The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Policy Committee

BILL:	SB 1508
INTRODUCER:	Senator Saunders
SUBJECT:	Medicaid Managed Care Programs
DATE:	March 22, 2008
REVISED:	03/26/08

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Favorable**
2.			HR	
3.			HA	
4.				
5.				
6.				

I. Summary:

This bill modifies the mandatory managed care assignment process for Medicaid recipients who do not choose a managed care plan or MediPass provider upon eligibility determination. The bill requires the Agency for Health Care Administration (AHCA), when assigning a recipient who does not make a choice, to take into account:

- How a managed care plan maintains, rather than whether it has, sufficient network capacity to meet the needs of members and the managed care plan's performance and compliance with the network adequacy requirements (which the AHCA must validate on an annual basis);
- Whether a managed care plan has sufficient network capacity to meet the urgent, emergency, acute, and chronic needs of its members and has consistently maintained compliance with the network adequacy requirements over the previous 12-month period; and
- The quality of service and the performance of managed care plans.

The bill requires the AHCA to establish quality-of-care and network adequacy standards for managed care plans, which the agency must monitor quarterly and evaluate annually, and specifies the criteria upon which these standards shall be based. If the managed care plan does not meet these network adequacy or quality standards, the AHCA may not continue to assign recipients to the plan as part of the mandatory assignment process.

The bill defines the term "Medicaid rate" or "Medicaid reimbursement rate," as used in this section and ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), F.S., as being equivalent to the amount paid directly to a hospital by the agency for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis. The bill requires the AHCA to include in its

calculation of the hospital inpatient component of a Medicaid HMO's capitation rate any special payments, including, but not limited to, upper payment limit, exemption payments, low income pool, or disproportionate share hospital payments made to qualifying hospitals through the fee-for-service program.

The bill prohibits managed care plans and the MediPass program from withholding payment for emergency services and care based on the enrollee's or the hospital's failure to notify the managed care plan or MediPass primary care provider in advance or within a certain period of time after the care is given. The bill also specifies allowable reimbursement for emergency services provided to an enrollee of a managed care plan under this section.

This bill amends ss. 409.9122, 409.9124, and 409.9128, F.S.

II. Present Situation:

Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, Florida Statutes.

For FY 2008-09, the Florida Medicaid Program is projected to cover 2.25 million people[3] at an estimated cost of $15.8 billion.[4]

Medicaid Managed Care Programs

The state of Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[5] and,

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid Program are codified in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on March 22, 2008).
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on March 22, 2008)
[5] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles

within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program. This bill does not affect these individuals, so they are excluded for this analysis.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor appropriateness of health care provided to their patients. MediPass providers receive a $3 monthly case management fee for each of their enrolled patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered.

The second major category of provider in the Medicaid managed care program is the managed care plan. Section 409.9122, F.S., defines managed care plans as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), provider service networks (PSNs), minority physician networks, the Children's Medical Services Network, and pediatric emergency department diversion programs. These plans tend to be reimbursed through a capitated payment where the plan receives a set amount per member per month and is responsible for providing all necessary Medicaid services within that capitation rate.

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of being determined eligible. There are 23 counties with MediPass as the only managed care choice, ten counties have one managed care plan and MediPass, and 29 counties have at least two managed care plans in addition to MediPass.

As of January 2008, there were 2,107,427 individuals enrolled in the Florida Medicaid Program. Of these Medicaid recipients, 195,230 are enrolled in the Medicaid reform pilot and 1,912,197 are enrolled in the non-reform component of the program. Of those individuals not in the reform counties, 1,265,562 are eligible for mandatory managed care. Of the individuals eligible for mandatory managed care enrollment, they are enrolled in the following types of plans in these numbers: 362,505 are enrolled in MediPass; 586,361 are enrolled in HMOs; 117,523 are enrolled in minority physician networks; 24,274 are enrolled in the Children's Medical Services Network; 7,521 are enrolled in PSNs; and 6,258 are enrolled in pediatric emergency room diversion plans.

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and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

Medicaid Managed Care Plan Network Adequacy Standards

The AHCA currently reviews managed care plan provider networks on an ongoing, routine basis, including when an expansion is requested, when changes in the provider network status occur (primarily upon notice of providers leaving the network), on an ad hoc basis upon receipt of complaints or issues regarding plan network providers and the annual contract required on-site review. For each managed care plan, an enrollment capacity is determined by the AHCA based on the number and types of health care providers contained within the plan's network. Managed care plans do not receive mandatory assignment if their enrollment capacity has been reached. The agency's determination process of enrollment capacity includes review and approval of managed care plan network capacity.

