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 Budget Committee

BILL:	SPB 7094
INTRODUCER:	For consideration by the Budget Committee
SUBJECT:	Medicaid
DATE:	February 13, 2012
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Rhodes	BC	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill makes the following changes to the Medicaid program:

- Directs the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) to work cooperatively to develop a new system of eligibility determination for Medicaid and the Kidcare program[1] consistent with federal and state laws; specifies the business objectives, system components, executive management team and timeline for the project; directs that the system developed by department is subject to approval of the Legislative Budget Commission (LBC); and provides that development of the system is subject to appropriation.
- Limits payment for hospital emergency department services for non-pregnant Medicaid recipients 21 years of age or older.
- Creates an exception to the prohibition in current law against the adjustment of hospital reimbursement rates after September 30 of a state fiscal year.
- Revises time frames, parameters, and requirements for the AHCA to plan and report on a process for converting Medicaid hospital reimbursements to a diagnosis related group (DRG) system instead of the current cost-based system.
- Revises requirements relating to the use of voluntary intergovernmental transfers (IGTs) of funds donated from local taxing authorities to the state for the purpose drawing federal matching dollars and funding certain hospital costs via fee-for-service.

[1] Kidcare is a Florida program affiliated with the federal Children's Health Insurance Program (CHIP) that uses state funds and federal match to provide subsidized and non-subsidized health and dental insurance coverage for eligible children in the state < http://www.floridakidcare.org/ >

- Creates conditions and parameters for the inclusion or exclusion of certain hospital costs in the calculation of capitations for prepaid health plans, based on the collection of voluntary IGTs donated for the purpose of funding those hospital costs within prepaid health plan capitations.
- Continues the years of audited data used in determining Medicaid and charity care days for hospitals in the Disproportionate Share Hospital (DSH) Program and changes the distribution criteria for Medicaid DSH payments to implement funding decisions for the DSH program; repeals statutes relating to the unfunded DSH programs for primary care and regional perinatal intensive care centers (RPICCs); and authorizes payment for the teaching hospital DSH program.
- Removes the MediPass program as a managed care option for recipients who are required to enroll in managed care and who reside in counties in which two or more managed care plans are enrolling Medicaid recipients, under specified parameters.
- In counties in which one or more managed care plans are enrolling Medicaid recipients, requires the AHCA to assign to a managed care plan those Medicaid recipients who fail to choose a managed care option, under specified parameters.
- Revises the methodology for determining a county's eligible recipients for the purpose of county billing for Medicaid expenditures; revises the methodology of collecting funds relating to required county contributions for Medicaid costs.
- Codifies two sections of non-statutory law and expands statewide the AHCA's telephony pilot project for home health care services and the AHCA's home health care management pilot project.
- Authorizes the expansion of Program for All-inclusive Care for the Elderly (PACE) services, provided under contract in Southeast Florida, into Broward County with 150 new slots.

The bill conforms the statutes to the budget decisions in the proposed Senate budget relating to health and human services. The bill has a number of provisions that will both cost the state and save the state money in general revenue and trust funds. In Fiscal Year 2012-2013, the bill is estimated to cost $44 million and save $376.4 million for a net savings of $332.4 million. The net savings for Fiscal Year 2013-2014 are estimated at $453.2 million.

This bill substantially amends the following sections of the Florida Statutes: 383.15, 409.902, 409.905, 409.908, 409.911, 409.9113, 409.912, 409.9121, 409.9122, 409.9123, 409.9126, 409.915, 409.979, and 430.04.

The bill creates the following sections of the Florida Statutes: 409.9132 and 409.9133.

The bill repeals the following sections of the Florida Statutes: 409.9112 and 409.9117.

The bill has an effective date of July 1, 2012, except as otherwise expressly provided in the bill.

II. Present Situation:

Eligibility System for Medicaid and Kidcare

The AHCA is designated as the single state agency authorized to administer the Medicaid program in Florida. State law delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Agency for Persons with Disabilities, and the Department of Elderly Affairs. The DCF is given the responsibility for Medicaid eligibility determinations.

The Florida Medicaid Management Information System (FMMIS) is operated by the AHCA and is used to enroll providers, process Medicaid claims, adjudicate claims, accept and process encounter claims for data collection, and reimburse providers. The DCF operates the Florida Online Recipients Integrated Data Access (FLORIDA) system to determine eligibility for Medicaid, Kidcare, and other public assistance. The FLORIDA System sends data to FMMIS nightly to add and remove individuals based on changes in eligibility.

The FLORIDA System was implemented in 1992. The system was transfer technology from the State of Ohio which was originally designed in the early 1980s. The FLORIDA System was designed to support a service model where face-to-face interviews were conducted at area offices and relies heavily on manual data entry by state employees with no option for direct input by clients. The DCF is facing problems related to the aging of the system including limited availability of hardware and software support; limited pool of trained users; and declining availability of third-party support for new technology and functions.

The DCF has identified risks related to continuing to operate the FLORIDA System without modification, including the escalation of system maintenance and modification costs; potential of system failures due to aging infrastructure; and inability to comply with federal law. Since the Medicaid program is a partnership between the state and the Federal government, the program must comply with all Federal requirements, including those outlined in the Patient Protection and Affordable Care Act (PPACA).[2]

The U.S. Congress passed the PPACA, and President Barack Obama signed the bill into law on March 23, 2010. Key policy areas of reform include: mandated individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs.

On the same day the PPACA was signed into law, Florida's Attorney General filed a federal lawsuit in Pensacola challenging the constitutionality of the new law.[3] On January 31, 2011, the Federal District Court for the Northern District of Florida, Pensacola Division, declared the individual mandate unconstitutional, and since the law lacks a severability clause, the entire Act was void.[4]

This decision was appealed to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit affirmed the decision that the individual mandate violates the Commerce

[2] P.L. 111-148, 124 Stat. 119 (2010).
[3] State of Florida v. U.S. Dept. of Health and Human Services, Case No.: 3:10-cv-91-RV/EMT (N.D. Fla.)
[4] *See* Florida v. U.S. Dept. of HHS, Case No. 3:10-cv-91-RV/EMT (N.D. Fla.), *Order and Memorandum Opinion on Defendants' Motion to Dismiss*, October 14, 2010.

Clause, but upheld the remaining portions of the PPACA.[5] The Supreme Court of the United States has granted review of the case. In addition to reviewing the constitutionality of the individual mandate, the Court will also review whether the changes to the Medicaid program are an unlawful coercion. The Court has scheduled oral arguments on March 26, 27, and 28.

If the Medicaid provisions of the PPACA are upheld, the state must comply with certain provisions of the PPACA or risk the loss of federal funding. Specifically, the PPACA requires that as condition of continued participation in the Medicaid program that by January 1, 2014, Florida must:[6]

- Maintain a web site that allows individuals to apply for and enroll in Medicaid and Kidcare and to apply for cost sharing benefits through a health benefits exchange. The system must allow for the use of electronic signatures.
- Maintain a web site that allows individuals to compare benefits, premiums, and cost-sharing available to the individual under Medicaid, Kidcare, and a health benefits exchange.
- Be able to accept application for and enrollment in Medicaid and Kidcare from individuals who applied through a health benefits exchange.
- Provide information to individuals about a health benefits exchange, including premium assistance, to individuals who apply for Medicaid or Kidcare but are not eligible.
- Utilize a secure electronic interface with a health benefits exchange sufficient to share information allowing for determination of an individual's eligibility for Medicaid, Kidcare, and premium assistance.

