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 Committee on Military and Veterans Affairs, Space, and Domestic Security

BILL:	SB 440
INTRODUCER:	Senator Garcia and others
SUBJECT:	Florida Veterans Care Program
DATE:	December 5, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Ryon	Ryon	MS	**Favorable**
3.			AP	

I. Summary:

SB 440 creates the Florida Veterans Care program (program) in statute, within the Agency for Health Care Administration (AHCA) to provide Florida veterans and their families an alternative for health care that is operated similar to or through the Medicaid managed care program. The bill authorizes AHCA to seek and negotiate a federal waiver, state plan amendment, or other federal authorization necessary to implement the program.

Participation by Florida veterans and their families is voluntary. Benefits and services provided through the program shall meet or exceed those provided in the Medicaid long-term care or managed care program as provided under part IV of chapter 409 and will be provided by plans competitively procured by AHCA.

No state funds may be used to provide services or administer the program. The AHCA may incur some administrative costs to negotiate final approval for the program. The AHCA is not permitted to implement the program without final legislative approval.

The effective date of the bill is July 1, 2018.

II. Present Situation:

Veterans' Health Care Services

Veterans of the United States Armed Forces may be eligible for a range of benefits which are codified in Title 38 of the United States Code. Certain former members of the Reserves or

National Guard who were called to active duty may also be eligible for benefits.[1] Benefits may include:

- Medical care;
- Disability compensation;
- Special monthly compensation;
- Housing grants for disabled veterans;
- Vocational rehabilitation and employment;
- Pension;
- Education and training;
- Home loan guaranty;
- Life insurance; and
- Dependents and survivors benefits.[2]

If a person served in the active military service and was separated under any condition other than dishonorable, that individual may be eligible for health care and other benefits under the federal Veterans Health Administration (VHA) through the United States Department of Veterans Affairs (VA). Most veterans who enlisted after September 7, 1980 or entered active duty after October 16, 1981, must have served at least 24 continuous months; however, this time standard may not apply to those veterans who were discharged due to a disability incurred or aggravated in the line of duty or under other exceptions.[3]

Veterans must register or apply for health care benefits through the VHA. Certain categories of veterans are provided enhanced enrollment. These veterans are those who:

- Are former Prisoners of War;
- Are Purple Heart Recipients;
- Are Medal of Honor Recipients;
- Receive compensable VA awarded service-connected disability[4] of 10 percent or more;
- Receive a VA pension;
- Were discharged from the military because of a disability (not pre-existing), early out, or hardship;
- Served in a Theater of Operations for 5 years post discharge;
- Served in the Republic of Vietnam from January 9, 1962 to May 7, 1975;
- Served in the Persian Gulf from August 2, 1990 to November 11, 1998;
- Were stationed or resided at Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987;
- Were found catastrophically disabled by the VA; or

[1] U.S. Department of Veterans Affairs, *Health Benefits*, https://www.va.gov/HEALTHBENEFITS/apply/veterans.asp (last visited Dec. 4, 2017).
[2] U.S. Department of Veterans Affairs, *Federal Benefits for Veterans, Dependents and Survivors* (2016 Edition), https://www.va.gov/opa/publications/benefits_book/2016_Federal_Benefits_for_Veterans.pdf (last visited Dec. 4, 2017).
[3] *Supra* note 1.
[4] A service-connected disability is an injury or illness that was incurred or aggravated during active military service. Compensation may also be paid for post-service disabilities that are considered related or secondary to disabilities occurring in service or presumed to be related to circumstances of military services, even if they arise after military service. To be eligible for compensation, the veteran must have been separated or discharged under conditions other than dishonorable. *See* https://www.benefits.va.gov/compensation/ (last visited Dec. 4, 2017).

