The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL:	PCS/SB 1484 (529344)
INTRODUCER:	Committee on Health and Human Services Appropriations
SUBJECT:	Medicaid
DATE:	March 17, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kynoch	Hansen	HA	**Pre-meeting**
2.			WPSC	
3.			RC	
4.				
5.				
6.				

I. Summary:

The Proposed Committee Substitute:

- Requires any entity which contracts with the Agency for Health Care Administration (AHCA or agency) on a prepaid or fixed-sum basis as a managed care plan to post a surety bond that is equivalent to a 1-year guaranteed savings amount as specified in the contract. If the provider terminates the contract early, the agency must pursue a claim against the surety bond in an amount equal to the guaranteed savings and any costs incurred by the state resulting from the early termination. The agency is required to terminate any vendor from all contracts with the agency if the contractor does not reimburse the state within 30 days after early termination of a prepaid or fixed-sum basis managed care plan contract.
- Authorizes the agency to apply for a waiver extension amendment of the Medicaid reform waiver obtained under s. 1115 of the Social Security Act (the Medicaid reform waiver) and to preserve the low income pool provisions of the waiver. The agency is directed to expand the waiver to counties that have two or more managed care plans that have capacity to serve the designated populations. In addition, the agency is authorized to expand the Medicaid reform waiver to other counties as plan capacity is developed.
- Requires the AHCA to fine any managed care plan which discriminates against a Medicaid recipient based on the recipient's health status.
- Revises the requirements for choice counseling of Medicaid recipients in reform counties to clarify the information a participant must be provided and repeals the requirement for face to face interaction between the counselor and the participant. The bill repeals the requirement that the entity performing choice counseling must determine if the recipient has made a choice, and the requirement that the agency contract with entities to perform choice counseling.

- Revises the requirements for the selection of a behavioral health care provider in Broward County for children who have a case open in the Department of Children and Family Services's HomeSafeNet (HSN, Florida's child welfare reporting) system,) to allow these children who are in the custody of the State to enroll in a managed care plan which provides both physical and mental health care services. The bill authorizes a participating specialty plan to receive an administrative fee for coordination of services based the receipt of the state share of the fee from intergovernmental transfers.
- Adds an additional item to the list of criteria the agency uses to assign those Medicaid recipients who fail to select a plan to a managed care plan: plan performance as designated by the agency.

For the Fiscal Year 2010-2011, expansion of the section 1115 Medicaid reform waiver to counties with two or managed care plans and capacity to serve all Medicaid recipients in those counties is projected to reduce Medicaid program expenditures by $28.6 million ($ 10.3 million general revenue) with annualized savings of $ 98.3 million ($ 40.6 m general revenue.)

This bill substantially amends, the following sections of the Florida Statutes: ss. 409.912; 409.91211, F.S.

II. Present Situation:

Medicaid Managed Care Programs

The State of Florida operates a Medicaid managed care program through a federal section 1915(b) waiver obtained from the Centers for Medicare and Medicaid Services in 1991. The managed care waiver provides the state with the authority to mandatorily assign eligible beneficiaries[1] and, within specific areas of the state, limit choice to approved managed care providers. The federal waiver requires Florida Medicaid recipients to be given a choice of managed care providers. The Medicaid managed care program is broken into two major categories of providers: MediPass and managed care plans. However, s. 409.91211, F.S., codifies the Medicaid reform managed care pilot program in Baker, Broward, Clay, Duval, and Nassau Counties. Eligible Medicaid recipients in these counties must enroll in a managed care plan and do not have the ability to choose the MediPass program.

The Medicaid Provider Access System (MediPass) is a primary care case management program for Medicaid recipients developed and administered by Florida Medicaid. MediPass was established in 1991 to assure adequate access to coordinated primary care while decreasing the inappropriate utilization of medical services. In MediPass, each participating Medicaid recipient selects, or is assigned, a health care provider who furnishes primary care services, 24-hour access to care, and referral and authorization for specialty services and hospital care. The primary care providers are expected to monitor the appropriateness of health care provided to their patients. MediPass providers receive a $2 monthly case management fee for each of their enrolled

[1] Certain persons are ineligible for mandatory managed care enrollment. The major population groups excluded from enrolling in managed care altogether include the Medically Needy, recipients who reside in an institution, those in family planning waivers, and those who are eligible for Medicaid through the breast and cervical cancer program. Dual eligibles (persons who have both Medicaid and Medicare coverage) are excluded from enrollment in MediPass, yet the dual eligibles and others (SOBRA pregnant women and children in foster care) may voluntarily enroll in any other type of managed care plan.

patients, as well as the customary reimbursement according to the Medicaid Provider Handbook for all services rendered. Currently, there are 2,482 enrolled Medicaid provider practices that include 5,087 individual providers.[2]

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

Depending on where an individual lives in the state and their eligibility status, Medicaid recipients are given a choice of either MediPass or a managed care plan when they enroll in the Medicaid program. Under s. 409.9122, F.S., the AHCA is required to assign all Medicaid recipients eligible for mandatory assignment into either MediPass or a managed care plan if they do not make a choice within 30 days of eligibility.