Florida's Medicaid Hospital Reimbursement Plan

Florida pays hospitals for Medicaid services using cost-based reimbursement methodologies, one for inpatient rates and one for outpatient rates. The methodologies are approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in official state Medicaid Hospital Reimbursement Plans. The plans are amended as necessary to follow policy and budgetary guidance passed by the Florida Legislature. The reimbursement process is complex and a number of far-reaching alterations have been applied over the years. The main elements are outlined below.

Cost Reports

Hospital payments are cost-based. Hospitals submit audited cost reports for Medicaid services annually. For each hospital, the most recently available cost reports are analyzed for allowable costs and put through a methodology to determine the hospital's reimbursement. The methodology includes many calculations to account for current and anticipated trends and for rate cuts and policy measures applied by the Legislature. Based on all these factors, a customized "per diem" is calculated for each hospital based on that hospital's cost reports and the various calculations contained in the methodology.

[5] State of Florida v. U.S. Dept. of Health and Human Services, 780 F. 3d 1235 (2011).

[6] See PPACA at Sec. 2201 and Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, Proposed Rule, 76 Fed. Reg. 51148-51199 (April 17, 2011)

Per Diems
Hospitals are paid a flat "per diem" for a Medicaid inpatient "day." An inpatient day occurs when a Medicaid patient is admitted to the hospital and stays overnight to receive treatment. One such overnight stay counts as an inpatient "day," and the hospital receives a per diem payment for that day that is the same for any Medicaid patient who stays overnight at that hospital, regardless of the treatments provided. For example, with any specific hospital, the Medicaid per diem reimbursement paid to the hospital for two separate inpatient days will be the same dollar figure, regardless of differences in the treatments provided.

Reimbursement Ceilings
In 1990, Florida began placing recurring "reimbursement ceilings" on the growth allowed for hospital per diems. For that year, the ceiling was set at 3.3%, meaning that a hospital's per diem was allowed to increase by no more than 3.3% of the previous year's rate, regardless of the increase called for by the cost-based methodology. In subsequent years, the ceiling has been set each year based on a formula using inflation factors.

Exemptions from Reimbursement Ceilings
The state began applying reimbursement ceilings effective July 1990, but certain hospitals are exempt from the ceilings, which means yearly increases in their rates are not limited by the full application of the reimbursement ceilings. A rate that is exempt from the ceilings is commonly called the "exempt rate." All hospitals that are defined as rural hospitals were exempted on an ongoing basis at the outset. Over the years, other hospitals have been made exempt from reimbursement ceilings:

- In 1991, hospitals whose charity and Medicaid days exceeded 15% of their overall days were exempted. (That percentage has been lowered over the years and now stands at 11%, which allows more hospitals to qualify for the exemption.)
- In 2000, certain teaching hospitals, children's hospitals, and certain specialized hospitals were made exempt.
- In 2001, trauma centers whose percentage of Medicaid days exceeded 9.6% were made exempt. (This percentage has also been reduced and is now 7.3%.)
- In 2004 and 2005, certain hospitals with neonatal intensive care units were made exempt.
- In 2008, more hospitals were made exempt, including hospitals experiencing an increase in Medicaid caseload by more than 25% in any year and hospitals whose Medicaid per diem rate is at least 25% below the Medicaid per patient cost for the year.

Currently 27 rural hospitals are exempt from the reimbursement ceilings and an additional 68 of Medicaid's 242 hospitals are exempt by virtue of meeting one of the above criteria. Being exempt can significantly increase a hospital's per diem. On the average, a non-rural hospital's exempt rate is about twice as high as what that hospital would be paid without the exemption.

Funding for Exemptions
Exemptions for rural hospitals are funded with state GR and federal Medicaid matching dollars. The other exemptions described above are funded through county and other local tax dollars that are transferred to the state and used to draw federal match. Local dollars transferred to the state and used in this way are known as "intergovernmental transfers" or IGTs. These IGTs allow the state to exempt certain hospitals from the reimbursement ceilings and pay them higher Medicaid rates without expending state GR.

IGTs in General
The IGTs described above are used to fund exemptions. IGTs are also used to augment hospital payments in other ways. All IGTs are contingent upon the willingness of counties and other local taxing authorities to transfer funds to the state in order to draw down federal match. The local taxing authorities donate IGTs voluntarily and are not required to provide the IGTs.

The Sources of IGTs for Exemptions
IGTs are sent to the state by local taxing authorities, but not all local taxing authorities donate IGTs in this way. A hospital may be exempt from the reimbursement ceilings based on meeting the criteria described above and is therefore paid the higher exempt rate, even though no local dollars from that hospital's county or local taxing district are donated. Certain donor counties and taxing authorities contribute IGTs that, along with federal match, are used to fund exemptions across the entire state for hospitals that meet the criteria for being exempt.

Self-funded Exemptions
In 2008, the Legislature began passing budget proviso each year allowing public hospitals that did not qualify for exemptions as described above to provide their own funds or local governmental funds in order to "self-fund" an exemption for the hospital. Such "self-funded" exemptions are not part of the process described above and are handled as stand-alone exemptions for individual hospitals that would not otherwise qualify for exemptions. Beginning in 2009, non-public hospitals with graduate medical education positions were also allowed to self-fund exemptions from their reimbursement ceilings in this way. For the 2011-12 fiscal year, the GAA contains proviso allowing any hospital to self-fund an exemption from the reimbursement ceilings, up to spending authority of $187 million in IGTs and $237 million in federal match, assuming IGTs can be secured to do so.

County Billing Rate
Under s. 409.915, F.S., counties are required to participate in paying for Medicaid care provided to the county's eligible recipients. When a Medicaid patient has more than 10 inpatient days in a given year, the county is responsible for 35% of the costs, starting with day 11, not in excess of 45 days. However, counties are not required to contribute toward the cost of a non-rural hospital's exemption from reimbursement ceilings. For exempt hospitals that are not rural hospitals, the county's 35% is based on what the hospital would be paid without being exempt, which is considerably less than the exempt rate. For each exempt hospital, AHCA calculates both an exempt rate and a non-exempt rate. A hospital's non-exempt rate is commonly known as the "county billing rate," or the "county rate."

Legislative Rate Cuts
Beginning in 2005, the Legislature began reducing rates for many Medicaid providers, including hospitals, to help balance the overall state budget. The GAA has included seven cuts to hospital rates and the hospital inpatient line item since 2005-06, for an average of about 4% for each cut. The current-year rate cut was the most severe at approximately 12.5%. According to AHCA, these cuts collectively amount to about 25.3% for inpatient and about 22.4% for outpatient. In its rate-setting methodology, AHCA refers to these cuts as "Medicaid Trend Adjustments," and each cut has been applied separately whenever new hospital rates have been calculated based on each year's most recent cost reports.

IGTs to "Buy Back" the Rate Cuts

In 2007 the GAA included proviso to use IGTs and federal match to reinstate rate reductions for hospitals whose Medicaid and charity days exceeded 30% and had more than 10,000 Medicaid days, and for hospitals or hospital systems that established a provider service network (PSN) during the prior state fiscal year. This was the precursor for what is known as "buying back" the rate cuts.