- Have a household income that is below the VA's National Income or Geographical – Adjusted Thresholds.[5]

Only certain veterans are required to provide income information to the VA as part of the application process. Veterans who do not have a VA-service connected disability, do not receive a VA pension, or have a special eligibility are required to participate in the financial assessment. The gross household income amounts that are used to determine priority groups or eligibility for cost-free care are adjusted annually. These amounts can also vary by geographic based assessments. Unreimbursed medical expenses are deductible from the veteran's gross income, including medical-travel related expenses, health insurance premiums, and prescriptions. For 2016, the VA National Income Threshold for a veteran with two dependents for cost-free health care was $40,694 or less.[6]

When a veteran enrolls, the individual is assigned to one of eight priority groups which the VA uses to balance the demand for services with available resources. Priority groupings are based on need for services, level of disability, discharge status, and income.[7] The highest priority group are those veterans with service-related injuries with at least a 50 percent service-connected disability and/or the veteran has been determined unemployable.[8] Group 8 is the lowest priority group and includes those veterans whose gross household incomes are above the VA national income threshold and who agree to pay copayments.

Florida Veterans

The federal VA system serves more than 1.5 million Floridians which is the third highest population of veterans in the country behind California and Texas.[9] Over half of the state's veterans are aged 65 and older with the majority of those veterans having served during the Vietnam Era with the Gulf Wars second as noted in the chart below.

Florida's Veteran Population by Period of Service[10]	
Period of Service	**Number of Veterans 9/30/2015**
WWII	91,799
Korea	168,208
Vietnam	544,921
Gulf War	487,422

[5] *Supra* note 1.
[6] U.S. Department of Veterans Affairs, *Annual Income Limits – Health Benefits, 2017 VA National and Priority Group 8 Relaxation Income Thresholds, Income Thresholds for Cost-Free Health Care, Medications and/Beneficiary Travel Eligibility, Based on Income Year 2016,* (last updated December 8, 2016) *available at* http://nationalincomelimits.vaftl.us/LegacyVAThresholds/Index?FiscalYear=2017 (last visited Dec. 4, 2017).
[7] *Supra* note 2.
[8] Id.
[9] U.S. Department of Veterans Affairs, *State Summaries – Florida* (2016), *available at* https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_Florida.pdf , p. 2, (last visited Dec. 4, 2017).
[10] Id.

In Florida, 725,000 individuals were enrolled in the VHA and over 500,000 unique enrollees received treatment in Fiscal Year 2016. The VHA operates 8 VA inpatient facilities, 71 outpatient facilities, and 24 Vet Centers in the state.[11] For 2016, the VHA reported expending $5,053,073 for medical care in Florida.[12]

Besides health care benefits, over 300,000 Florida veterans also receive disability compensation payments.[13] For Fiscal Year 2016, the average number of service-connected disabilities per veteran nationally is reported as 4.91.[14]

Uninsured Florida Veterans

The most recent projections indicate that approximately 49,000 Florida veterans are uninsured or 7.4 percent of the state's veteran population which is a 5.2 percent reduction over the state's 2013 uninsured rate of 12.5 percent.[15] Census figures released earlier this year showed that most veterans either had TRICARE[16] or VHA coverage alone or paired it with private coverage (716,228 enrollees) compared with a coupling with public coverage such as Medicare or Medicaid (610,462 enrollees).[17]

Nationally, uninsured rates among nonelderly veterans also fell from 9.6 percent in 2013 to 5.9 percent in 2015, a nearly 40 percent drop.[18] Similarly, there were also corresponding drops in the uninsured among veterans' spouses and dependent children. Florida had the second highest rate of decline among all states, for both those that did and did not expand Medicaid, and the largest drop in the number of uninsured among those states that did not expand Medicaid.[19]

In a study by the RAND Corporation, it found that most care provided to non-elderly veterans is delivered outside of the VA system.[20] VA data show that while health care benefits are the