Medicaid Reform

During the 2005 legislative session, chapter 205-133, Laws of Florida, authorized the Agency to apply for a section 1115 waiver to implement a Medicaid managed care pilot program.[3] Pursuant to the authority provided in that law, the agency received approval of the waiver application on October 19, 2005. Once the agency received legislative approval,[4] it began implementing the pilot program in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007.[5]

Florida's Medicaid reform waiver is a 5-year demonstration, which began July 1, 2006, and runs through June 30, 2011.[6] The federally-approved waiver is accompanied by Special Terms and Conditions (STC) which, combined, constitute the guiding agreement between the state and the federal government on the implementation of the Medicaid reform proposal. The Centers for Medicare and Medicaid Services (CMS) STC document describes the details of the Medicaid reform section 1115 demonstration waiver.

The STC identifies the four fundamental elements of Florida's Medicaid Reform Pilot Project as:

1) *Risk-adjusted premiums* are developed for Medicaid enrollees in managed care plans. The premium have two components, comprehensive care and catastrophic care, and are actuarially comparable to all services covered under the current Florida Medicaid program.

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[2] Agency for Health Care Administration, Managed Care in Florida, Presentation before the Senate Ways and Means Committee, February 17, 2010. Found at: <http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/managed_care_in_fl_medicaid_02-17-2010.pdf> (Last visited March 10, 2010).

[3] Laws of Florida, Ch. 2005-133.

[4] Laws of Florida, Ch. 2005-358.

[5] Section 409.91211, F.S.

[6] Agency for Health Care Administration, Centers for Medicare and Medicaid Services Special Terms and Conditions, Medicaid Reform 1115 Demonstration., Found at: < http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf> (Last visited January 15, 2010).

2) *Enhanced Benefits Accounts* are established to provide incentives for Medicaid reform enrollees for healthy behaviors. As enrollees earn access to these incentives, funds are deposited into individual enhanced benefits accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals and vitamins.
3) *Employer-Sponsored Insurance (ESI)* is provided to allow individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace.
4) The *Low-Income Pool (LIP)* is provided for direct payment and distribution of funds to safety-net providers in the state for the purpose of providing coverage to the uninsured through provider access systems. The LIP program replaced the hospital upper-payment-limit program and is a capped annual allotment of $1 billion total computable for each year of the 5-year Medicaid demonstration period.[7]

Medicaid Behavioral Health Care Services

Behavioral health care services are an optional Medicaid service under s. 409.906(8), F.S. The law provides that the agency may pay for rehabilitative services provided to a recipient by a mental health or substance abuse provider under contract with the agency or the Department of Children and Family Services (DCFS.) The agency provides reimbursement for mental health targeted case management and community behavioral health care services. The DCF Mental Health Program Office, in conjunction with the Medicaid program, is responsible for approving policy for the Medicaid mental health management program.[8] The DCF is responsible for collaborating with and joint development of all behavioral health Medicaid policies, budgets, procurement documents, contracts and monitoring plans.[9] The agency is required to offer community mental health providers, child welfare providers, and mental health providers, under contract with the DCF under part IV of ch. 394, F.S., under contract with the DCF in Areas 1 and 6, and licensed pursuant to ch. 395, F.S., respectively, the opportunity to participate in any Medicaid provider network for prepaid behavioral health care services.