Beginning in 2008, the Legislature began passing proviso in the GAA allowing certain hospitals to use additional IGTs (above and beyond the IGTs used to fund exemptions) to "buy back" all or a portion of the rate cuts imposed by the GAA in the 2008-09 fiscal year and in prior years. In this way, certain hospitals would not be paid less due to the Legislative rate cuts if local IGTs could be secured to offset the effect of the rate cuts. In the first year that "buy-backs" were implemented (2008-09), they were applied to the following hospitals:

- Hospitals that were part of a system that operates a PSN, including Jackson Memorial, hospitals in Broward Health, hospitals in Memorial Healthcare System, Shands Jacksonville, and Shands Gainesville;
- Children's specialty hospitals whose Medicaid and charity days equaled or exceeded 30%;
- Rural hospitals; and
- Public hospitals, teaching hospitals that had 70 or more resident physicians, and hospitals whose Medicaid and charity days exceeded 25%.

In 2009, designated trauma hospitals were added to the list of hospitals allowed to use IGTs to buy back their rate cuts. In 2010, hospitals with graduate medical education positions that did not otherwise qualify were added to the list.

For 2011-12, several changes were made in the GAA relating to inpatient buy-backs, including:

- Proviso language similar to prior years (along with specific spending authority for IGTs and federal match) relating to buy-backs for public hospitals, teaching hospitals that had 70 or more resident physicians, designated trauma hospitals, and hospitals with graduate medical education positions, was left in place.
- In addition to the proviso above, proviso was included to allow all other hospitals to use up to $161 million in IGTs and $204 million in federal match to buy back their inpatient and outpatient rate cuts, assuming IGTs could be secured.

Potential Application and Effect of IGTs Has Grown

When exemptions and buy-backs were first implemented, they were limited in scope for certain hospitals meeting certain criteria. Over the years, their scope has gradually expanded. With the language in the 2011-12 GAA, IGTs can theoretically be used to (1) apply exemptions to any hospital in the state and (2) buy back the Legislative rate cuts for any hospital. In order to do so, however, IGTs must be secured to pay the non-federal share, and the spending authority designated in the GAA may not be exceeded.

The Effect of Exemptions and Buy-backs on Medicaid Prepaid Health Plan Capitation Rates
Hospital exemptions and buy-backs are almost exclusively funded with IGTs and federal match, not GR. The dollars for exemptions and buy-backs are specifically applied directly to hospital reimbursement through inpatient per diems or outpatient claims.

These IGT-augmented hospital payments have an effect on the capitations paid by the state to Medicaid prepaid health plans. Hospital costs account for at least one-third of the capitation the state pays to the health plans, so when the state pays augmented rates to hospitals via fee-for-service, regardless of the funding source, those higher hospital payments cause the state's payments to prepaid health plans to rise also.

Unlike exemptions and buy-backs that are funded with IGTs and federal match, capitations for prepaid health plans are funded with state revenue and federal match. So, while the use of IGTs allows the state to hold hospital rates harmless from ceilings and rate cuts – and to do so without directly spending state revenue – those policies can still increase state revenue expenditures by increasing capitations for prepaid plans.

The Legislature sought to partially address this issue in the 2010-2011 and 2011-2012 GAAs by passing proviso language to prevent the AHCA from automatically including a portion of the IGTs and federal match for exemptions and buy-backs into the calculation of capitation rates for Medicaid prepaid health plans, unless IGTs were secured for that purpose. In the 2011-12 GAA, AHCA was directed to exclude up to $366 million used for hospital buy-backs, and to exclude up to $493 million used for hospital exemptions, when calculating capitations for prepaid plans. This proviso was intended to reduce the need for GR to fund hospital costs embedded in prepaid health plan capitations.

Despite the proviso, however, capitation rates for prepaid health plans are required by federal law to be actuarially sound. For 2010-11 alone, when actuaries analyzed data showing dollars paid by prepaid plans to hospitals, the use of IGTs for hospital buy-backs resulted in the need for $161 million in state GR for prepaid health plans to account for those IGT-augmented hospital costs.

Frequency of Hospital Rate-setting

In 2011, the Legislature directed the AHCA to move to an annual rate-setting cycle for hospitals, effective July 2011. The prior standard had been twice annually – once in July and once in January, resulting in two "rate semesters" per year. In addition, the AHCA was directed in 2011 to establish a deadline of September 30 beyond which hospital rates could not be adjusted until the next fiscal year. The deadline requires that the AHCA must execute letters of agreement (LOAs), or promissory notes, for hospital-related IGTs no later than September 30 for any state fiscal year in order for the IGTs to be effective during that fiscal year.

Diagnosis Related Group (DRG) System for Hospital Reimbursement

DRG is a type of prospective payment system for reimbursing hospital inpatient services that provides an alternative to cost-based per diem reimbursement. DRGs classify an inpatient stay into a group based on the patient's diagnoses, sex, age, and other factors which can include costs

of labor, hospital case mix, and overall wellness or acuity of the population. When demographics and external factors that affect cost are considered, groups of related diagnoses are designed to provide a stable and fairly predictable indication of the resources needed for treating a particular patient. This type of system is used in Medicare and seeks to tailor reimbursement more closely to actual costs of treatment for each individual patient.

Disproportionate Share Hospital (DSH) Program

Each year the Low-Income Pool Council (LIP Council) makes recommendations to the Legislature on the Medicaid Disproportionate Share Hospital Program's funding distributions to hospitals that provide a disproportionate share of the Medicaid or charity care services to uninsured individuals. However, the Legislature delineates how the funds will be distributed to each eligible facility.

There are currently five separate Medicaid disproportionate share programs that are operational in Florida. The programs are: the original program (Regular DSH) established in s. 409.911, F.S.; the Teaching Hospital DSH program established in s. 409.9113, F.S.; the Mental Health Hospital DSH program established in s. 409.9115, F.S.; the Rural Hospital/Financial Assistance DSH program established in s. 409.9116, F.S.; and the Specialty Hospital DSH program established in s. 409.9118, F.S.

Additionally, there are three separate Medicaid DSH programs that are listed in law but are not operational at this time. The programs are as follows: the Regional Perinatal Intensive Care Center (RPICC) DSH program established in s. 409.9112, F.S.; the Primary Care DSH program established in s. 409.9117, F.S.; and the Specialty Hospitals for Children DSH program established in s. 409.9119, F.S.

The Regional Perinatal Intensive Care Centers (RPICC) DSH Program

The RPICC Program was established in 1974 and is a comprehensive, statewide, perinatal health care delivery system administered by Children's Medical Services in the Department of Health. The RPICC Program provides obstetrical services to women identified as having high-risk pregnancies, and neonatal intensive care services to critically ill/low birth-weight newborns. The ultimate goal of the RPICC Program is to improve the immediate and long-term outcomes for pregnancy and infants born at risk.

The RPICC DSH program was implemented in 1991. The program distributed approximately $7.3 million in fiscal year 2003-2004 to qualifying hospitals, which was the final year of payments under the program. To qualify for a RPICC DSH payment, a hospital would satisfy the Regular DSH criteria and then meet several programmatic requirements pertaining to neonatal intensive care and high-risk maternity care. Eleven hospitals received a RPICC DSH distribution each year between 1991-1992 and 2003-2004. The statute was amended in 2005 to prohibit payments in fiscal year 2005-2006. The Legislature has amended statute each year since then to prohibit further payments on a year-by-year basis.