[11] Id at 1.
[12] Id.
[13] Id.
[14] U.S. Department of Veterans Affairs, Veterans Benefits Administration, *Annual Benefits Report Fiscal Year 2016-Compensation Section,* (Updated February 2017), https://www.benefits.va.gov/REPORTS/abr/ABR-Compensation-FY16-0613017.pdf (last visited Dec. 4, 2017).
[15] Jennifer Haley, et al, *Veterans Saw Broad Coverage Gains Between 2013 and 2015,* Robert Wood Johnson Foundation and Urban Institute, p. 5, https://www.urban.org/sites/default/files/publication/89756/2001230-veterans-saw-broad-coverage-gains-between-2013-and-2015.pdf (last visited Dec. 4, 2017).
[16] TRICARE is a military healthcare program for active duty personnel, military retirees, and their dependents which is managed by the Defense Health Agency under the federal Department of Defense (DOD). TRICARE, formerly known as CHAMPUS, provides comprehensive health care services through military hospitals and clinics with civilian health care networks. The CHAMPVA is managed by DVA which shares the cost of covered health care services with eligible beneficiaries. *See https://www.va.gov/COMMUNITYCARE/programs/dependents/champva/index.asp* (last visited Dec. 4, 2017).
[17] U.S. Census Bureau, *American Fact Finder, Private and Public Health Insurance Coverage by Type – 2016 American Community Survey 1-Year Estimates* (chart created Nov. 2, 2017) (on file with the Senate Committee on Health Policy).
[18] *Supra* note 15, at 3.
[19] Id at 5.
[20] Michael Dworksy, et al, *Veterans' Health Insurance Coverage Under the Affordable Health Care Act and Implications of Repeal for the Department of Veterans Affairs: Research Report,* RAND Corp., (2017), p. 28, *available at* https://www.rand.org/pubs/research_reports/RR1955.html (last visited Dec. 4, 2017).

largest veterans' benefit program,[21] most veterans are covered by non-VA health insurance even if they are enrolled in the VA. Implementation of the Affordable Care Act was followed by reduction in the number of veterans who lacked any form of health insurance and increases in the number of VA-covered veterans who were dually-enrolled in some non-VA source of insurance.[22]

Veterans' Health Care Delivery System

Nationally, the VA has 155 inpatient sites and over 1,000 outpatient sites with another 300 Vet Centers which provide counseling services, outreach and referral services to combat veterans and their families. Veterans can receive health care services at any VA health care facility in the country. Health care enrollment and utilization has increased with outpatient visits growing from 46.5 million visits in 2002 to 95.2 million visits in 2015.[23]

Health care is primarily delivered through 21 regional networks know as Veterans Integrated Service Networks or VISNs nationwide. For Florida, two networks cover the state with one responsible for 60 counties in the northern, central, and southern regions of the state[24] and the other network for the remaining seven counties in northwest Florida.[25]

Starting predominantly in 2014, news stories and VA federal Office of the Inspector General (OIG) reports accused the VHA of systemic failures and other management challenges.[26,27,28] Long wait times for primary care appointments, fraud in the appointment times scheduling system, and an overwhelmed health care system led to the federally-chartered *Special Medical Advisory Group (SMAG)* composed of medical experts to advise the Secretary of Veterans Affairs, through the Under Secretary of Health, on matters relating to health care delivery, research, education, training of health care staff, and shared issues facing VA and the Department of Defense on a federal legislative response.