Medicaid Prepaid Behavioral Health Plans

In March 1996, the agency implemented a Prepaid Mental Health Plan (PMHP) demonstration pilot, under the authority of the section 1915(b) Medicaid managed care waiver. The program was piloted for many years in two areas of the state before being expanded statewide in 2004, and is codified in s. 409.912(4), F.S. A prepaid behavioral health plan is a managed care organization that contracts with the agency to provide comprehensive behavioral health care services to its members through a capitated payment system. The agency pays a per member, per month (PMPM) fee to the plan based on the age and eligibility category of each member. Services provided by these plans must include:

- Inpatient psychiatric hospital services (45 days for adult recipients and 365 days for children);
- Outpatient psychiatric hospital services;

[7] Agency for Health Care Administration, Centers for Medicare and Medicaid Services Special Terms and Conditions, Medicaid Reform Section 115 Demonstration, p. 24. Found at: <http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf> (Last visited January 15, 2010).
[8] See, Florida Medicaid, Mental Health Targeted Case Management Handbook. Found at: <http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_07_070601_MH_Case_Mgmt_ver2.2.pdf> (Last visited on March 14, 2010).
[9] s. 409.912(4), F.S.

- Psychiatric physician services;
- Community mental health services; and
- Mental health targeted case management.

Medicaid recipients who elect to enroll in MediPass for the provision of their physical health care services are assigned to a prepaid behavioral health plan for the provision of their mental health services, unless they are ineligible. Ineligible persons include:

- Recipients who have both Medicaid and Medicare coverage (dual eligibles);
- Persons living in an institutional setting, such as a nursing home, state mental health treatment facility, or prison;
- Medicaid-eligible recipients receiving services through hospice;
- Recipients in the Medically Needy program;
- Newly enrolled recipients who have not yet chosen a health plan;
- Consolidated Omnibus Budget Reconciliation Act eligible pregnant women and presumptively eligible pregnant women;
- Individuals with private major medical coverage;
- Members of a Medicaid HMO if the HMO has chosen to provide behavioral health services;
- Recipients receiving Florida Assertive Community Treatment services; and
- Children enrolled in the HSN database, unless they are enrolled in a Medicaid reform managed care plan in Broward County.

Because of their unique situation, children in the HSN database are excluded from participating in a prepaid behavioral health plan. A separate prepaid plan was developed for these children to provide services (including behavioral health care services) operated by community based lead agencies as of July 1, 2005, that are contracted through the DCF.

Prepaid behavioral health plans under s. 409.912(4)(b), F.S., are required to spend 80 percent of the capitation rate paid to the plan for the provision of behavioral health care services. If a plan spends less than 80 percent of its behavioral health capitation rate on behavioral health care services, then the difference must be returned to the agency. The agency is required to provide each managed care plan that covers behavioral health services a letter that indicates the amount of capitation paid during each calendar year for behavioral health care services. Medicaid HMOs that provide behavioral health care services must also meet the 80 percent requirement.

Medicaid beneficiaries who choose to enroll in MediPass are automatically enrolled into prepaid behavioral health plans for behavioral health care services. Beneficiaries, who choose to enroll in a Medicaid HMO receive their behavioral health care services through the HMO. In Medicaid reform areas, behavioral health care services are provided through HMOs or provider service networks (PSNs.)

Medicaid Behavioral Health Plans for Foster Children

The provision of child welfare services in Florida is a privatized system of care. In 2001, the Florida legislature instructed the Florida Department of Children and Family Services (DCF) to privatize the provision of foster care and related serves statewide. The privatization of foster care was completed through the creation of Community Based Care Agencies (CBC's.) These

agencies either took over the provision of foster care services in their district or formed a group of agencies that split the responsibility.

In 2004, the state began to expand the Prepaid Mental Health plans statewide through competitive procurement. The Prepaid Mental Health plans provide mental health services to the MediPass population. The Medicaid HMOs are required to provide the same services as the Prepaid Mental Health Plans to all enrolled recipients, adults and children.

Legislation also mandated that a carve out, specialty plan be created, and competitively procured, to serve the specialized needs of Medicaid eligible children confirmed for abuse and/or neglect and who had open cases for child welfare services. This became the Child Welfare Pre-Paid Mental Health Plan (CWPMHP). One of the predominant goals was to create a plan that specializes in the foster care population by charging the foster care industry with the development and management of the plan. Creating an entity responsible for both behavioral health and foster care services reduced instances of fragmented care, poor coordination between service providers, duplication of services and unmet service needs.

Section 409.912(4)(b), F.S., directs the development of a specialty Mental Health Prepaid Plan for children that receive child welfare services and are registered in the DCF HSN (now Florida Safe Families) database.

Original statutory language directed that the CWPMHP is a statewide managed care plan for Medicaid-enrolled children who are served by community based agencies that the DCF contracts with to provide protective and foster care related services to prevent childhood abuse and neglect. This plan was to cover all areas of the state, including Reform areas, with the exception of AHCA areas 1 (Pensacola) & 6 (Tampa).

