HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HFPC 09-01 Medicaid
SPONSOR(S): Health & Family Services Policy Council
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Health & Family Services Policy Council		Gormley	Gormley
1)				
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

Managed care has been a part of the Florida Medicaid program for more than 20 years. Medicaid currently uses a variety of managed care models to provide health care coverage to low income persons. Approximately half of all Medicaid participants, or 1.1 million people, are enrolled in a Medicaid managed health care program. The largest share of these individuals—more than 934,000 people—are enrolled in Medicaid HMOs. Approximately 217,000 Medicaid participants are included in the reform pilot, which relies on managed care organizations, either HMOs or provider service networks, to establish integrated systems for delivery of health services.

The bill creates a new pilot based on a medical home concept with federally qualified health centers (FQHCs) coordinating care with medical schools for specialty care and hospitals for inpatient services. The bill provides a framework for the medical home including purpose, organization, service capabilities, principles, enrollment, access standards, financing, shared savings, quality assurance, and evaluation. In contrast to the reform pilot, the medical home network will be financed through fee-for-service payments. The bill authorizes some enhanced payments and the opportunity for shared savings, subject to appropriations, in order to create financial incentives for care management. The pilot is created through development of at least one network in Alachua, Hillsborough, Orange and Miami-Dade Counties. Enrollment in the pilot consists of Medicaid patients receiving care at participating FQHCs. Additional enrollment will be built from persons subject to mandatory assignment based on a ratio of 65 percent for the medical home pilot and the remaining 35 percent to other managed care organizations.

The bill authorizes a phase-in of risk-adjusted capitation rates beginning in 2011. The bill also directs the Agency for Health Care Administration (AHCA) to develop, and the prepaid health plans to comply with, an encounter data system. Additionally, the bill directs AHCA to provide regular reports on the financial status of Medicaid HMOs and authorizes the agency to designate a portion of the capitation rates paid to prepaid plans to be used as incentives for healthy behaviors. The bill creates a technical advisory panel for assisting AHCA with the transition to risk-adjusted rates. A workgroup is established to assess the financial status of Medicaid managed care plans and develop recommendations for policy changes in the future.

The bill requires recipients of LIP funds or rebased rates to provide services to all Medicaid patients regardless of county of origin. The date for provider service networks to move to capitation instead of fee-for-service is delayed for two more years.

The bill creates a monitored negotiation process for resolving, at the request of the parties, an impasse in contract negotiations in those cases when contracts are necessary for managed care organizations to meet network adequacy standards.

The fiscal impact of the bill to the state is indeterminate, but could be significant.

The bill takes effect July 1, 2009.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medicaid Overview

Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration and financed by federal and state funds. Key characteristics[1] of Florida's Medicaid program may be summarized as follows:

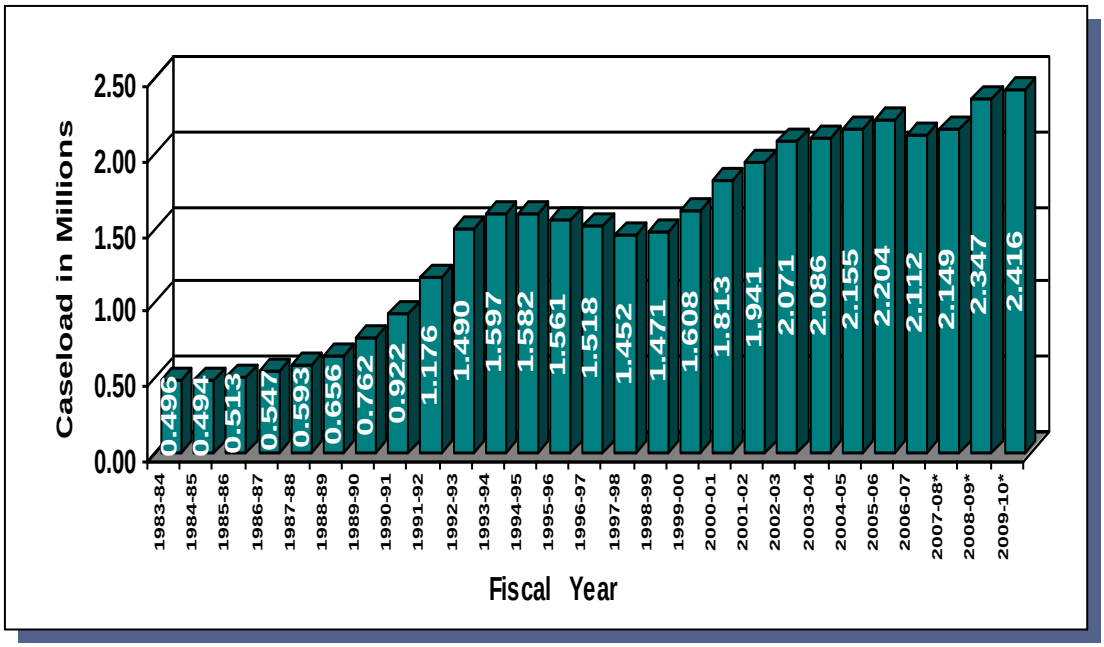
- 2.3 million eligibles.
- $15.7 billion estimated spending in Fiscal Year 2008-09.
- Florida will spend approximately $6,709 per eligible in Fiscal Year 2008-2009.
- 45 percent of all Medicaid expenditures cover:
  - Hospitals;
  - Nursing homes;
  - Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); and,
  - Low Income Pool and Disproportionate Share supplemental payments.
- Of the 2.3 million eligibles, 1.5 million are enrolled in some type of managed care including:
  - 500,996 in primary care case management (PCCM or MediPass);
  - 934,802 in health maintenance organizations (HMOs);
  - 97,699 in provider service networks (PSNs);
- Approximately 80,000 providers participate in fee-for-service Medicaid'
- 23 managed care organizations, which includes 16 HMOs and 7 PSNs.

Florida, like most other states, turned to managed care for improving access to primary care, containing costs and enhancing quality. The history of Medicaid provides ample documentation of the impact of low reimbursements on provider participation. Despite these low payment rates, costs for Medicaid exploded over the years due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. Between 1984 and 1990, Medicaid enrollment nationally increased to 36 million, up from an average of 20-23 million in the prior 15 years.[2] Spending also grew rapidly, increasing from $51.3 billion nationally in 1993 to $125.2 million just five years later.