The Primary Care DSH Program

The Primary Care DSH Program was implemented in July 1997 and distributed approximately $10.6 million in fiscal year 2003-2004 to qualifying hospitals, which was the final year of payments under the program. The purpose of this program was to provide supplemental payments to hospitals that had established a network for providing health care to uninsured individuals within a geographic boundary. The statute was amended in 2005 to prohibit payments in fiscal year 2005-2006. The Legislature has amended statute each year since then to prohibit further payments on a year-by-year basis.

Medicaid Managed Care

Managed care in the state Medicaid program began in 1982 when the Palm Beach County Public Health Unit began operating the first Medicaid managed care plan. In 1984 Florida was selected as one of five states to receive a federal waiver to implement a program to create a statewide, mandatory managed care system to provide for more efficient and effective service delivery that would enhance quality of care for certain eligibility groups.

Roughly two-thirds of Florida's Medicaid recipients are currently enrolled in some form of managed care program for primary and acute care services. Florida has authorized at least 15 different managed care models, including primary care case management (PCCM), provider service networks (PSNs), health maintenance organizations (HMOs), minority physician networks (MPNs), prepaid behavioral health plans (PBHPs), prepaid dental plans (PDHPs), the capitated nursing home diversion (NHD) waiver, and pediatric emergency room (ER) diversion programs. Some managed care models are designed to deliver comprehensive care while others are limited to specialty care. Florida operates most of its Medicaid managed care programs through a section 1915(b) waiver obtained from the federal CMS in 1990. The AHCA is responsible for administering these managed care programs, sometimes in conjunction with other state agencies.

Florida Medicaid uses two main methods of payment within managed care. When services are delivered to recipients and billed to the state on an individual or itemized basis, payment is made via "fee-for-service" (FFS), i.e. payment is made for each service after the service has been rendered and the state has been billed. Conversely, the state also contracts to make payments on a prepaid basis, which results in a fixed, lump-sum payment per recipient, typically made on a monthly basis, designed to cover services needed in the aggregate for any given month in a 12-month period. Such a fixed, prepayment is known as a "capitation."

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering all covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitated entities, often referred to as prepaid health plans or prepaid plans, sometimes assume full risk, i.e. the coverage is comprehensive with no mitigation factors for the risk assumed, and others assume partial risk, i.e. the coverage is limited as opposed to comprehensive and/or the risk may be mitigated by loss prevention or shared-savings arrangements. Capitation is designed to provide the state with less risk and more predictability for Medicaid spending and to incent the capitated entities to manage the provision of services in a cost-effective manner.

The AHCA is charged by statute with developing capitation rates for managed care plans by administrative rule. The rule is designed to represent a discount from what the state would otherwise pay for the same services provided to comparable populations on a fee-for-service basis. Capitation rates must be certified as actuarially sound by a third-party actuary in compliance with federal guidelines.

MediPass

The Medicaid Provider Access System (MediPass) is a managed care program consisting of a PCCM system established in 1991. MediPass is available statewide to all Medicaid recipients who are eligible for managed care except for most recipients in the five-county Medicaid Managed Care Pilot Program[7] (Medicaid Reform pilot). MediPass was designed to provide Medicaid recipients with coordinated primary care while decreasing the inappropriate utilization of medical services. The state contracts with a health care provider – usually the recipient's primary care physician (PCP) – to provide basic care and to coordinate any needed specialty care or other services furnished by other physicians or providers. However, MediPass enrollees are not required to consult with their PCP before obtaining other services. The MediPass PCP is paid a case management fee per person per month, and the PCP's services, as well as services from other providers, are paid for by the state on a fee-for-service basis. MediPass is managed care but is administered at the individual provider level, not by a managed care organization or managed care plan.

Provider Service Networks

A PSN in the Medicaid program is a managed care plan that is majority-owned and operated by Florida health care providers, such as hospitals, physician groups, and/or federally qualified health centers. The PSN program began in 1997 when the Legislature authorized the Florida Medicaid program to establish a Medicaid PSN demonstration project to capitalize on high-volume Medicaid providers and their ability to manage the medical care of Medicaid recipients they serve. The first Medicaid PSN became operational by 2000.

The initial PSN contract was awarded by competitive bid. The AHCA currently awards PSN contracts based on an open application process, meaning the AHCA will offer a PSN contract to every applicant that applies for and meets the state's standards for a Medicaid PSN contract. The AHCA is authorized to pay PSNs a capitation if the PSN chooses to assume financial risk, or services rendered to PSN members may be paid on a fee-for-service basis. Fee-for-service PSNs are paid monthly primary care case management fees, as well as administrative allocations per member. Florida Statutes direct the AHCA to conduct periodic financial reconciliations to determine cost-savings. PSNs in the Medicaid program are required to demonstrate cost effectiveness. If cost savings do not occur, the PSN may be required to refund a portion of the payment it receives through its monthly administrative allocations.

Health Maintenance Organizations

The AHCA is authorized to contract with HMOs for the provision of services to Medicaid recipients. Medicaid HMOs are required to be licensed by the Office of Insurance Regulation

[7] The Medicaid Managed Care Pilot Program began in 2006 and is currently implemented in Baker, Broward, Clay, Duval, and Nassau counties.

(OIR) under ch. 641, F.S. The AHCA typically contracts with HMOs in an open application process for the provision of comprehensive health coverage to Medicaid recipients who become HMO members. HMOs are paid a fixed capitation to assume full financial risk for delivering a set of comprehensive primary and acute care services. HMOs are expected to employ managed care principles in order to achieve cost effectiveness and to eliminate overutilization, fraud, and abuse, while providing for all covered, medically necessary services. Like commercial HMOs, Medicaid HMOs are subject to regulations and solvency standards required by OIR for HMO licensure.

Medicaid Managed Care Choice and Assignment Process

Under current Florida law,[8] some Medicaid recipients are required to enroll in one of a number of managed care options. Other recipients are not required to enroll in managed care but may do so voluntarily. A third group of recipients are prohibited from enrolling in managed care. Under those parameters, Medicaid recipients are sometimes referred to as "mandatory", "voluntary," or "excluded," respectively, regarding managed care enrollment.

Regulations determining who is mandatory, voluntary, or excluded differ slightly between the Medicaid Reform pilot counties and the other 62 non-Reform counties. However, for "mandatory" recipients under either program, the opportunities for choice and the procedures for assignment to a managed care option are the same.

Medicaid recipients have several opportunities to select a managed care option. In general, a recipient can make a choice:

- Upon initially becoming eligible for Medicaid;
- During the 90-day period after choosing a managed care option, without cause;
- Anytime after the 90-period, with good cause[9]; and
- Annually during a 30-day enrollment period.

When someone becomes Medicaid eligible and is determined to be mandatory for enrollment in managed care, the recipient is notified that he or she has a month in which to select a managed care option. If the recipient fails to choose a managed care option, they are assigned to one through the AHCA's assignment process. In the 62 non-Reform counties, mandatory recipients may select either MediPass or a managed care plan – if a managed care plan is participating in the recipient's county of residence[10] – during the initial enrollment period. In Medicaid Reform pilot counties, mandatory recipients must select either a prepaid health maintenance organization, a prepaid provider service network (PSN), or a fee-for-service PSN, depending on which options are available in a recipient's county of residence.