Medicaid pays the CWPMHP) a PMPM fee. The mandatory mental health services covered by this Plan includes mental health related inpatient, outpatient, and psychiatric physician services, community mental health, mental health targeted case management services, and specialized therapeutic foster care services.

The CWPMHP covers inpatient and outpatient hospital services, psychiatric and physician services, community mental health services, and targeted case management services. Recipients receive physical health care services from their primary care provider within the health plan network or the Medicaid fee-for-service system, and mental health care services from the prepaid mental health plan contractor. The prepaid mental health plan contractor is required to coordinate the recipient's mental health services with the primary care provider to promote continuity of care.

In addition to these mental health services, the CWPMHP also includes Medicaid funded mental health services designed specifically for children in the foster care system including comprehensive behavioral health assessments for every child entering physical custody; Specialized therapeutic foster care and therapeutic group care.

Substance abuse services and pharmacy services are not covered components of the CWPMHP and may be accessed on a fee for service basis or through their managed care plan.

On August 2, 2006, the Community Based Care Partnership, a partnership between the Community Based Care Providers and Magellan Behavioral Health Care of Florida, Inc., was awarded the competitively procured contract for the Child Welfare Prepaid Mental Health Plan. An issue has arisen relating to the delivery of mental health services for children who have an open case for child welfare services in the HSN and reside in the Medicaid reform Area 10 (Broward County.) The privatized child welfare Community Based Care (CBC) provider in Area 10, ChildNet, challenged the inclusion of the children they serve in the state wide Child Welfare Prepaid Mental Health Plan, indicating a believe that they should be able to develop their own plan under the Reform legislation.

In 2008, legislation was passed to authorize service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906, F.S., to Medicaid-eligible children whose cases are open for child welfare services in the HSN system. These services must be coordinated with community-based care providers as specified in s. 409.1671, F.S., where available, and be sufficient to meet the medical, developmental, behavioral, and emotional needs of these children. These service delivery mechanisms were to be implemented no later than July 1, 2008, in the AHCA Area 10 in order for the children in AHCA Area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)8, F.S.

Also in 2008, legislation was enacted to require than all Medicaid-eligible children, except children in area 1 and children in Highlands County, Hardee County, Polk County, or Manatee County of area 6, that are open for child welfare services in the HSN system, to receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan must provide mechanisms to maximize state and local revenues. The specialty prepaid plan must be developed by the agency and the DCF. The AHCA was authorized to seek federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HSN system and who reside in AHCA area 10 are exempt from the specialty prepaid plan upon the development of a service delivery mechanism for children who reside in area 10 as specified in s. 409.91211(3)(dd), F.S.

Since the changes to the law specified in the two foregoing paragraphs, Medicaid staff has worked consistently with both South Florida Community Care Network (SFCCN) and ChildNet in order to identify and plan implementation of a solution that would serve the children in Broward County. Due to the fact that no funding is available for administrative fees for SFCCN, an alternative solution is needed to allow SFCCN to serve only those children assigned to their plan for medical services.

III. Effect of Proposed Changes:

Section 1 amends s. 409.912, F.S., relating to cost effective purchasing of health care in the Medicaid program, to do the following:

- Require the AHCA to fine any managed care plan which discriminates against a Medicaid recipient based on the recipient's health status. Current law authorizes the agency to fine plans which discriminates against plan participants, but does not require the agency to do so. A Medicaid managed care plan could potentially profit by discouraging unhealthy Medicaid eligible's from enrolling or by encouraging them to disenroll in their plan. Forcing the agency to fine a plan which violates this provision may discourage plans from engaging in this practice.
- Require any entity which contracts with the AHCA on a prepaid or fixed-sum basis as a managed care plan to post a surety bond in an amount equivalent to a 1-year guaranteed savings as specified in the contract. If the provider terminates the contract early, the agency must pursue a claim against the surety bond in an amount equal to the guaranteed savings and any costs incurred by the state resulting from the early termination. The agency is required to terminate any vendor from all contracts with the agency if the contractor does not reimburse the state within 30 days after early termination. This provision is added in an effort to ensure managed care plans guarantee savings to the state. In some counties plans have terminated contracts early which have resulted in the state incurring additional administrative costs associated with reassigning plan participants to other managed care plans.