The managed care plan contracts include requirements that plans provide emergency, urgent and routine care, and appointments within specified time frames and within specific geographic access standards based on federal regulations [42. CFR 438.206(b)(1-5) and (c)(1)]. Plan network capacity is based in part on the plan having an adequate number of providers in the network to meet these specific time frames on emergent, urgent and routine care. Sanction requirements in the contracts allow the AHCA to stop assignments and voluntary enrollments if the plan has violated its contract with the AHCA.

Medicaid Managed Care Quality of Care Standards

Section 409.9122(2), F.S., provides that the AHCA shall not enroll or assign eligible recipients to a managed care plan or MediPass, unless the plan or MediPass has complied with specified quality of care standards. For managed care plans, the quality of care standards are based upon, but not limited to:

- Compliance with the accreditation requirements as provided in s. 641.512, F.S.
- Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.
- The percentage of voluntary disenrollments.
- Immunization rates.
- Standards of the National Committee for Quality Assurance and other approved accrediting bodies.
- Recommendations of other authoritative bodies.
- Specific requirements of the Medicaid program, or standards designed to specifically assist the unique needs of Medicaid recipients.
- Compliance with the health quality improvement system as established by the AHCA, which incorporates standards and guidelines developed by the Medicaid Bureau of the federal Centers for Medicare and Medicaid Services as part of the quality assurance reform initiative.

The AHCA requires managed care plans to report annually on selected performance measures including HEDIS (Healthcare Effectiveness Data and Information Set) measures and agency-defined measures. Managed care plans also participate in annual provider satisfaction surveys that indicate quality of care, recipient access to services and overall satisfaction.

Medicaid Managed Care Capitation

The Florida Medicaid Program uses a capitated reimbursement model for HMOs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Managed care plan provider reimbursement requirements are specified in ss. 409.912, 409.9124, and 409.9128, F.S.

Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid Program has been using capitated reimbursement systems since the early 1990s.

The HMOs are by far the largest of these provider types and receive the majority of reimbursements within the Medicaid managed care program. Medicaid HMOs in Florida are reimbursed based on capitation payments calculated for the applicable contract year. Currently, the AHCA, as the administrating agency, is responsible for calculating the capitation payment rates for reimbursement to the HMO managed care plans.[6] The agency's methodology is established through the administrative rule process (59G 8.100, F.A.C.) and is available to the public. The methodology is very complex, but can be summarized as follows:

- The capitation payment is the fixed amount paid monthly by the AHCA to an HMO for each enrolled HMO member to provide covered services needed by each member during the month as specified in each contract.

- The AHCA uses 2 years of certain historical expenditure data (excluding some fees and payments as described in the rule) from the Medicaid fee for service program for the same service the HMO is responsible for delivering.

- These data are then categorized into "rate cells" by age, gender, eligibility group, geographic region and are forecasted to the applicable year using inflation factors adopted by the Legislature in the Social Services Estimating Conference. Once forecasted to the applicable year, these expenditure data are adjusted to reflect policy changes adopted by the Legislature. Any policy changes that will be implemented in the coming year that may affect fee-for-service expenditures are accounted for in the capitation rates (i.e., reductions in the fee-for-service hospital inpatient reimbursement rates).

- After the adjustment for policy issues, the AHCA applies a discount factor and a trend adjustment to each rate cell to remain within appropriations. The discount factor ranges from 0 to 8 percent and varies by rate cell depending on the geographic region and eligibility category.

- Upon completion, the rates are reviewed and certified by an independent actuarial firm. Upon actuarial certification, and confirmation by the Centers for Medicare and Medicaid Services, the AHCA will begin reimbursing HMOs the monthly capitation payment for each recipient enrolled in the plan.

[6] S. 409.9124, F.S.

Medicaid Exempt Rates for Hospitals

Medicaid participating hospitals are reimbursed at a daily rate (per-diem) that is calculated using a cost-based reimbursement methodology. To calculate the daily rate, the methodology uses each hospital's prior year costs inflated forward with a health care indexing inflation factor. However, there are factors within the methodology (called ceilings) that limit the growth in the calculated daily rate each year. Due to the ceilings, the final daily rate may not equal a hospital's actual cost of providing services.