After initial managed care plan or MediPass enrollment, whether through selection or assignment, all recipients have a 90-day window to disenroll from their choice and select a new option for any reason. Following the 90-day window, most recipients are locked into their choice

[8] *See* ss. 409.9122 and 409.91211, F.S.
[9] *See* ss. 409.9122(2)(i) and 409.91211(4)(e), F.S.
[10] At least one managed care plan is participating in Medicaid in 48 of the 62 non-Reform counties, according to data available at the AHCA web site. *See* < http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/med_data.shtml >

for the remainder of the year unless the recipient has a "good cause" for disenrollment prior to their next annual enrollment period. All recipients enrolled with a managed care plan or MediPass are annually provided with a 30-day enrollment period during which they can choose to remain with their current option or select any other managed care option available to them. During the annual enrollment period, recipients who fail to choose a new option remain enrolled in the option in which they had previously been enrolled.

County Contributions to Medicaid

Chapter 72-225, Laws of Florida, created s. 409.267, F.S., which required county participation in the cost of certain services provided to county residents through Florida's Medicaid program. In 1991, s. 409.267, F.S., was repealed and replaced with s. 409.915, F.S., which provides that the state shall charge counties for certain items of care and service. Counties are required to reimburse the state for:

- 35% of the cost of inpatient hospitalization in excess of 10 days, not to exceed 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program, and for adult lung transplant services; and
- 35% of the cost of nursing home or intermediate facilities in excess of $170 per month, limited to $55 per resident per month, with the exception of skilled nursing care for children under age 21.

Counties are required to set aside funds to pay for their share of the cost of certain Medicaid services based upon statements provided by the AHCA. The AHCA provides counties with a monthly bill listing Medicaid residents for which the county is responsible for paying. Counties review the information to verify the individuals' county of residence and determine whether the bill is accurate. If the county determines that the bill is correct, it remits a payment to the AHCA that is deposited into the General Revenue Fund.

If a county determines that an individual for which it has been billed is not a county resident, the amount of the bill is denied and returned to the AHCA. The AHCA researches each rejected bill and provides additional documentation to the county to support its original determination of residency or identifies another county that should be billed. This process continues until the county pays the bill, another county is billed for the individual in question, or until the AHCA determines that the cost cannot be billed to a specific county. The majority of disputes with the AHCA are over determining the correct county of residence.

Backlog of Past Due Billings

As of December 31, 2011, unpaid billings from all counties totaled $325.5 million. This amount includes bills that have been disputed by a county, researched by the AHCA and rebilled, and are awaiting payment by the counties. For the period from state fiscal year 1994-1995 through 2006-2007, county contributions to Medicaid collections totaled approximately 93 percent of total billings in any fiscal year. Each fiscal year since 2007-2008, county contributions to Medicaid collections have dropped to less than 90 percent of total billings, with only 64.7 percent of billings billed in 2010-2011 being paid in that year. The decline in amount of billings collected has resulted in the backlog of past due billings.

County Revenue Sharing Program[11]
The Florida Revenue Sharing Act of 1972 was a major attempt by the Legislature to ensure a minimum level of revenue parity across units of local government.[12] Provisions in the enacting legislation created the Revenue Sharing Trust Fund for Counties. Currently, the Trust Fund receives 2.9 percent of net cigarette tax collections and 2.044 percent of sales and use tax collections.[13] An allocation formula serves as the basis for the distribution of these revenues to each county that meets the strict eligibility requirements. The county revenue sharing program is administered by the Department of Revenue (DOR) and monthly distributions are made to the eligible counties.

There are three categories of shared revenues received by the counties, including the guaranteed entitlement, the second guaranteed entitlement, and a third category which includes an adjustment for growth in revenues. The guaranteed entitlement is equal to the aggregate amount received from the state in fiscal year 1971-1972 under then-existing statutory provisions. The second guaranteed entitlement is equal to the aggregate amount received from the state in fiscal year 1981-1982 under then-existing statutory provisions minus the guaranteed entitlement. The revenue is adjusted so that all counties receive at least their minimum entitlement, which means the amount of revenue necessary for a county to meet its obligations as a result of pledges, assignments, or trusts entered into which obligated Trust Fund monies. Finally, after making these adjustments, any remaining Trust Fund monies shall be distributed on the basis of additional revenue of each qualified county in proportion to the total additional revenues for qualified counties.

There are no restrictions on the use of these revenues other than a statutory limitation regarding funds that can be used as a pledge for indebtedness. Chapter 218.25, F.S., restricts the amount of funds that can be pledged for bonded indebtedness. Counties are allowed to pledge the guaranteed entitlement proceeds.[14] Additionally, the second guaranteed entitlement may also be assigned, pledged, or set aside as a trust for the payment of principal or interest on bonds, tax anticipation certificates, or any other form of indebtedness.[15] However, a county may only assign, pledge, or set aside as a trust for the payment of principal or interest on bonds, tax anticipation certificates, or any other form of indebtedness, an amount up to 50 percent of the funds received in the prior year.[16]

[11] A full description including tables providing estimates of distributions to counties from the county revenue sharing program can be found in the 2011 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic Research, 2011 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at http://edr.state.fl.us/Content/local-government/reports/lgfih11.pdf
[12] Chapter 72-360, L.O.F.
[13] Sections 212.20(6)(d)4. and 210.20(2)(a), F.S.
[14] Section 218.25(1), F.S.
[15] Section 218.25(2), F.S.
[16] Section 218.25(4), F.S.

Local Government Half-Cent Sales Tax Program[17]

Authorized in 1982, the local government half-cent sales tax program generates the largest amount of revenue for local governments among the state-shared revenue sources currently authorized by the Legislature.[18] The program distributes a portion of state sales tax revenue via three separate distributions to eligible county or municipal governments. Additionally, the program distributes a portion of communications services tax revenue to eligible local governments. Allocation formulas serve as the basis for these separate distributions. The program's primary purpose is to provide relief from ad valorem and utility taxes in addition to providing counties and municipalities with revenues for local programs.

The program includes three distributions of state sales tax revenues collected pursuant to ch. 212, F.S. The ordinary distribution to eligible county and municipal governments is possible due to the transfer of 8.814 percent of net sales tax proceeds to the Local Government Half-cent Sales Tax Clearing Trust Fund.[19] The emergency and supplemental distributions are possible due to the transfer of 0.095 percent of net sales tax proceeds to the Trust Fund.[20] The emergency and supplemental distributions are available to select counties that meet certain fiscal-related eligibility requirements or have an inmate population of greater than seven percent of the total county population, respectively.

As of July 1, 2006, the program includes a separate distribution from the Trust Fund to select counties that meet statutory criteria to qualify as a fiscally constrained county.[21] A fiscally constrained county is one that is entirely within a rural area of critical economic concern as designated by the Governor pursuant to s. 288.0656, F.S., or for which the value of one mill of property tax levy will raise no more than $5 million in revenue based on the taxable value certified pursuant to s. 1011.62(4)(a)1.a., F.S. This separate distribution is in addition to the qualifying county's ordinary distribution and any emergency or supplemental distribution.

The half-cent sales tax distribution formula is determined annually based on population figures that are established as of April 1 for the state fiscal year beginning July 1. The DOR makes monthly distributions from the Local Government Half-cent Sales Tax Clearing Trust Fund to participating counties.

A county is also authorized to pledge the proceeds for payment of principal and interest on any capital project.[22] For any eligible county receiving a fiscally constrained distribution, the revenues may be used for any public purpose, except to pay debt service on bonds, notes, certificates of participation, or any other forms of indebtedness.[23]

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[17] A full description including tables providing estimates of distributions to local governments from the half-cent sales tax program can be found in the 2011 Local Government Financial Handbook. See Florida Legislature, Office of Economic and Demographic Research, 2011 LOCAL GOVERNMENT FINANCIAL INFORMATION HANDBOOK, available online at http://edr.state.fl.us/Content/local-government/reports/lgfih11.pdf

[18] Chapter 82-154, L.O.F.

[19] Section 212.20(6)(d)2., F.S.

[20] Section 212.20(6)(d)3, F.S.

[21] Section 218.67, F.S.

[22] Section 218.64(2), F.S.

[23] Section 218.67(5), F.S.

The estimated state revenues shared with counties for fiscal year 20011-2012 are:

- Local Government Half-cent Sales Tax – $1,056.6 million
- County Revenue Sharing - $338.8 million

Medicaid Home and Community Based Services Waiver Program

In 1981, the U.S. Congress approved the use of Medicaid home and community-based-services (HCBS) waiver programs to allow states to provide certain Medicaid services in the home for persons who would otherwise require institutional care in a hospital, nursing facility, or intermediate care facility. These programs are federally-approved Medicaid initiatives authorized by Title XIX of the Social Security Act, Section 1915.

The HCBS waiver programs are initially approved for three years and may be renewed at five-year intervals. If a state terminates an HCBS waiver, federal law requires that recipients receive continued services in an amount that does not violate the comparability of service requirements established in the Social Security Act. In effect, the state has to transition recipients into programs with comparable services. Florida currently operates 15 home and community-based-services waiver programs.

The Adult Day Health Care Waiver program, initially implemented in April 2004, is designed to meet the health and supportive needs of adults with functional and/or cognitive impairments through an individual plan of care implemented at an adult day health care center. This program serves adults who are physically impaired or mentally confused and may require supervision, increased social opportunities, and assistance with personal care or other daily living activities. Adult day health care services allow frail elders to remain in their home or community instead of going to a nursing facility.

The Adult Day Health Care Waiver program is available only to residents of Lee County. Currently, there are approximately 25 recipients enrolled in this waiver program, and it is set to expire in March 2012. It is anticipated that the 25 recipients will choose to transition into either the Nursing Home Diversion Waiver or the Aged and Disabled Adult Waiver programs. Both programs offer comparable services.

Pilot Project to Monitor Home Health Services

The AHCA has implemented a Pilot Project to Monitor Home Health Services[24] which utilizes voice recognition technology (telephony) to ensure home health worker visits occur as reported. The telephony pilot became effective July 1, 2010. This project ensures that home health nurses and aides actually go to the homes of recipients that have been prior-authorized to receive home health visits and actually provide the services outlined in the recipients' plans of care. It ensures that home health service providers receive reimbursement only for services actually provided. The project utilizes Interactive Voice Response Authentication (IVRA) technology to verify the presence of a direct-care home health service provider in the recipient's home.

[24] See s. 31, ch. 2009-223, LOF, and s. 44, ch. 2010-151, LOF.

Pilot Project for Home Health Care Management

The AHCA implemented the Comprehensive Care Management Pilot Project[25] on July 1, 2010. The purpose of this home health pilot project is to identify potential overutilization and potential fraud or abuse of Medicaid services and to ensure that the level of services provided match the needs of the recipients. An AHCA contractor performs a minimum of 250 home visits each month. During those visits, a nurse performs a face-to-face assessment of the recipient. The results of the assessment are then compared against documentation provided by the home health agency and/or prescribing physician during the prior-authorization process.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing. The model was tested through CMS demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers.

For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than receiving services in other more costly long term care settings. Capitated financing allows providers to deliver all the services that participants need rather than being limited to those services reimbursable under the Medicare and Medicaid fee-for-service systems.

The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide the PACE services to Medicaid recipients as a state option without a Medicaid waiver. The state plan must include PACE as an optional Medicaid benefit before the state and federal governments can enter into program agreements with PACE providers.

A PACE organization is a not-for-profit private or public entity that is primarily engaged in providing the PACE services and must:

- Have a governing board that includes community representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have demonstrated fiscal soundness; and
- Have a formal participant bill of rights.

The PACE project is a unique federal/state partnership. The federal government establishes the PACE organization requirements and application process. The state Medicaid agency or other state agency is responsible for oversight of the entire application process, which includes reviewing the initial application and providing an on-sight readiness review before a PACE

[25] See s. 32, ch. 2009-223, LOF.

organization can be authorized to serve patients. An approved PACE organization must sign a contract with the CMS and the state Medicaid agency.

Florida PACE Project
The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in Chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care. The PACE project is administered by the Department of Elder Affairs in consultation with the AHCA.

In addition to receiving the necessary legislative authority, the development of a new PACE organization or the expansion of an existing program is a lengthy process that includes: identifying a service area, acquiring and renovating a PACE facility, and processing the PACE application through the state and the federal review systems.

III. Effect of Proposed Changes:

Section 1 amends s. 383.15, F.S., relating to perinatal intensive care services, to conform to the repeal of the RPICC DSH program under Section 6 of the bill.

Section 2 amends s. 409.902, F.S., relating to a designated single state agency for Medicaid:

- Directs, to the extent funds are appropriated, the DCF to collaborate with the AHCA to develop a system for eligibility determination for Medicaid and Kidcare that complies with all applicable federal and state laws and requirements. The AHCA must complete a feasibility study of two alternative methods of compliance and submit a system development plan to the Legislative Budget Commission for approval. The system must be completed by October 1, 2013 and be ready for implementation by January 1, 2014.
- In addition to timely and accurately enrolling individuals in public assistance programs, directs that the system must provide a single point of access to information that explains benefits, premiums, and cost-sharing available through Medicaid, Kidcare, or any state or federal health insurance exchange, prevent eligibility fraud, and provide fiscal analysis of eligibility cost drivers.
- Requires the system to have the following functionalities: allow completion and submission of an online application for eligibility determination that includes the use of electronic signatures; automatic enrollment of qualified individuals in Medicaid, Kidcare, or other state or federal exchanges; determination of Medicaid eligibility that is based on the Modified Adjusted Gross Income; determination of specific categories of Medicaid eligibility and interface with the FMMIS to support a determination; and production of transaction data, reports, and performance information.
- Designates the Director of Economic Self-Sufficiency for the DCF as having overall responsibility for the project. The project will be governed by an executive steering committee that comprises three staff members of the DCF appointed by the DCF Secretary, three staff members of the AHCA, including at least two Medicaid program staff, appointed by the AHCA Secretary, and one staff member of Children's Medical

Services within the Department of Health appointed by the Surgeon General. The executive steering committee will have the overall responsibility for ensuring that the project meets its primary business objectives. If the executive steering committee determines that the primary business objectives cannot be achieved, it shall recommend suspension or termination of the project to the Governor, President of the Senate, and Speaker of the House of Representatives.

Section 3 amends s. 409.905, F.S., relating to mandatory Medicaid services:

- Limits the number of paid hospital emergency department visits for non-pregnant adults to six per fiscal year.
- Authorizes the AHCA to request the Legislative Budget Commission (LBC) to approve adjustments to hospital rates when needed, including after the September 30 deadline, due to insufficient commitments or collections of IGTs.
- Revises the AHCA's time frames for developing a plan to transition the state's cost-based reimbursement system for hospital inpatient fees to a DRG system. The plan must provide detailed definitions, descriptions, and payment estimates. The AHCA is required, through a competitive procurement, to engage an experienced consultant to develop the plan and to report to the LBC on the development of the plan under certain conditions.

Section 4 amends s. 409.908, F.S., relating to reimbursement of Medicaid providers:

- Specifies that the AHCA may continue to accept voluntary IGTs for the purpose of funding the costs of special Medicaid payments to hospitals, the costs of exempting hospitals from reimbursement ceilings, or the costs of buying back hospital Medicaid trend adjustments authorized under the GAA, except that the use of these IGTs for fee-for-service payments to hospitals is limited to the proportionate use of such funds accepted by the AHCA for covering those hospital costs within prepaid health plan capitations. "Proportionate use" means that the use of IGT funds for fee-for-service hospital costs must be in the same proportion to the use of such funds in prepaid health plan capitations, relative to the need for funding hospital costs via each payment system.
- Prohibits the AHCA, effective September 1, 2012, from including the costs of special Medicaid payments to hospitals, the costs of exempting hospitals from reimbursement ceilings, or the costs of buying back hospital Medicaid trend adjustments authorized under the GAA, when those costs are funded through IGTs, in the calculation of capitations for prepaid health plans. Requires this prohibition to be construed so that inpatient hospital costs included in the calculation of prepaid health plan capitations are identical to county billing rates for hospital costs.
- Prohibits Medicaid prepaid health plans, effective September 1, 2012, from reimbursing hospitals for the costs of special Medicaid payments to hospitals, the costs of exempting hospitals from reimbursement ceilings, or the costs of buying back hospital Medicaid trend adjustments authorized under the GAA, when those costs are funded through IGTs, except that prepaid plans may contract with hospitals to pay inpatient per diems that are between 95 percent and 105 percent of county billing rates, and hospitals and prepaid plans may negotiate mutually acceptable higher rates for medically complex care.
- Notwithstanding the prohibitions above that become effective September 1, 2012, authorizes the AHCA to accept voluntary IGTs in order to fund the inclusion of the costs of special Medicaid payments to hospitals, the costs of exempting hospitals from

reimbursement ceilings, or the costs of buying back hospital Medicaid trend adjustments authorized under the GAA, when calculating capitation rates for prepaid health plans. Requires the AHCA, after securing such IGT commitments for that purpose, to develop prepaid plan capitations including those costs if those components of the capitations are funded with IGTs and not with GR. The methodology must preserve federal match for the IGTs and result in actuarially sound rates. Requires that amounts included in a prepaid plan's capitations for this purpose must be used exclusively to enhance hospital payments and be calculated by the AHCA as accurately as possible to equal the hospital costs in question.

- Relocates a statutory provision regarding Medicaid reimbursement from s. 409.9122, F.S., to s. 409.908, F.S.

Section 5 amend s. 409.911, F.S., relating to hospital disproportionate share, to remove a reference to a statute being repealed under Section 6 of the bill and to update the dates in the Regular DSH program.

Section 6 repeals s. 409.9112, F.S., relating to the RPICC DSH program.

Section 7 amends s. 409.9113, F.S., to authorize payment for the DSH program for teaching hospitals.

Section 8 repeals s. 409.9117, F.S., relating to the primary care DSH program.

Section 9 amends s. 409.912, F.S., relating to cost-effective purchasing of health care, to conform to changes in the AHCA's managed care assignment process being made in Section 11 of the bill.

Section 10 amends s. 409.9121, F.S., relating to legislative intent for Medicaid managed care, to conform to changes in the AHCA's managed care choice and assignment processes being made in Section 11 of the bill.

Section 11 amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment:

- Provides that a Medicaid recipient who is required to enroll in managed care and who resides in a county in which two or more managed care plans are accepting Medicaid enrollees, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, will be given a choice from among those managed care plans, not MediPass. A recipient residing in a county in which only one plan is eligible to accept Medicaid enrollees will be given a choice of the plan or a MediPass provider. A recipient residing in a county in which no managed care plan is accepting Medicaid enrollees will choose a MediPass provider.[26]
- Provides that when a Medicaid recipient who is required to enroll in managed care and who resides in a county in which one or more managed care plans are accepting Medicaid

[26] Currently there are 32 non-Reform counties in which two or more managed care plans are accepting Medicaid enrollees, there are 16 non-Reform counties in which only one managed care plan is accepting Medicaid enrollees, and there are 14 non-Reform counties in which no managed care plan is accepting Medicaid enrollees, according to data available at the AHCA's web site. *See* <http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/med_data.shtml >

enrollees, fails to choose a managed care option, then the AHCA must assign the recipient, including a recipient who was enrolled in MediPass at the commencement of his or her 30-day choice period, to a managed care plan, not MediPass. A recipient who fails to choose a managed care option and who resides in a county in which no managed care plan is accepting Medicaid enrollees will be assigned to a MediPass provider.

- Provides that if a managed care plan reaches its enrollment capacity, as determined by the AHCA, the plan may not enroll or be assigned additional Medicaid enrollees until the AHCA determines that the plan's enrollment is sufficiently less than its enrollment capacity, due to a decline in enrollment or by an increase in enrollment capacity. If a plan notifies the AHCA of its intent to exit a county, the plan must not enroll or be assigned additional Medicaid enrollees in that county before the exit date.
- Provides that the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by statute or the GAA.
- Requires the AHCA to maintain MediPass provider networks in all counties, including those in which two or more managed care plans are accepting Medicaid enrollees.
- Provides that the changes to the AHCA's managed care choice and assignment processes contained in the bill will be applied in the 62 non-Reform counties, not in counties in which the Medicaid Reform pilot is being implemented.
- Provides that the changes to the AHCA's managed care choice and assignment processes contained in the bill pertain only to "mandatory" managed care recipients. The bill does not require recipients who are voluntary or excluded from managed care under current law to enroll in managed care.
- Directs the AHCA to seek a state plan amendment or federal waiver authority, as needed, to implement the bill's revisions to the managed care choice and assignment processes.

Section 12 amends s. 409.9123, F.S., relating to quality-of-care reporting, to conform to changes in the AHCA's managed care choice and assignment processes being made in Section 11 of the bill.

Section 13 reenacts s. 409.9126(1), F.S., relating to children with special health care needs, to prevent changes being made to the AHCA's managed care choice and assignment processes, contained in Section 11 of the bill, from superseding the provision in s. 409.9126(1), F.S., that exempts children eligible for the Children's Medical Services program from s. 409.9122, F.S.