Section 2 amends s. 409.91211, F.S., relating to the Medicaid managed care pilot program, to do the following:

- Authorize the agency to apply for a waiver extension amendment of the Medicaid reform waiver obtained under s. 1115 of the Social Security Act (the Medicaid reform waiver) and to preserve the low income pool (LIP) provisions of the waiver. The agency is directed to expand the waiver to counties that have two or more managed care plans that have capacity to serve the designated populations. In addition, the agency is authorized to expand the reform waiver to other counties as plan capacity is developed. Florida's existing 1115 waiver expires June 30, 2011 and must be renewed in order to assure the continuation of LIP. Loss of LIP would mean a reduction of hundreds of millions of federal matching funds for Florida and a return to the predecessor program to LIP, the Upper Payment Limit (UPL) program, which provides states with much less flexibility in program design. Currently, 19 counties in Florida have two or more Medicaid managed care plans with the capacity to serve all Medicaid recipients: Brevard, Citrus, Dade, Gadsden, Hernando, Hillsborough, Jefferson, Lake, Liberty, Madison, Manatee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Seminole, and Wakulla. These 19 counties have a total Medicaid population which would be transitioned into a managed care plan of 247,671.
- Revise the requirements for choice counseling of Medicaid recipients in reform counties to clarify the information a participant must be provided and to repeal a requirement for face to face interaction between the counselor and the participant. Also repeals a requirement that the entity performing choice counseling must determine if the recipient has made a choice, and repeals a requirement that the agency contract with entities to perform choice counseling. By eliminating the requirement for face to face choice counseling, administrative costs related to Medicaid expansion are reduced and savings to the state increased.
- Revise the requirements for the selection of a behavioral health care provider in Broward County for children who have a case open in the Department of Children and Family's HSN system, to allow these children who are in the custody of the state to enroll in a specialty plan which provides both physical and mental health care services. The bill authorizes a

participating specialty plan to receive an administrative fee for coordination of services based on the receipt of the state share of the fee from intergovernmental transfers. This language makes it possible for HSN children to be enrolled in SFCCN and receive both their physical health and behavioral health services from the same plan, or they could be enrolled by ChildNet into a different plan to receive their physical health services. Parents of children not in the custody of ChildNet would retain choice of a physical health care provider.

- Add an additional item to the list of criteria the agency uses to assign Medicaid recipients (who fail to select a plan) to a managed care plan: plan performance as designated by the agency. This provision will allow the agency to assign Medicaid recipients in reform areas to the most cost effective plans in order to maximize savings.

Section 3 provides an effective date of July 1, 2010.

Other Potential Implications:

One issue which may prove problematic in expanding Medicaid reform to counties with 2 or more managed care plans is the funding source used for Medicaid hospital services. Currently, many local governments in Florida provide tax revenue to the state in the form of intergovernmental transfers (IGTs) which are used to "buy back" rate reductions and ceiling limitations placed on hospital payments by the legislature. Absent these IGTs, state Medicaid reimbursement covers approximately 56 percent of a hospital's costs. The use of IGTs (which are used to draw down federal matching funds) increases this percentage to over 90 percent of costs for some hospitals.

There is a question as to whether local governments will be willing to contribute IGTs if these funds are not paid directly to a hospital, but rather are paid to a managed care plan which will then reimburse the hospital. If this issue cannot be resolved, moving Medicaid patients into capitated managed care plans could result in the loss of hundred millions of dollars in federal matching funds.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Medicaid managed care plans will have to opportunity to serve additional Medicaid recipients in the 19 counties with two or more such plans. Medipass and Medicaid fee-for-service providers will see a concomitant reduction in their patient volume.

Choice counseling providers could possibly see a reduction in their opportunities for government contracts.

Medicaid managed care providers will be required to post a surety bond to guarantee the state the level of savings contained in its Medicaid managed care contract, and to pay any administrative costs experienced by the state associated with early termination of a contract by the managed care provider. Failure to pay these costs could result in the termination of all contracts the provider has with Medicaid.

Medicaid providers which discriminate against Medicaid eligible patients based on the health status of the patient will be fined by the agency.

If the intergovernmental transfers (IGTs) issue cannot be resolved, hospitals could lose a significant sum of local funds and the associated federal match.

C. Government Sector Impact:

Expanding the section 1115 Medicaid reform waiver to counties with two or managed care plans and capacity to serve all Medicaid recipients in those counties is projected to reduce Medicaid expenditures by $28.6 million ($10.3 milliion general revenue) in Fiscal Year 2010-11 with annualized savings of $98.3 million ($40.6 million general revenue.)

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.