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[21] U.S. Department of Veterans Affairs, *Unique Veterans Users Profiles, FY 2015* (December 2016), *available at* https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Unique_Veteran_Users_2015.pdf (last visited Dec. 4, 2017).
[22] *Supra* note 20, at 26.
[23] U.S. Department of Veterans Affairs, *Selected Veterans Health Administration Characteristics, FY 2001 to FY 2015*, https://va.gov/vetdata/Expenditures.asp (last visited Dec. 4, 2017).
[24] VISN 8 is the Sunshine Healthcare Network and covers 60 Florida counties, 19 rural counties in South Georgia, and Puerto Rico and the U.S. Virgin Islands. VISN 8 includes seven outpatient clinics of which six are located in Florida and one is located in Puerto Rico. For more information on VSN 8, see https://www.visn8.va.gov/VISN8/about/index.asp (last visited Dec. 4, 2017).
[25] VISN 16 is the South Central VA Health Care Network and serve veterans in Arkansas, Louisiana, Mississippi, and parts of Texas, Missouri, Alabama, Oklahoma, and Florida. VISN 16 has eight Veterans Affairs Medical Centers (VAMC) of which none are located in Florida, one outpatient clinic in Texas, and 68 outpatient sites or Vet Centers of which six are located in Florida.
[26] Rachel Landen, *Pattern of problems with Veterans Affairs healthcare system*, Modern Healthcare, May 7, 2014, http://www.modernhealthcare.com/article/20140507/NEWS/305079939, (last visited Dec. 4, 2017).
[27] Associated Press, Watchdog report details 'systemic' problems at VA facilities, Fox News, August 25, 2014, http://www.foxnews.com/politics/2014/08/26/no-proof-delays-in-care-caused-vets-to-die-va-says.html, (last visited Dec. 4, 2017).
[28] Department of Veterans Affairs, Office of Inspector General, *2014 Major Management Challenges* (October 1, 2014), *available at* https://www.oversight.gov/report/va/office-inspector-general-department-veterans-affairs-2014-major-management-challenges (last visited Dec. 4, 2017).

The VA's SMAG developed a Blueprint for Excellence with a goal of delivering both excellent care and an excellent experience of care to every veteran it served.[29] Five priorities were established under the Blueprint:

- Access: We will provide timely access to Veterans as determined by their clinical needs.
- Employee Engagement: We see a work environment where employees are valued, supported and encouraged to do their best for veterans.
- High Performance Network: We will ensure that Veterans receive the highest level of coordinated care within VA or from participating providers.
- Best Practices. We will use best clinical practices in research, education, and management.
- Trust in VA Care. We will be there for our Veterans when they need us.[30]

In its 2016 SMAG Progress Report, the VHA reported an increase in the number of sites offering same-day services since September 2016 from 52 sites to 166 sites and more than 3.1 million appointments had been scheduled nationally in the last two years.[31] More than 22,000 additional staff had been on-boarded at the VHA since the beginning of 2015 fiscal year through the end of 2016 fiscal year.[32]

Veterans Choice Program

Partially, in response to the issues raised in the multiple OIG audits, Congress directed the VA through the *Veterans Access, Choice, and Accountability Act of 2014 (VACCA) (P.L. 113-146)*, and specifically, the Veterans Choice Program (VCP) to furnish hospital care and medical services through alternative means when veterans could not access services in a timely manner. To be eligible, a veteran may optionally enroll if he or she faces an unacceptable burden in accessing a provider of more than 40 miles driving distance to the nearest VA medical facility and has been identified to have an appointment more than 30 days out from a preferred appointment date; faces other geographic challenges; encounters environmental challenges; or has a medical condition that impairs the veterans ability to travel.

When a veteran attempts to schedule an appointment at a VHA medical facility or meets the driving condition or one of the other special circumstances and cannot be seen within 30 days, the veteran is placed on the Veterans Choice List (VCL). Once the veteran is placed on this list, the veteran has the ability to opt into the program and receive care from the designated Third Party Administrator (TPA) managed provider network.

The legislation also mandated other changes such as requiring the use of electronic waiting lists (ECLs), making such waiting lists accessible so veterans can make informed choices about whether or not to receive care at such facilities, requiring VCP cards be issued to certain veterans, requiring non-VA health care providers to have the same credentials as VA health care providers, requiring the establishment of performance metrics, setting appointment access standards, requiring a number of reports, and publishing wait times of VA facilities publicly.