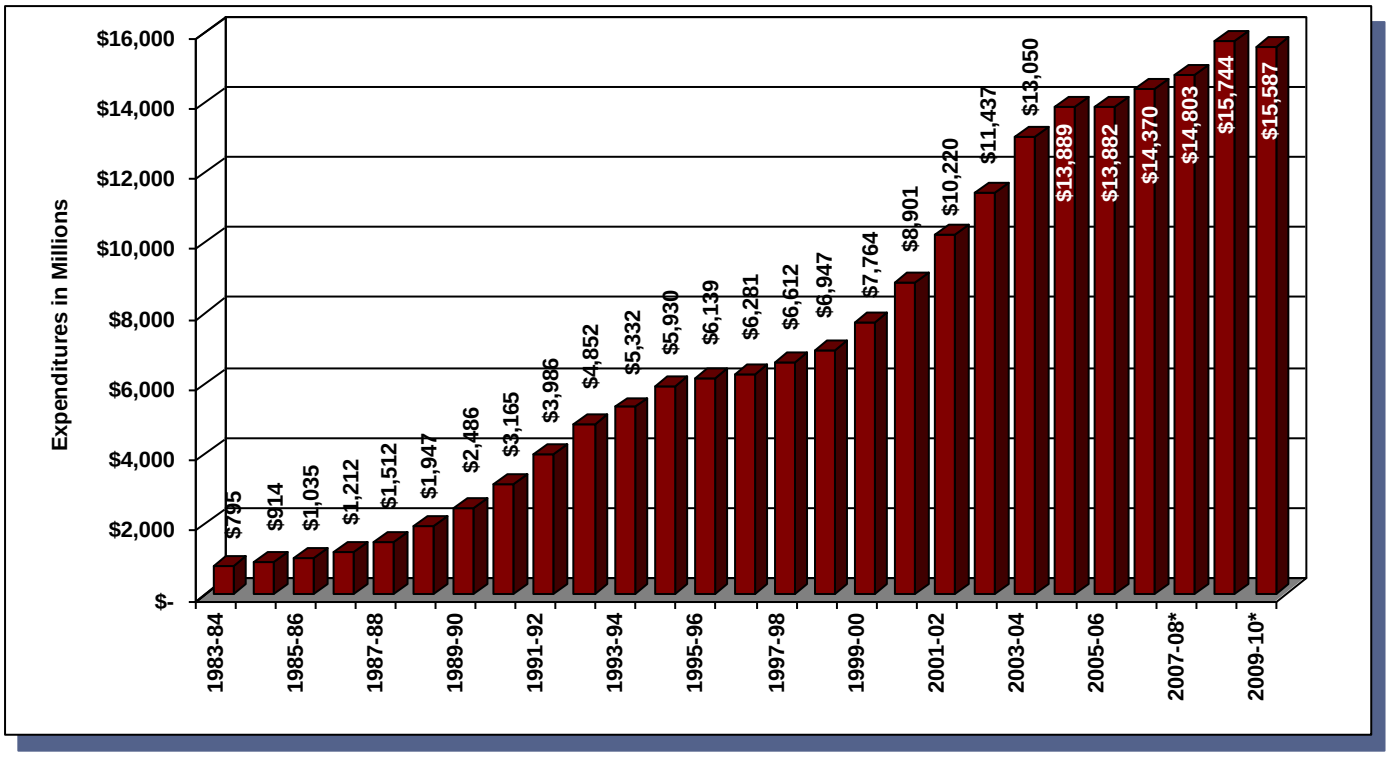
[1] Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Florida Legislature, February 2009.
[2] Between Welfare, Medicine, and Mainstream Entitlement: Medicaid at the Political Crossroads.

Growth in Florida's Medicaid population and expenditures mirrored the national trends as shown in the figures below.[3]

Growth in Florida Medicaid Caseload, 1983-2009



Growth in Florida Medicaid Spending, 1983-2009



[3] *Supra*, note 1.

Trends toward higher caseloads and higher spending, coupled with economic pressures on states, led to the next wave of managed care expansion. In the early 1990s, President Clinton eased federal regulations affecting Medicaid managed care, making it easier for states to expand these programs. By the late 1990s, more than half of all Medicaid beneficiaries were in managed care arrangements. As of 2006, more than 65 percent of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models.

The managed care models used in Florida include prepaid health plans (HMOs), primary care case management (MediPass), provider service networks (PSNs), minority physician networks (MPNs), MediPass disease management, prepaid mental health plans (PMHP), prepaid dental health plans (PDHP) and pediatric emergency room diversion[4].

Primary care case management was the state's first managed care initiative and was begun in the early 1980s. Although the program includes gatekeeping and care management by a primary care practitioner, this program is generally considered as a fee-for-service system since no entity bears risk as part of the MediPass program.

Florida began contracting with prepaid health plans in the early 1990s and by 1994,[5] more than 400,000 of the state's then 1.6 million beneficiaries were enrolled. Inadequate state oversight and involvement by speculative HMO entrepreneurs led to a number of problems and the state temporarily froze enrollment while conducting an investigation and establishing new forms of control. Following these adjustments, enrollment grew steadily, though not uniformly, across the state. Many rural counties continue to rely exclusively on MediPass since no HMOs have entered the market. The most recent surge in managed care enrollment occurred as part of Medicaid Reform, where all beneficiaries including those on public assistance and persons with disabilities were required to select a managed care organization—either an HMO or a PSN.

Encounter Data

In MediPass, providers are paid based on filed claims and the claims information establishes the foundation of an encounter data system. The agency is able to use this data to track service utilization by type, by cost, by category of eligibility and by provider. Although some preliminary work was done to develop an encounter data system for managed care organizations, the agency did not make significant progress until the implementation of Medicaid Reform. Based on the experience of other states, it typically takes three to five years to fully implement a mature encounter data system. Because this data will need to be used in the future to help set capitation rates as well as to evaluate plan performance, it is essential that the agency establish a reliable data system that includes adequate methods for validating the information.

