders since 1980, when the Legislature expanded the Community Care for the Elderly program statewide. The Community Care for the Elderly Act required that each PSA in the state develop at least one community care service system to enable functionally impaired elders to live independently in the community and prevent unnecessary nursing home placement.

Managed Long-term Care

Over the past 20 years, states have been increasingly interested in bringing the financial incentives inherent in managed care to bear on the long-term care population. During the 1990s, several states, including Florida, received grants from the Robert Wood Johnson Foundation to assist in the development of managed models of long-term care. These grants resulted in the development of a variety of managed long-term care program models in Florida, Oregon, Texas, Minnesota, New York, Utah, Maryland, and others. Current managed long-term care programs are characterized by plan assumption of risk for a range of medical services and assumption of full or partial risk for nursing home care. To prevent or delay expensive nursing home services, managed long-term care plans provide a set of home and community-based services, which are authorized by care managers who are responsible for ensuring that participants have access to needed medical and home care services. In addition, managed long-term care plans make use of alternative facility services such as assisted living for participants who are unable to remain in their own homes, but who do not have medical complexities requiring 24 hour nursing care. In general, satisfaction of Medicaid managed long-term care participants has been higher than that of recipients in fee-for service systems, in large part because of the presence of a "care manager" who is responsible for assisting the recipient in accessing needed community-based services.

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), 1915 (c). Under section 409.912 (11), Florida Statutes, the agency may apply for any federal waiver believed necessary to more efficiently or effectively manage the state's Medicaid program. The Legislature approves 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 five years and can be extended for three years.

Florida has numerous waivers.

1115	*1915(b)*	*1915(c)*
❖ *Consumer Directed Care*	*(1) – (4) Managed Care*	❖ *MR/DD (Developmental Disabilities)*
❖ *Pharmacy Plus*	❖ *MSPSI under 21*	❖ *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)*
		❖ *Traumatic Brain/Spinal Cord Injury*
		❖ *Spinocerebellar (Model)*
		❖ *Adult Cystic Fibrosis*
(b)/(c) Comprehensive Adult Day Health - (b)/(c) Alzheimer Waiver		

Special Medicaid 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.

In addition, there is a supplemental payment mechanism—Upper Payment Limit (UPL)—which is a complex funding arrangement between local organizations, 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 58.9 percent, which means that the federal government pays 58.9 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. If downturns in the economy occur over a long period of time, however, states may find it difficult to balance their budgets even with this assistance.

Florida's Medicaid expenditures have grown in several distinct surges since the program's 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 more than $12.5 billion in FY 2003-04. Since 1999, Medicaid expenditures have doubled, growing by more than 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 have Medicaid costs increased so much? The factors that have been identified as contributing to the rapid growth of Medicaid are numerous.[2] The more frequently cited factors in the increased cost of Medicaid include:

- Increases 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 percent increase.
- Increases 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 Medicaid recipients.
- Medical inflation—This has surpassed the yearly growth in state revenues.
- Economic downturns—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 percent of the Medicaid budget. In 2005, it represents approximately, 18 percent of the Medicaid budget.
- Advance in medical technology—Better technology has been developed, but more cost is associated with using the technology.
- Obesity—The Centers for Disease Control and Prevention (CDC) conducted a study that shows that deaths because of poor diet and physical inactivity rose by 33 percent over the last decade. About two of every three U.S. adults are overweight or obese, according to the CDC. Obesity has serious, long-term consequences. The incidence of type II diabetes has increased in U.S. children in parallel with the rising prevalence of obesity. Hypertension, hypercholesterolemia, heart disease, asthma, mental health concerns (e.g., depression and low self-esteem), and orthopedic disorders have all been linked to obesity. Minorities, individuals with low income, and low levels of education attainment are disproportionately affected by obesity.

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. This changed just in the last couple of years, however, with prescription drugs expenditures increasing 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 percent of all expenditures), nursing home care ($2.3 billion or 15.73 percent of expenditures), hospital inpatient services ($1.76 billion or 11.98 percent of expenditures), and prepaid health plans/HMOs ($1.6 billion or 11.03 percent of expenditures).