To account for this difference, the Legislature has allowed certain hospitals to qualify for "exemptions" from the ceiling limitations. To qualify, a hospital's sum of charity care and Medicaid days as a percentage of adjusted patient days must equal or exceed 11 percent (7.3 percent if designated or are a provisional trauma center), or must be a Specialized Statutory Teaching and Community Hospital Education Program (CHEP) hospital. The exempt amount is equal to the difference between a hospitals actual daily cost and the final calculated daily rate that is limited by the ceilings in the methodology. To pay for the exemptions, the state certifies local funds, or Intergovernmental Transfers (IGT's), as the state contribution in order to draw down federal matching funds.

The following is a hypothetical example of the reimbursement methodology for ABC Hospital, which meets the qualifications for exempt payments:

ABC Hospital's cost to serve a Medicaid recipient for 1 day: (This is referred to as the exempt rate.)	$2,000.00
ABC Hospitals Medicaid Reimbursement (non-Exempt Rate): (This amount is financed using General Revenue/Tobacco/PMATF as the state share to draw down federal matching funds)	$1,700.00
Difference:	$ 300.00

A ceiling exemption allows a local government to contribute funds to be used as the state share to draw down federal match to make up the difference between the exempt and non-exempt rate (the $300 in the example above):

Local government contribution	$ 129.27
Federal match	$ 170.73
Total	$ 300.00

The total payment to the hospital from the AHCA	$2,000.00
State GR/Tobacco/PMATF financed reimbursement rate	$1,700.00
Amount using local government funds as state share:	$ 300.00

Hospitals in Florida that serve large Medicaid populations and Medicaid managed care organizations have been in contention for a number of years regarding how these exempt rates are included in the capitation rates for managed care plans. The AHCA has reported that the exempt rates are included in the HMO capitation rates, but the HMOs use the agency's actuarial

certification of these rates to argue that the rate is set too low for the plans to pass through the exempt rates to each hospital.

These entities have also been in contention regarding the interpretation of the terms "Medicaid rate" and "Medicaid reimbursement rate" as used in ss. 409.912(19), 409.9122, 409.9124, 409.9128(5)(d), and 641.513(6)(d), F.S. This issue is whether or not these terms should be interpreted to mean the "exempt" rates when Medicaid HMOs are required to pay non-contracted hospitals who serve their enrollees.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.9122, F.S., relating to the mandatory assignment of Medicaid recipients into managed care plans, to specify that when making a mandatory assignment, the AHCA must take into account: how a managed care plan maintains, rather than whether it has, sufficient network capacity to meet the needs of members; and the managed care plan's performance and compliance with the network adequacy requirements, which the AHCA must validate on an annual basis.

The bill specifies that when a Medicaid recipient does not choose a managed care plan or MediPass provider and the AHCA assigns a recipient into a managed care plan, the AHCA must take into account whether a managed care plan has sufficient network capacity to meet the urgent, emergency, acute, and chronic needs of its members and has consistently maintained compliance with the network adequacy requirements over the previous 12-month period. The bill also *requires* the AHCA to make mandatory assignments based on quality of service and performance of managed care plans.

The bill requires the AHCA to establish quality-of-care and network adequacy standards for managed care plans, which the AHCA must monitor quarterly and evaluate annually. These standards shall be based upon, among other criteria, specific requirements of the Medicaid program and network adequacy standards designed to specifically meet the unique needs of Medicaid recipients, including patient access standards for specialty care providers, and network adequacy as established by contract, rule, and statute for urgent, emergency, acute, and chronic care.

The bill deletes a reference to chapter 216, F.S., Planning and Budgeting, in a provision authorizing the AHCA to contract with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid health plans. In entering into these contracts, the AHCA would be subject to a specific appropriation in the General Appropriations Act. The bill allows the AHCA to extend eligibility for Medicaid recipients enrolled in contracted managed care plans, not just licensed health maintenance organizations, for the duration of the enrollment period or for 6 months, whichever is earlier, provided the AHCA will certify that such an offer will not increase state expenditures.

The bill requires Medicaid managed care plans and MediPass providers to document their activities to ensure Medicaid recipients receive the health care service to which they are entitled in a timely manner.