The agency's current contracts with managed care organizations require the submission of a variety of reports including specific quality indicators, financial reports, behavioral health reports, enrollment/disenrollment information, network provider lists, utilization summaries, and reports on suspected fraud. The data gathered through these summary reports is not sufficient for evaluations that need to be performed at the encounter level.

Development of the encounter data system is a complex process that involves a number of steps to test the system, followed by adjustments and further tests. The process has been further complicated by the transition to a new third party administrator. As of April 2008, managed care organizations had submitted approximately 5.2 million test encounter data records. The agency expects the system to be able to produce initial reports by January 2010.

[4] 2008-2009 Florida Medicaid Summary of Services, Agency for Health Care Administration.
[5] *Health Policy Report: Medicaid and Managed Care*, John Iglehart, New England Journal of Medicine, Vol. 332, No. 25 (1995).

Medicaid Payment and Risk Adjusted Capitation Rates

The Florida Medicaid Program pays for services in three ways: fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; capitated payments to certain managed care organizations (HMOs) which create provider networks by contract with health care providers and which bear full risk for the care of Medicaid recipients who enroll in the managed care organization; and fee-for-service reimbursement to certain managed care organizations (PSNs) which create provider networks by contracting with health care providers and which must share any savings with the Medicaid program or pay Medicaid for lack of savings.

Medicaid uses a capitated payment model for Health Maintenance Organizations (HMOs), Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.

Rates for HMOs are set for specific demographic cohorts based on age, sex, geographic location and eligibility group. While these factors are linked with utilization patterns to some extent, they do not capture or reflect any detailed understanding of a person's clinical risk. Medicaid reform initiated a process for adjusting rates to reflect clinical risk. The adjustments were phased in over a three-year period with a 10 percent risk corridor to limit any dramatic changes in payment levels.

Medicaid uses fee-for-service reimbursement for Provider Service Networks (PSNs) such as minority physician networks. PSNs also receive a per-patient case management fee. Provider service networks are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

Managed Behavioral Health Care

AHCA provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs. Florida began testing managed care models for providing mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration project in 1996 in the Tampa Bay area. The purpose of the demonstration was to create a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the initial demonstration project, Florida has continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the MediPass plan, both physical health and pharmacy benefits were paid for on a fee-for-service basis. For beneficiaries enrolled in a HMO, physical health and pharmacy benefits were paid for through a capitated arrangement.

State Plan services for mental health include:

- Inpatient psychiatric services
- Outpatient hospital services for covered diagnoses
- Community mental health services
- Mental health targeted case management
- Psychiatrist physician services

Persons who are eligible for prepaid mental health plans must be assigned to a MediPass, Minority Physician Network, Exclusive Provider Organization, or a Provider Specialty Network plan.

Beneficiaries in Medicaid Reform are excluded from prepaid mental health services and receive behavioral health care through their regular managed care organization[6].

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are private, non-profit community-based organizations that receive a federal grant under Section 330 of the Public Health Service Act. FQHC services include primary care—medical, dental, and behavioral health services. The primary purpose of FQHCs is to expand access to people who experience financial, geographic, or cultural barriers to care and who live in or near medically underserved areas.

By 2007, more than 1,000 health centers operated in 6,672 sites around the nation; the centers provided approximately 63 million visits for 16 million individuals.[7] Florida currently has 42 FQHCs operating more than 200 clinic sites located in a variety of medically underserved areas. FQHCs are required to: serve everyone, without regard to ability to pay; operate on a sliding fee scale; and accept all types of insurance.

In accordance with federal regulations, Medicaid pays FQHCs a prospective payment rate. This rate was calculated based on the average of the clinic's Medicaid per diem rates in effect for state fiscal years 1999 and 2000. Since 2001, the clinic rate has been increased annually based on the Medicare Economic Index. The average clinic rate as of October, 2008 was $122.86. Medicaid paid FQHC clinics $49.2 million for 386,327 encounters. These payments provided reimbursement for the following types of services:

- Adult health screening services;
- Child health check-ups
- Chiropractic services
- Dental services
- Family planning services
- Medical primary care
- Mental health services
- Optometric services
- Podiatric services.