[2] "Florida's Medicaid Budget: Why are Costs Going Up?", Policy Brief, Winter Park Health Foundation., July, 2004 and the Centers for Disease Control and Prevention http://www.cdc.gov/nccdphp/dnpa/obesity/

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%
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

Subsection (1) LEGISLATIVE FINDINGS AND INTENT

Subsection (2) WAIVER AUTHORITY—Authorizes the Agency for Health Care Administration to seek 1115 demonstration waivers, notwithstanding any law to the contrary, contingent on federal approval to preserve the upper-payment-limit (UPL) and disproportionate share program (DSH), including a methodology to allow the use of a portion of the savings from the demonstration may be used to increase total UPL and DSH payments.

Subsection (3) IMPLEMENTATION OF DEMONSTRATION PROJECTS—Directs the agency to request waiver authority to establish managed care demonstration projects in at least one urban and one rural area.

Subsection (4) DEFINITIONS

Subsection (5) 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, who are 60 years of age or older, individuals who have developmental disabilities, and residents of institutions or nursing homes; and all children covered under Titles XIX (Medicaid) of the Social Security Act.

Subsection (6) CHOICE COUNSELING—Establishes procedures for choice counseling and requires efforts to prevent fraud, duress or threats by plans.

Subsection (7) PLANS—Requires the agency to develop a capitated system of care that promotes choice and competition and specifies basic plan benefits, including mandatory services (pursuant to 409.905, F.S.), behavioral health care (s. 409.906(8), F.S.), and pharmacy benefits (s. 409.906(20), F.S.), and other optional and supplemental care.

- Requires plans to provide wellness and disease management programs.
- Requires plans to provide and manage pharmacy benefits, including pharmacy fraud, waste, and abuse initiative.
- Requires establishment of a managed care plan purchasing alliance for pharmaceuticals.
- Makes behavioral health care part of a managed care plan (not a carve-out) and allows the agency to set standards.

Subsection (8) ENHANCED BENEFIT COVERAGE—Establishes a framework to reward recipients that comply with wellness or disease management plans by depositing funds in Flexible Spending Accounts and Individual Development Accounts to allow recipients to purchase enhanced health benefits.

Subsection (9) COST SHARING—Allows the agency to require recipients to share in costs through co-payments, deductibles, portion of insurance premium or fees based on income.

Subsection (10) CATASTROPHIC COVERAGE— Requires the agency to establish a catastrophic coverage fund or purchase stop-loss coverage for purposes of covering services when the cost of care for a recipient has exceeded a predetermined monetary threshold.

Subsection (11) CERTIFICATION—Requires entities obtain a certificate of operation from the agency to participate as a managed care plan. Requires the agency to establish standards for certification including requirements for financial solvency specified in chapter 641, F.S., service network capacity, administrative infrastructure. Allows Jackson Memorial Hospital and North and South Broward Hospital Districts to continue to operate a currently authorized provider service network.

Subsection (12) ACCOUNTABILITY AND QUALITY ASSURANCE—Requires the agency to establish standards for plan compliance, quality assurance and performance improvement standards, peer or professional review standards, grievance policies, and program integrity policies.

Subsection (13) STATUTORY COMPLIANCE—Requires any entity certified under this section to comply with ss. 627.613, 641.3155, relating to the prompt payment of claims, and 641.513, F.S., relating to requirements for providing emergency services and care.

Subsection (14) RATE SETTING AND RISK ADJUSTMENT—Requires the agency to develop an actuarially sound rate setting and risk adjustment system that may be based on a methodology that adjusts payment for risk assumed by managed care plans, includes criteria to adjust risk, and pays provider service networks fee-for-service during the first year of the demonstration.

Subsection (15) MEDICAID OPT-OUT OPTION—Authorizes the agency to provide an opt-out option to recipients to allow recipients to purchase insurance from an employer-sponsored insurer instead of through a Medicaid-certified plan on a voluntary basis with certain conditions.

Subsection (16) FRAUD AND ABUSE—Requires the agency to apply and enforce statutory provisions related to fraud and abuse and to have certification, licensure and credentials, financial solvency, and other protections for Medicaid recipients.

Subsection (17) INTEGRATED MANAGED LONG-TERM CARE SERVICES—Provides authorization for the agency, subject to federal approval, to integrate state-funded services for individuals 60 years of age or older, and includes additional requirements on both the agency and managed care plans. Specifies entities which can participate in managed care plans for the elderly.

Subsection (18) FUNDING DEVELOPMENT COSTS OF ESSENTIAL COMMUNITY PROVIDERS—Provides for funding development costs of community long-term care providers; authorizes loans of up to $500,000 for six years through a grant application process to certain traditional community aging providers to assist them in becoming managed care providers. Repayment terms include interest equal to or greater than the federal funds rate.

Subsection (19) MEDICAID BUY-IN—Requires AHCA to conduct a feasibility study on a Medicaid buy-in program.

Subsection (20) APPLICABILITY—Specifies that the provisions of this act only apply in the waiver demonstration sites and allows the agency to apply and enforce any provision of statutes not in conflict with the provisions of this act and not referenced in this act to ensure the safety, quality, and integrity of the waiver.

Subsection (21) RULEMAKING—Provides authority to the agency to promulgate rules.

Subsection (22) IMPLEMENTATION—Requires approval from the Senate and House of Representatives Select Committees on Medicaid Reform before waiver requests may be submitted and Legislative approval before they may be implemented. Long-term care integration waivers are not subject to these requirements. .

Subsection (23) EVALUATION—Requires the Office of Program Policy Analysis and Government Accountability to conduct an evaluation study and analyze the impact of the Medicaid reform waiver two years after the implementation of the waiver, and again at five years after implementation. In addition, the agency must provide status reports, submit copies of reports or evaluations required by the Centers for Medicare and Medicaid Services and contract for evaluation to compare the waiver with the Medipass fee-for-service program.

Subsection (24) REVIEW AND REPEAL—Provides repeal on July 1, 2010, unless reenacted by the Legislature.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See D. Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The opt-out option as delineated in subsection (14) of the bill could provide a stimulus for the insurance market.

The bill allows AHCA to award up to $500,000 to help entities develop managed care networks.

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.

Knowing that the waiver must be budget neutral, then it can be presumed that this bill will not have a negative fiscal impact. However, the bill creates a new eligibility group through the proposed Medicaid Buy-In. This would have a fiscal impact.

The bill requires greater choice counseling, which would require additional funds. A portion of the $8 million appropriated in the House General Appropriations Act, House Bill 1885, for Medicaid modernization could be used for the enhanced choice counseling and the loan program.

Appropriation in House Bill 1885	FY 2005-06
General Revenue Fund	$4,000,000
Administrative Trust Fund	$4,000,000
Total Funds	$8,000,000

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 expenditures 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 authority to the Agency for Health Care Administration to promulgate rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 20, 2005, the Fiscal Council adopted a strike-all amendment with several amendments, and favorably reported the committee substitute. The strike-all amendment changes the bill in the following ways.

- Requires a recipient to choose a managed care plan within thirty-days of eligibility determination or lose eligibility. Until a plan is chosen, a recipient is eligible for emergency services only.
- Adds federally qualified rural health clinics to the list of entities that may participate in the demonstration project.
- Removes AHCA's ability to set appropriate behavioral health medication guidelines.

- Removes demonstration site designations.
- Removes Title XXI children from the eligibility group.
- Removes minimum number of disease management programs that must be offered by managed care plans.
- Changes the rate setting and risk adjustment system.
- Removes Office of Insurance Regulation involvement in Medicaid Opt-Out Option.
- Requires the agency to receive legislative approval prior to submitting waiver applications.
- Exempts provider service networks from the competitive bid requirements in s. 409.912.
- Requires that competing plan benefits are equivalent in value.
- Allows the agency to extend an existing contract with a hospital-based provider service network for a period not to exceed three years.
- Requires the agency to contract for an evaluation by an entity experienced in evaluating managed long-term care plans.
- Allows recipients to retain use of enhanced benefits three years after loss of eligibility.
- Provides exemption for public entities from certain financial solvency requirements.
- Requires levels of enrollment sufficient to conduct a valid test of the managed care project.

This analysis reflects the committee substitute.