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[29] U.S. Department of Veterans Affairs, *SMAG Progress Report 2016,* p. 5, *available at* https://www.va.gov/health/smag_report/smag_progress_report_2016.asp, (last visited Dec. 4, 2017).
[30] Id.
[31] Id at 6.
[32] Id at 8.

The VCP was initially funded by Congress with $10 billion. The legislation would sunset upon either the exhaustion of the funds or three years from the Act's enactment, whichever occurred first.[33] Before either event could happen, the program's termination date was removed and additional funds were authorized in 2017.[34]

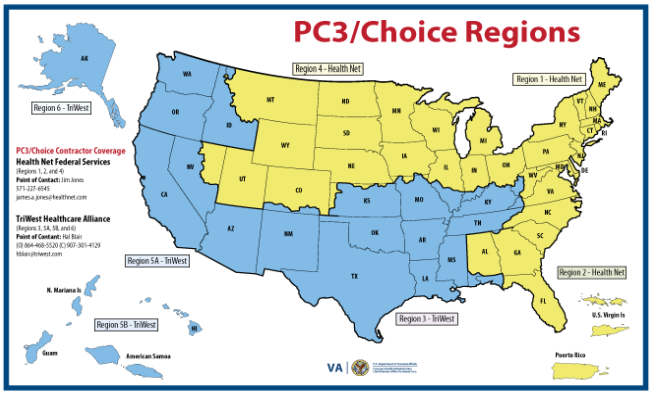
Patient Centered Community Care Program

Existing prior to VCP, if care was not readily available either because of time or geography, a veteran's health care facility could and still can use a Patient Centered Community Care Contract (PC3) to purchase care from a non-VA provider. More than 3.5 million authorizations for services under PC3 contracts have been made from September 1, 2015 through August 31, 2016, a 13 percent increase over the same period in 2014-2015.[35] In comparison, internal VA appointments for 2015-2016 were 58.3 million.[36]

Florida is covered by two different health network contracts: Health Net Federal Services and TriWest Healthcare Alliance.[37] A map of the regions covered by the contracts is shown below. The PC3 program does not provide coverage for all benefits. Coverage is limited only to primary care, limited emergency care, mental health care, inpatient and outpatient specialty care, and limited newborn care for enrolled female veterans following the birth of a child.[38] Services are managed nationally by one of two TPA managed provider networks based on where the veteran is located.

The Veterans "Choice" Programs

Collectively known as the Veterans Choice Programs, the VA provides veterans with options under the VCP, the PC3, and non-VA fee programs for pre-authorized medical care only. Millions of appointments had been provided under the programs and billions of dollars had been expended in health care funds with an additional $235 million spent on administrative costs to the health care networks over a several year time span.[39]



[33] Veterans Access, Choice, and Accountability Act of 2014, Pub. L No. 113-146, §101(p) (August 7, 2014), 128 STAT. 1763 (August 7, 2014).
[34] VA Choice and Quality Employment Act of 2017, P.L. 115-26, 131 STAT. 129-130 (April 19, 2017).
[35] *Supra* note 29, at 9.
[36] Id.
[37] U.S. Department of Veterans Affairs, *VHA Office of Community Care, Patient Centered Community Care (PC3),* (last updated May 11, 2017) *available at* https://www.va.gov/COMMUNITYCARE/programs/veterans/pccc/index.asp (last visited Dec. 4, 2017).
[38] Id.
[39] Testimony of Michael J. Missal, Inspector General of U.S. Department of Veterans Affairs before the Committee on Veterans' Affairs, U.S. House of Representatives, Hearing on "Shaping the Future: Consolidating and Improving VA Community Care," (March 7, 2017), p. 2, *available at* https://www.va.gov/oig/pubs/statements/VAOIG-Statement-20170307-missal.pdf (last visited Dec. 4, 2017).