Medicaid also reimburses FQHCs for emergency services, services delivered offsite and immunizations at regular fee-for-service rates.

[6] *Supra*, note 3.
[7] Patients Served by Federally-Funded Federally Qualified Health Centers, 2007, http://www.statehealthfacts.org/comparemaptable.jsp?ind=426&cat=8 (last viewed March 31, 2009).

Medical Home Pilot Project

The term "medical home" was first coined by the American Academy of Pediatrics in 1967. The model is supported by the American Academy of Family Physicians and the American College of Physicians. The National Committee for Quality Assurance (NCQA) released standards in January 2008 for patient centered medical homes. A medical home is a patient-centered model of care that provides a home base—a personal health care professional, usually a physician, who coordinates and facilitates access to medical care. The personal provider is the patient's first contact as well as his continuing contact throughout the delivery of a comprehensive range of services. Medical homes are characterized by use of health information technology, the coordination of specialty and inpatient care, preventive services, disease management, behavioral health care, patient education, and the diagnosis and treatment of acute illness. A variety of studies have validated the model and indicated that this approach to services results in lower hospitalization rates, lower rates of death for heart disease, cancer and stroke, and reduced rates of medical errors.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized the Agency for Health Care Administration (AHCA) to seek and implement a federal waiver for a managed care pilot program. AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. Current law sets a goal of statewide expansion by 2011.

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially based, risk-adjusted, capitated rates. Reform allowed AHCA to open competition in the delivery of health care benefits by establishing a certification process, which permits a broad array of entities to become managed care plans upon meeting certain financial, programmatic, and administrative requirements.

In reform, risk-adjusted rates are achieved by considering the four factors used for non-reform HMOs (age, sex, geographic location and eligibility group), and an additional factor: clinical history. Recipients' clinical risk is scored based on a combination of historic drug claims and historic diagnosis information gleaned from encounter data submitted to AHCA by the health plans. Without clinical risk adjustment, managed care organization payments might not reflect the level of risk they actually assume, and any one managed care plan may be overpaid or underpaid depending on the health status of the recipients who choose to enroll in that plan. This kind of risk adjustment creates disincentives for managed care plans to market to healthier recipients or to promote disenrollment by sicker individuals, often called "cherry picking." Rather, it creates incentives for managed care plans that have sicker patients to identify them as early as possible and work to manage their care to avoid experiencing high costs. Similarly, clinical risk adjustment creates opportunity for innovative managed care organizations to create plans that specialize in meeting the needs of high-risk patient groups.

The terms and conditions of the Medicaid Reform waiver created a Low Income Pool to be used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. This pool constituted a new method for such supplemental payments, different from the prior program called Upper Payment Limit. Based on the waiver, Florida was able to increase these payments to hospitals and other providers by approximately $250 million. The federal waiver sets a capped annual allotment of $1 billion for each year of the 5-year demonstration period for the LIP.[8] The LIP program also authorized supplemental Medicaid payments to provider access systems, such as federally qualified health centers, county health departments, and hospital primary care programs, to cover the cost of providing services to Medicaid recipients, the uninsured and the underinsured.

In 2008, $1 billion in LIP payments were made to more than 60 hospitals and other providers.

[8] Centers For Medicare & Medicaid Services Special Terms and Conditions, Section 1115 Demonstration Waiver No. 11-W-00206/4, Florida Agency for Health Care Administration, at 24.

Managed Care Enrollment

Federal regulations require Medicaid beneficiaries to have a choice of providers. This requirement may be satisfied with a choice of HMOs, or a choice between an HMO and MediPass, or a choice among MediPass providers.

Upon enrollment in Medicaid, recipients have 30 days to exercise their choice of providers. Choice counseling is available during this period through a toll-free help line in non-reform counties and through telephone, face-to-face counseling, mailings and outreach activities in Reform. Those who select a managed care plan are enrolled for a 12-month period. After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next nine months.