Section 14 amends s. 409.915, F.S., relating to county contributions to Medicaid:

- Provides that the AHCA shall determine each county's eligible recipients by using recipient address information contained in the federally approved Medicaid eligibility system within the DCF. If the Medicaid eligibility system's address information may indicate a need for revision, counties may apply for a refund of future billings.
- Provides that 85% of each county's billings that remain unpaid as of April 30, 2012, shall be deducted from the county's monthly revenue sharing distribution over a three-year period, starting with the October 2012 distribution. The past due billings for each county will be spread equally over a 36 month period. However, the reduction in the county's revenue sharing distribution may not exceed 50% of each county's distribution. If after

36 months, the reductions for each county do not equal the total amount initially certified by the AHCA, DOR shall continue to reduce each distribution by up to 50% until the total amount certified is reached. The amounts by which the distributions are reduced are transferred to the General Revenue Fund.

- Provides that beginning May 1, 2012, and each month thereafter, AHCA shall certify to DOR the amount of monthly statements rendered to each county based on each county's eligible recipients. DOR shall reduce each county's monthly distribution from the Local Government Half-Cent Sales Tax Trust Fund by the amount certified by AHCA. The amounts by which the distributions are reduced are transferred to the General Revenue Fund.
- Since half of the county revenue sharing revenues can be bonded and all of the half cent revenues can be bonded, the bill creates an assurance to bondholders for bonds issued before the effective date of the bill. The distributions to a county will not be reduced below the amount necessary for the payment of principal and interest required under the covenants of any bond resolution for any county that can demonstrate to DOR that it will be unable to pay debt service on such bonds.
- Allows counties to submit written requests for refunds using a process developed by the AHCA and the DOR. After a refund is submitted, AHCA shall make a determination whether a refund request is appropriate and should be approved. If approved, the AHCA shall certify to the DOR the amount of the refund and the DOR is required to issue the refund from the General Revenue Fund. The refund process does not apply to billings that remain unpaid as of April 30, 2012 (past due billings).
- Provides for transfers from the General Revenue Fund to the Lawton Chiles Endowment Fund in fiscal year 2013-2014 through fiscal year 2020-2021. The transfer shall equal the amounts transferred to the General Revenue Fund in the previous fiscal year from deductions due to billings for county contributions to Medicaid which are in excess of the official estimate for medical hospital fees for such previous fiscal year adopted by the Revenue Estimating Conference on January 12, 2012. By July 20 of each year, the Office of Economic and Demographic Research shall certify the amount to be transferred to the Chief Financial Officer. The transfer must occur prior to July 31 of each year until the total transfers for all years equals $265 million.
- Provides that this section of the bill is effective upon becoming law.

Sections 15 and 16 amend ss. 409.979 and 430.04, F.S., respectively, to remove references to the Adult Day Health Care Waiver, which is expiring in 2012 and will not be renewed.

Section 17 amends s. 31, ch. 2009-223, Laws of Florida, as amended, and redesignates the section as s. 409.9132, F.S., to expand statewide the Pilot Project to Monitor Home Health Services and to authorize the AHCA to exclude from the expansion those counties in which the program will not be cost effective.

Section 18 amends s. 32, ch. 2009-223, Laws of Florida, and redesignates the section as s. 409.9133, F.S., to expand statewide the Pilot Project for Home Health Care Management, to add personal care services and private duty nursing to the services under review, and to authorize the AHCA to exclude from the expansion those counties in which the program will not be cost effective.

Section 19 creates a non-statutory provision of law to authorize, subject to an appropriation, up to 150 initial enrollee slots in a new PACE project in Broward County.

Section 20 provides that the bill takes effect July 1, 2012, except as otherwise expressly provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, Section 18(a) of the Florida Constitution, states that "Except upon approval of each house of the legislature by two-thirds of the membership, the legislature may not enact, amend, or repeal any general law if the anticipated effect of doing so would be to reduce the percentage of a state tax shared with counties and municipalities as an aggregate on February 1, 1989." While the bill does not reduce the percentage of a state tax shared with counties and municipalities, it does reduce the distributions of shared taxes to each county in order to recover each county's statutorily required contribution to the Medicaid program. In effect, the bill ensures the state's collection of county Medicaid contributions. It is unclear whether section 14 of the bill would be considered a local mandate.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private hospitals may be reimbursed a lower amount for Medicaid days under the bill if additional intergovernmental transfers are not secured to replace a portion of the general revenue removed from prepaid plans under Medicaid. Limiting the Medipass program to those areas with only one managed care plan may result in lower reimbursement to health care providers to the extent that the plans pay less than the current reimbursement rates under fee for service reimbursement.

C. Government Sector Impact:

The bill has a number of provisions that will be an additional cost the state. The bill also has a number of provisions that will save money for the state. Cost savings due to limiting reimbursement for emergency room for non-pregnant adults, removing GR

funding from prepaid health plans supporting hospital rate subsidies from intergovernmental transfers (IGTs), limiting the Medipass program, and expansion of the home health fraud prevention project were estimated by the Social Services Estimating Impact Conferences, held January 13 and 27, 2012. In Fiscal Year 2012-2013, the bill is estimated to cost $44 million and save $376.4 million for a net savings of $299.5 million (see table below). The net savings for Fiscal Year 2013-2014 are estimated at $299.5 million.

Fiscal Impact of the Bill	**FY 2012-2013**			**FY 2013-2014**		
	General Revenue	**Trust Fund**	**Total**	**General Revenue**	**Trust Fund**	**Total**
Estimated Costs ($ millions)						
Study & first year revisions to the public assistance eligibility system (FLORIDA system)	0.4	35.1	35.5	n/a	n/a	n/a
Development of Florida DRGs for hospital inpatient reimbursement	0.4	0.5	0.9	n/a	n/a	n/a
Administrative resources for Medipass savings	1.6	1.8	3.4	1.6	1.8	3.4
Costs of home health fraud prevention project	2.1	2.1	4.2	2.1	2.1	4.2
Costs Subtotal	**4.5**	**39.5**	**44.0**	**3.7**	**3.9**	**7.6**
Estimated Savings ($ millions)						
	General Revenue	**Trust Fund**	**Total**	**General Revenue**	**Trust Fund**	**Total**
Limit to 6 ER visits per year for non-pregnant adults	19.6	27.1	46.7	22	30.4	52.4
Remove GR funded hospital rate subsidy from prepaid health plans	218.7		218.7	264.4		264.4
Medipass savings	8.6	10.6	19.2	31.2	43.4	74.6
Savings from home health fraud prevention project	6	8.3	14.3	n/a	n/a	n/a
Improved county billing for Medicaid transferred to Lawton Chiles Endowment		77.5	77.5		69.4	69.4
Savings Subtotal	**252.9**	**123.5**	**376.4**	**317.6**	**143.2**	**460.8**
Total	**248.4**	**84.0**	**332.4**	**313.9**	**139.3**	**453.2**

VI. Technical Deficiencies:

None.

VII. Related Issues:

Under the bill, IGTs must be used to subsidize the cost of Medicaid hospital reimbursements paid under both fee-for-service and prepaid plans. The proposed Senate budget allows for receipt of additional IGTs to maintain current year hospital reimbursement rates. If IGTs are insufficient to fully fund the current rates, AHCA will lower the hospital reimbursement rates for fee-for-service and lower the prepaid plan capitations.

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.