The bill also specifies that the AHCA must accept the managed care plan's representations that it is in compliance with this subsection based on the certification of its primary care physicians, unless the agency has an objective indication that access to primary care is being compromised, such as failure to maintain network adequacy or receiving complaints or grievances relating to access to care. If the managed care plan is unable to obtain this certification, the AHCA may not continue to assign patients to the plan through the mandatory assignment process.

The bill defines the term "Medicaid rate" or "Medicaid reimbursement rate," as used in this section and ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), F.S., as being equivalent to the amount paid directly to a hospital by the AHCA for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis. The bill requires exemption payments and low income pool payments to be included in the agency's calculation of the hospital inpatient component of a Medicaid HMO's capitation rate.

Section 2. Amends s. 409.9124, F.S., to define the term "Medicaid rate" or "Medicaid reimbursement rate," as used in this section and ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), F.S., as being equivalent to the amount paid directly to a hospital by the AHCA for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis. The bill requires the AHCA to include in its calculation of the hospital inpatient component of a Medicaid HMO's capitation rate any special payments, including, but not limited to, upper payment limit, exemption payments, low income pool, or disproportionate share hospital payments made to qualifying hospitals through the fee-for-service program. The AHCA may seek federal waiver approval or state plan amendments as needed to implement this adjustment.

The bill also repeals obsolete language pertaining to a one-time additional adjustment in calculating the capitation payments to Medicaid prepaid health plans in FY 2005-06.

Section 3. Amends s. 409.9128, F.S., to prohibit managed care plans and the MediPass program from withholding payment based on the enrollee's or the hospital's failure to notify the managed care plan or MediPass primary care provider in advance or within a certain period of time after emergency services and care is given. The bill also specifies that reimbursement for emergency services provided to an enrollee of a managed care plan under this section by a provider who does not have a contract with the managed care plan shall be the lesser of: the provider's billed charges; the usual and customary provider charges for similar services in the community where the services were provided; the charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or the Medicaid rate defined as equivalent to the amount paid directly to a hospital by the agency for providing inpatient and outpatient services to a Medicaid recipient on a fee-for-service basis.

Section 4. Provides that this act shall take effect on July 1, 2008.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The dynamics between Medicaid managed care plans and health care providers (in particular, hospitals) would be fundamentally changed. The result of defining the Medicaid reimbursement rate as proposed in the bill would establish a floor for network contracting negotiations which would likely favor the health care providers.

C. Government Sector Impact:

Agency for Health Care Administration

The bill directs the AHCA to calculate the hospital inpatient component of a Medicaid health maintenance organization's capitation rate and include any special payments, including, but not limited to, upper payment limit, exemption payments, low income pool, or disproportionate share hospital payments made to qualifying hospitals through the fee-for-service program. Currently, to the extent these special payments are included in the hospital per diem, the payments are included in the HMO rate.

Preliminary communications with the federal Centers for Medicare and Medicaid Services indicate that the inclusion of low income pool (LIP) payments in the HMO capitation methodology and payments would not be allowed. Per Special Terms and Conditions (STC) #91 of Florida's Medicaid Reform 1115 Waiver, the LIP program is designed to "ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations." According to STC #101, "Providers with access to the LIP and services funded from the LIP shall be known as the provider access system." The LIP is a $1.0 billion per year program which operates pursuant to the Reform Waiver and as funded and authorized by the Legislature. Low income pool payments are made in quarterly payments, not through the claims based fee-for-service system.

It is important to note that the state share of funding for LIP comes from IGTs or local government contributions. Even if LIP payments could be included in capitation

payments to HMOs, the IGT revenue that currently provides a large portion of the state share of LIP funding would likely not be available for capitated managed care payments. The relationship between IGT funding and payments is not direct when services are provided through capitated managed care plans.

In addition, the bill allows the AHCA to extend eligibility for Medicaid recipients enrolled in *contracted managed care plans*, not just contracted licensed health maintenance organizations, for the duration of the enrollment period or for 6 months, whichever is earlier, *provided the agency will certify* that such an offer will not increase state expenditures. While current law allows for the extension of eligibility for those enrolled in health maintenance organizations, the agency cannot certify that an extension to contracted managed care plans could be offered without a significant increase in state expenditures, and therefore the policy has not been adopted. The additional cost of the extension of eligibility proposed in this legislation by the inclusion of those enrolled in other managed care plans would be $110,268,653. The AHCA reports that since it is unlikely the additional cost could be certified as required by law, this provision could not be implemented. This means that there would be no actual fiscal effect.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.