For those who do not make a choice, current law requires AHCA in non-reform counties to assign recipients "until an enrollment of 35 percent in Medipass and 65 percent in managed care plans" is achieved. The law further requires enrollment procedures to maintain this same proportionate distribution over time. After these considerations, assignment procedures may consider past choices of the participants.

In reform areas, all participants are assigned to managed care plans, but mandatory assignments are "based on the assessed needs of the recipient as determined by the agency."[9] In making such assignments, the agency must take into account several factors: the plan's network capacity; a prior relationship between the recipient and the plan or one of the plan's primary care providers; the recipient's preference for a particular network, as demonstrated by prior claims data; and geographic accessibility.

Contracts between Managed Care Organizations and Providers

HMOs are required to meet network adequacy standards; in other words, HMOs must contract with a sufficient number of various types of providers in order to assure that the plan's enrollees have access to Medicaid covered services. In some areas, specific types of services may only be available from one or a very small number of providers. In these cases, providers are likely to demand higher payment rates or other concessions from the HMO. HMOs receive capitation rates that are established based on fee-for-service expenditures and, unlike private plans, cannot adjust their prices to respond to higher costs. Therefore, higher costs due to providers' demands for payments greater than those in fee-for-service Medicaid cannot be sustained.

Hospitals are required by federal[10] and state[11] law to provide appropriate medical screening and treatment for emergency conditions. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer may be implemented.[12]

The Legislature has witnessed the tension between HMOs and providers as several bills have been debated that would establish parameters for these contractual arrangements or place requirements on the parties when no contract is reached. Florida law requires AHCA to maintain an inventory of hospital emergency services; hospitals with emergency departments are required to provide services when a person requests service or services are requested on a person's behalf. The law establishes

[9] s. 409.91211(4), F.S.
[10] s. 1867(a) of the Social Security Act.
[11] s. 395.1041, F.S.
[12] EMTALA Overview, http://www.cms.hhs.gov/emtala/, (last viewed March 31, 2009).

conditions and arrangements for transfer including a requirement for a physician to certify that the transfer is necessary. The law specifically requires the provision of services within the hospital's capability and without regard to the patient's ability to pay.

Effect of Proposed Changes

The bill creates a new pilot based on a medical home concept with federally qualified health centers (FQHCs) coordinating care with medical schools for specialty care and hospitals for inpatient services. The following framework is established for the pilot:

- Purpose: to test a coordinated care model in a fee-for-service environment.
- Organization: at least one network in each pilot county; networks must consist of FQHCs for primary care, medical schools for specialty care, and hospitals for inpatient services.
- Service capabilities: core services consist of primary care, case management, care coordination, pharmacy services, outpatient specialty care, and inpatient care; networks must also arrange for patients' access to all mandatory Medicaid services.
- Principles: a personal medical provider leads an interdisciplinary team to meet patient needs through coordinated care and integrated care service delivery; information technology is utilized to improve clinical performance and enhance outcomes.
- Enrollment: patients of FQHCs are offered the option of participating; other participants are assigned from the pool of Medicaid participants subject to mandatory assignment in a ratio of 65 percent for the medical home pilot and 35 percent for other managed care plans in the pilot counties.
- Access standards: written agreements establish the network's capability for referral, access to medical records and follow up care.
- Financing: medical home network providers are paid through the normal fee-for-service reimbursement system; subject to appropriations, the following payment enhancements may also be available:
    - Enhanced case management fee;
    - Enhanced fee for specialty care through physician upper payment limit program;
    - Facility fees for outpatient specialty clinics;
    - Eligibility for LIP supplemental payments and exempt hospital rates.
- Shared savings: subject to appropriations, the network may be allowed to share savings evident by comparison to spending levels for prepaid health plans; when the savings are equal to the area discount factor, they may be shared; when they exceed the area discount factor the full amount of the excess savings may be appropriated.
- Quality assurance: medical home networks are required to maintain records and clinical data for ongoing quality improvement.
- Evaluation: the agency shall contract with the University of Florida for a two-year preliminary evaluation and a five-year final report.