The IG of the DVA reported on contacts received by its office from October 1, 2015 through January 31, 2017 and noted they fell into four general complaint categories:

- 48% had concerns about appointments and scheduling;
- 35% had concerns about referrals, authorizations, or consults;
- 12% had concerns about veteran and provider payments; and,
- 5% had concerns about program eligibility or enrollment.[40]

The IG reviewed appointment wait times, authorization practices, scheduling procedures, and timeliness of care of various offices and facilities. Several barriers to care were found, including 1.2 million appointments from November 1, 2014 through September 30, 2015 for veterans in the various VHA programs waiting over 30 days for care at VHA medical facilities.[41] In the October 2016 report, the IG published its review of the Phoenix VA Health System in which it had determined that more than 22,000 patients had 34,000 open consults. One patient waited in excess of 300 days for a consult.[42] The review of the Phoenix office included services delivered in both the traditional and non-traditional VA care settings.

In February 2016, another Inspector General reported looked at timely care in Colorado Springs. Out of 450 consults and appointments, 288 veterans in Colorado Springs encountered wait times in excess of 30 days. Of those 288 who had wait times in excess of 30 days, none of those 288 veterans were added to the VCL or did not add them in a timely manner which would make them eligible to receive services under that program.[43]

Access to Care in Florida

News reports and other OIG reports indicate that the VA struggled to implement the new Choice programs from November 1, 2014 through September 30, 2015, including the special OIG Choice Implementation report requested by U.S. Senator Johnny Isaakson of Georgia and Chairman of the Senate Committee on Veterans' Affairs.[44] Within this audit, one Florida facility was included, the North Florida/South Georgia Veterans Health System. The audit noted the struggles of the VA to meet the expedited 90-day implementation timeline of the original 2014 legislation, inadequate provider networks once the program was implemented, third party liability concerns by veterans for non-payment of medical bills to providers, appointment wait times in excess of 30 days, and provider administrative burden issues.[45]

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[40] Id.

[41] Id at 3.

[42] Id at 4. The publication title of the report is *Review of Alleged Consult Mismanagement of the Phoenix VA Health Care System (PVAHCS)*, VA Office of Inspector General, Office of Audits and Evaluation, (October 4, 2016), Report 15-046720342, *available at* https://www.va.gov/oig/pubs/VAOIG-15-04672-342.pdf (last visited Dec. 4, 2017).

[43] U.S. Department of Veterans Affairs, VA Office of Inspector General Office of Audits and Evaluation, Veterans Health Administration, *Veterans Health Administration – Review of the Alleged Untimely Care at the Community Based Outpatient Clinic Colorado Springs, CO*, (February 4, 2016), Report 15-02472-46, *available at* https://www.va.gov/oig/pubs/VAOIG-15-02472-46.pdf (last visited Dec. 4, 2017).

[44] U.S. Department of Veterans' Affairs, VA Office of Inspector General Office of Audits and Evaluation, *Veterans Health Administration Review of the Implementation of the Veterans Choice Program*, (January 30, 2017), Report 15-04673-333, *available at* https://www.va.gov/oig/pubs/VAOIG-15-04673-333.pdf (last visited Dec. 4, 2017).

[45] Id at vi.

One of the examples included of TPA's inability to provide services was a veteran served by the Gainesville VA Center in Florida who called the TPA for appointment assistance with an Ear, Nose, and Throat specialist and was scheduled with a specialist in California.[46] The TPA staff did not have geographical awareness. Network inadequacy made it difficult for veterans to seek care outside of the VHA if they wanted to opt out to the VCP program. Approximately 13 percent returned to VHA without receiving any care, on an average of 48 days later.[47]

For purposes of determining sampling sizes, the audit report stratified the different medical systems included in the audit report. The North Florida/South Georgia Veterans Health System fell in the report's "High" stratum which indicated that more than 20,000 veterans were on the VCL.[48] The next level, "Medium" had a range of 4,000 to 20,000 on the VCL.

An OIG review on tampering of the VCL at the James A. Haley Veterans' Hospital (JAHVH) in Tampa, Florida was conducted in 2015. The complainant in that instance alleged, among other issues, that not all veterans were added to the VCL when their scheduled appointment was greater than 30 days.[49] That allegation was substantiated as was an allegation that staff inappropriately removed veterans from the VCL. Errors were corrected and staff was re-trained as a result of those audit findings.

In its response to the audit report, the Secretary of the DVA noted that the Choice programs have changed dramatically since implementation and have seen a growth rate in authorizations from October 2015 to March 2016 of 103 percent.[50] The DVA requested authorization to consolidate all of the Community Care Programs into a singular authority tied to Medicare reimbursement for like services to address issues related to provider network adequacy and administrative burdens on both the DVA and the provider.[51]

Florida Department of Veterans Affairs

In 1988, Florida citizens voted to create the Department of Veterans Affairs (department) by constitutional amendment. The department is responsible for advocating on behalf of Florida's veterans to improve their quality of life and to provide access to federally funded medical care for eligible veterans.

The department also manages one assisted living facility and six state veterans' nursing homes with an eighth in its final planning stages in St. Lucie County and planned ground breaking in the first half of 2018.[52] To be eligible for admission, a veteran must have had an honorable discharge, be a state resident prior to admission, and have received a certification of need of assisted living or skilled nursing care as determined by a VA physician.

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[46] Id at 4.
[47] Id at 7.
[48] Id at 22.
[49] U.S. Department of Veterans' Affairs, VA Office of Inspector General Office of Audits and Evaluation, *Veterans Health Administration Review of Alleged Patient Scheduling Issues at VA Medical Center Tampa, FL,* (February 5, 2016), Report 15-03026-101, *available at* https://www.va.gov/oig/pubs/VAOIG-15-03026-101.pdf (last visited Dec. 4, 2017).
[50] *Supra* note 44, at 25-26.
[51] Id at 33.
[52] Florida Department of Veterans Affairs, *State Veterans' Homes,* http://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Dec. 4, 2017).

Other services are available to veterans in county services offices which may be co-located in VA Regional Offices in Bay Pines, each VA Medical Center and many of the VA Outpatient Clinics.

Florida Medicaid

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and financed with federal and state funds. Approximately 4 million Floridians are currently enrolled in Medicaid, and the programs estimated expenditures for the 2017-2018 fiscal year are over $26 billion.[53]

Eligibility for Medicaid is based on a number of factors, including age, household, or individual income, and assets. State eligibility payment guidelines are provided in s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children.

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care program (SMMC). The SMMC, authorized under federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate[54] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. As of October 2017, 3.2 million Medicaid recipients were enrolled in an SMMC plan while 716,260 were enrolled in Medicaid on a fee-for-service basis.[55]

[53] Social Services Estimating Conference, *Medicaid Caseloads and Expenditures – July 17, August 3, and August 9, 2017 – Executive Summary*, http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited Dec. 4, 2017).
[54] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.
[55] The Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report* (October 2017), *available at* http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Dec. 4, 2017).

Medicaid enrollees are surveyed regularly regarding their satisfaction with their plan and experiences with health care. The 2016 MMA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results provided the following results for Medicaid:

CAHPS Survey on Consumers and Patient Experiences with Health Care - MMA[56]		
CAHPS Survey Item	**Adults**	**Parents**
Respondents who responded that their plan satisfaction rates 8, 9, or 10 out of 10	73%	84%
Respondents or rated their MMA Quality of Care an 8, 9, or 10 out of 10	75%	86%
Respondents who reported that it is usually or always easy to get needed care (vs. sometimes or never)	80%	82%
Respondents who reported that it is usually or always easy to get care quickly (vs. sometimes or never)	82%	89%
Respondents who reported that they are able to get help from customer service (vs. sometimes or never)	88%	86%

The SMMC program is authorized under an 1115 waiver which may be modified through a state plan amendment. Amendments are submitted in Florida by the AHCA for reviewed and approval by CMS.

III. Effect of Proposed Changes:

The bill creates s. 292.17, F.S., the Florida Veterans Care program within the AHCA to provide Florida veterans and their families' access to a quality alternative to the federal veterans' health care system. The program would allow Florida veterans and their families to voluntarily use the Medicaid managed care program or a program that is similar to the Medicaid managed care program that is described under part IV of chapter 409, in lieu of or in addition to the federal veterans' health care system.

The bill directs the AHCA and the Department of Veterans' Affairs to negotiate with the appropriate federal agencies to seek approval for a waiver, a state plan amendment, or any other appropriate federal authorization needed to receive federal funding for the program.

Eligibility for the program is determined by the federal Veterans Health Administration or the United States Department of Veterans Affairs. Those eligible may voluntarily enroll in the program and receive all the necessary benefits and services that meet or exceed those offered under Medicaid managed medical assistance and long-term care, including nursing and community-based services. Services and benefits would be delivered by those plans selected through a competitive bid process meeting the requirements of part IV of chapter 409.

The bill also includes a few caveats:

[56] Beth Kidder, Agency for Health Care Administration, *Florida Medicaid*,(January 11, 2017). Presentation to Senate Committee on Health and Human Services Appropriations, slide 29, *available at* http://ahca.myflorida.com/medicaid/recent_presentations/Senate_Health_Human_Services_Appropriations_Sub_Med_101-MMA_2017-01-11.pdf (last visited Dec. 4, 2017)

- Prohibits the use of state funds for the payment of medical or long-term care services or for administrative costs of the program;
- Receipt of services under this program does not affect a person's eligibility for Medicaid; and
- The AHCA and DVA may not implement this program without prior legislative approval.

The effective date of this bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

For those health insurance plans, providers, and facilities that are participating in the current SMMC, an influx of additional enrollees into the program from the VHA could have an impact on that particular entity's enrollment mix. Depending on how the program is implemented and blended with the existing SMMC, or if it is handled as a separate specialty plan within SMMC, health care providers could see additional patients with a different level of unmet need.

Providing an option for Florida's veterans under MMA to meet their health care needs may have a positive impact on other community resources as veterans have their needs met through appropriate, and more effective health care methods.

The health care plans and facilities serving this population will need to continuously review and monitor the need for additional specialists given the medical needs of the VHA population.

C. Government Sector Impact:

While the legislation specifically prohibits expending funds for services or administration for the program, the AHCA has indicated a need for administrative funds to negotiate the federal waiver, state plan amendment, or authorization for federal funds for the program. Additional resources would be needed to assist with research, engagement of subject matter experts, and dedication of other staff time to gain federal approval of the proposal. Negotiations will likely include several federal agencies, including some of which the AHCA has not previously sought waivers or other federal funding. The actual amount needed by either the AHCA or, possibly also the department, is not known.

The Veterans Care program cannot be implemented without prior legislative approval. It is expected that the AHCA and the department will bring back to the Legislature a proposal that includes a timeline, expected costs, and a federal funding proposal following negotiations with the appropriate agencies. No funds for a veterans' health care program would be expended until a program has been negotiated by the AHCA and approved by the legislature, including how the program would be funded, both medical and administrative costs.

No state funds are expected to be expended for veterans' health care services as all funds should be federally appropriated once a program has been negotiated, approved, and implemented. Currently, all veterans' health care services are federally funded. In the future, any fiscal impact to the state may be seen in administrative costs at the AHCA for the implementation of and ongoing programmatic oversight of the program. These costs may be reimbursable from the federal government. This provision would be part of the negotiations between the state and the federal government.

The inclusion of additional enrollees to the SMMC networks may also have an impact to availability of providers in certain areas should a large number of veterans opt for this network and may impact capitated rates if an unexpected number of unhealthy veterans enroll in certain regions.

The Florida Department of Veterans Affairs reports no fiscal impact.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 292.17 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.