The pilot is created through development of at least one network in Alachua, Hillsborough, Orange and Miami-Dade Counties. Enrollment in the pilot consists of Medicaid patients receiving care at participating FQHCs. Additional enrollment will be built from persons subject to mandatory assignment based on a ratio of 65 percent for the medical home pilot and the remaining 35 percent to other managed care organizations.

The bill authorizes a three-year phase-in of risk-adjusted capitation rates beginning in 2011. During the phase-in a 10 percent limit, or risk corridor, is placed on the rates to prevent more dramatic swings in revenue to capitated plans. A technical advisory panel is created to assist AHCA with transition to risk-adjusted rates.

The bill authorizes AHCA to designate a portion of the capitation rates paid to prepaid plans to be used as incentives for healthy behaviors. Qualifications for the enhanced benefits will be established by the agency. The types of rewards that may be used include health and related services not normally covered by the prepaid plans.

The bill also directs AHCA to develop, and the prepaid health plans to comply with, an encounter data system. Additionally, the bill directs AHCA to provide regular reports to the Governor and the Legislature on the financial status of Medicaid HMOs. The bill creates a workgroup to assess the financial status of Medicaid managed care plans and develop recommendations for policy changes in the future.

The bill also includes the following specific changes to current policy or practice in the Medicaid program:

- Recipients of LIP funds or rebased rates are required to provide services to all Medicaid patients regardless of county of origin.
- The date for provider service networks to move to capitation instead of fee-for-service is delayed for two more years.
- The FQHC prepaid health plan is permitted to provide behavioral managed care.
- Financial requirements for the FQHC prepaid health plan are revised to be consistent with OIR standards.
- The behavioral managed care plan operated by Jackson Memorial Hospital is permitted to integrate this care with acute care services.
- Medicaid recipients with HIV/AIDS shall remain in specialty plans unless they actively opt out.

The bill creates a monitored negotiation process for resolving, at the request of the parties, an impasse in contract negotiations in those cases when contracts are necessary for managed care organizations to meet network adequacy standards. The monitoring process includes three steps, after which the agency must modify its contracts with the involved provider and/or plan in one of two ways:

- The managed care plan shall pay the provider at a rate equal to 90 percent of the provider's fee-for-service rate as of July 1 of the contract year; or,
- The agency shall reimburse the provider on a fee-for-service basis for the managed care plan's enrollees and recoup 110 percent of the costs of these payments at the end of the contract year.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.907, F.S., relating to Medicaid provider agreements.

Section 2. Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.

Section 3. Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.

Section 4. Creates s. 409.91207, F.S., relating to the Medical Home Pilot Project.

Section 5. Amends s. 409.91211, F.S., relating to the Medicaid managed care pilot program.

Section 6. Amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment.

Section 7. Amends s. 409.9124, F.S., relating to managed care reimbursement.

Section 8. Creates s. 409.9129, F.S., relating to monitored negotiations of managed care contracts.

Section 9. Provides an effective date of July 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Some increased revenue may be associated with the recoupment provision of the monitored negotiation process. The amount is indeterminate.

2. Expenditures:

While the bill authorizes several enhanced payment rates, each of these are subject to specific authority in the General Appropriations Act.

The bill authorizes payment of exempt rates to hospitals that participate in the medical home networks. Without knowing which hospitals will participate, the fiscal impact of this provision is indeterminate. More than 60 hospitals already qualify for exempt rates, including those hospitals with the highest proportion of Medicaid and indigent patients.

Increased costs may be associated with the movement of Medicaid participants from prepaid managed care plans to the medical home network. Enrollment of Medicaid participants in prepaid health plans guarantees savings compared to fee-for-service spending due to the discount factor built into the capitated rate. Savings associated with the medical home model are indeterminate although similar models in other states have demonstrated savings compared to prior fee-for-service utilization and expenditure patterns.

The cost to the agency for executing the monitored negotiation process is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some increase in cost may occur for hospitals that receive LIP funds and currently limit use by out-of-county residents. The amount of this impact is indeterminate.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority pursuant to s. 409.919, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES