

FINAL BILL ANALYSIS

BILL #: CS/HB 7107

FINAL HOUSE FLOOR ACTION:

79 Y's 39 N's

SPONSOR: Rep. Schenck

GOVERNOR'S ACTION: Approved

COMPANION BILLS: SB 1972

SUMMARY ANALYSIS

CS/HB 7107 passed the House on March 31, 2011. The bill was amended by the Senate on May 6, 2011, and subsequently passed the House on May 6, 2011. The bill was approved by the Governor on June 2, 2011, chapter 2011-134, Laws of Florida, and takes effect July 1, 2011.

Medicaid is a state and federal partnership established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. The program's history is characterized by significant growth in caseload and expenditures.

The bill creates part IV of Chapter 409, F.S., entitled "Medicaid Managed Care," comprised of new sections 409.961 through 409.985, F.S. The bill establishes the Medicaid program as a statewide, integrated managed care program for all covered services, and requires AHCA to obtain and implement state plan amendments or federal waivers necessary to implement the program. Medicaid is created as two managed care programs:

- The Medicaid Managed Medical Assistance Program – primary and acute care
- The Long-Term Care Managed Care Program – residential and home and community based care, alone or paired with primary acute care for comprehensive coverage
- The statewide managed care program has the following characteristics:
- Care and services provided in a managed care model
- Mandatory participation for most populations, voluntary participation for some (including persons with disabilities on the home and community-based services waiver), and some populations excluded
- Competitive, negotiated selection of qualified managed care plans that meet strict selection criteria
- Regionalized plan selection of a limited number of plans to ensure coverage in rural areas
- Limited plan numbers in the 11 regions to ensure stability but allow significant patient choice
- Varying models of managed care, including HMOs, PSNs, specialty plans, and medical home plans
- Specific plan accountability measures, including network standards, achieved savings rebates, encounter data, performance measures, and fraud and abuse measures
- Negotiated payments based on risk-adjusted rates
- Customized benefits to allow meaningful recipient choice
- Opt Out Program for recipients to use their Medicaid dollars to purchase other forms of coverage

The bill is anticipated to have a positive and negative fiscal impact to state government. (See Fiscal Comments.)

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Current Situation

Medicaid Overview

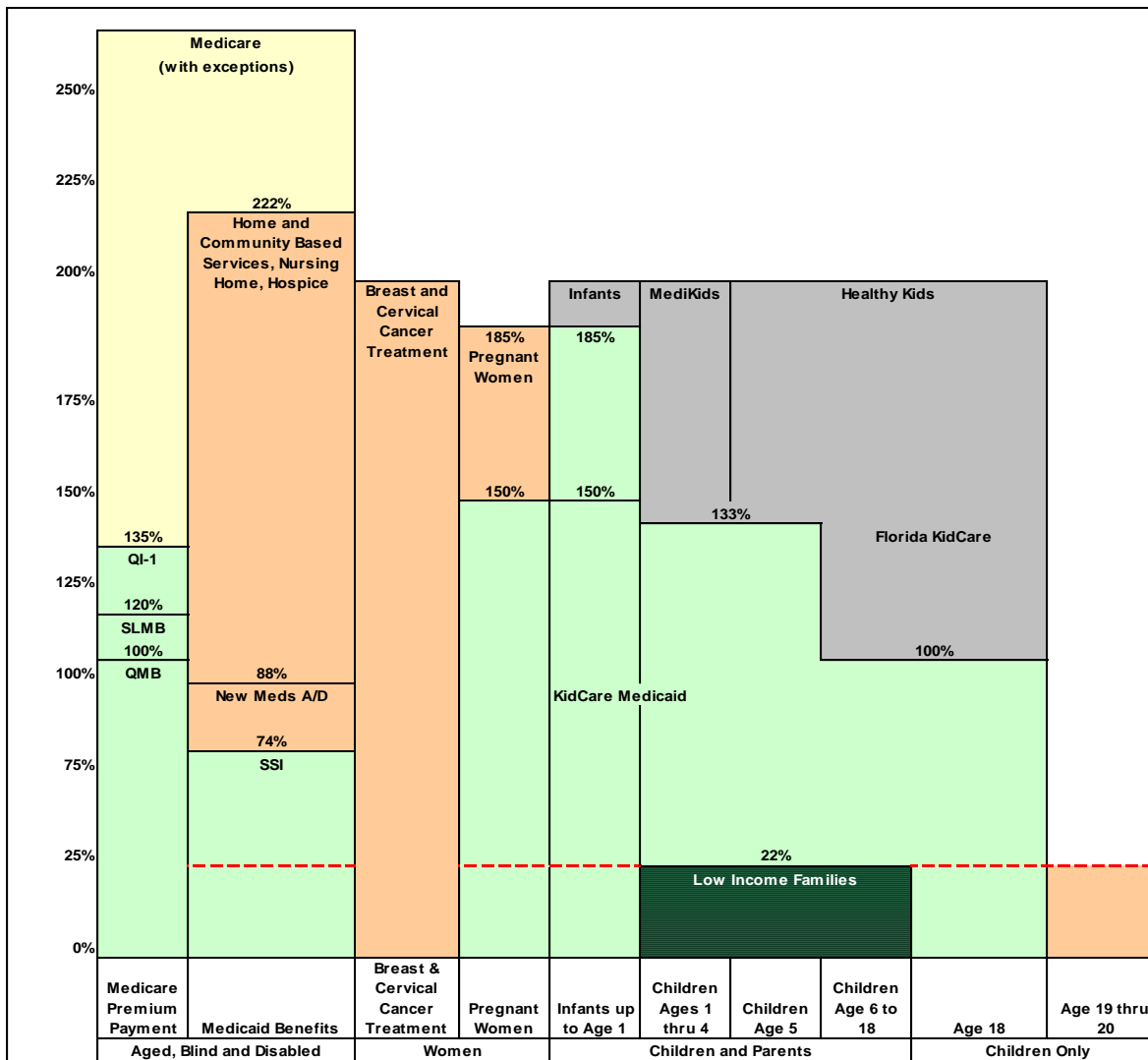
Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs. Key characteristics¹ of Florida's Medicaid program are as follows:

- Over 2.9 million enrolled recipients.
- \$20.3 billion estimated spending in Fiscal Year 2010-2011.
- \$7,000 estimated per recipient spending in Fiscal Year 2010-2011.
- Over half the childbirths in Florida are paid for by the Medicaid program.
- 27% of Florida children are covered by Medicaid.
- Over 1.9 million of the 2.9 million recipients are enrolled in some type of Medicaid managed care.
 - 1.1 million in HMOs.
 - 196,000 in PSNs.
 - 613,000 in Medipass.
- 936,000 of the 2.9 million recipients are enrolled in fee-for-service Medicaid.
- 24 managed care organizations, including 19 HMOs and 6 PSNs
- 100,000 fee-for-service providers

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. In the following chart, the yellow and light green sections are mandatory populations by federal law. States can add eligibility groups, with federal approval. In the chart, the orange sections show the groups Florida has added over the years. Once these optional groups are part of the Medicaid program the entitlement applies to them as well.

¹ Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the House Health and Human Services Committee, January 2011; Comprehensive Medicaid Managed Care and Medicaid Pilot Enrollment Report, February 2011, Agency for Health Care Administration.



The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.² States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.³

States do have some flexibility. States can ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has 20 separate waiver programs for distinct populations, services and service delivery models.

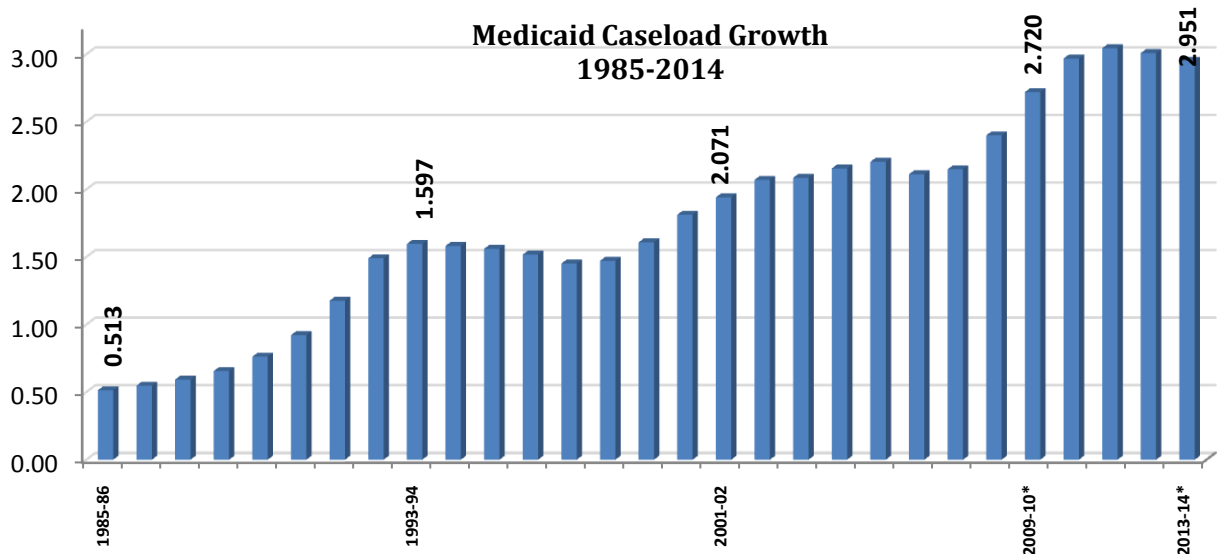
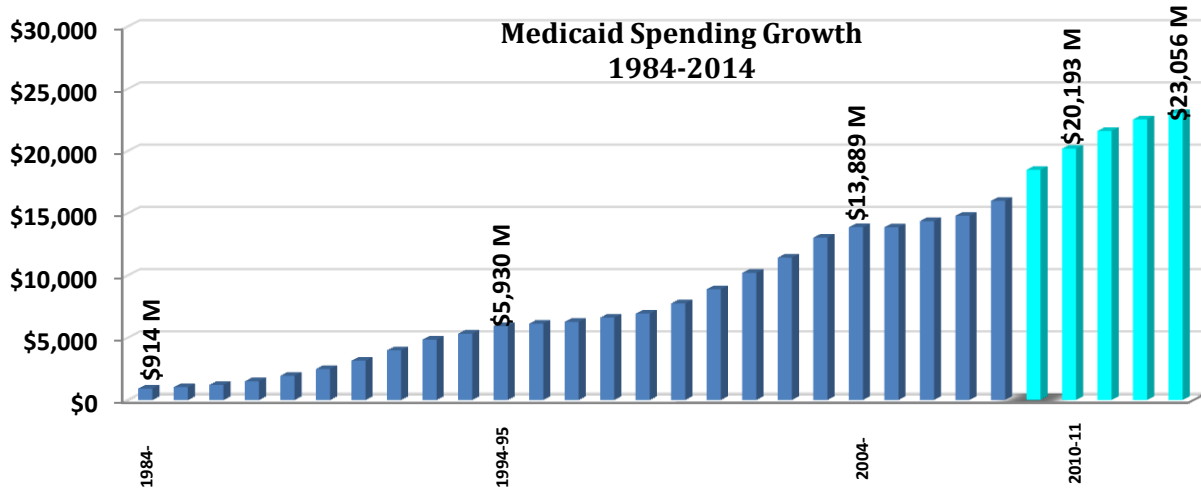
Florida Medicaid is the second largest single program in the state, behind public education, representing 28 percent of the total FY 2010-11 budget. Medicaid General Revenue expenditures represent 17 percent of the total General Revenue funds appropriated in FY 2010-11. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures.

Florida's Medicaid costs have increased significantly since its inception, due to substantial eligibility expansion as well as the broad range of services and programs funded by Medicaid expenditures. The growth in Florida's Medicaid population and expenditures is shown in the following figures.⁴

² S. 409.905, F.S.

³ S. 409.906, F.S.

⁴ *Supra*, note 1.



Current estimates indicate the program will cost \$21.4 billion in FY 2011-2012. By FY 2013-2014, the estimated program cost is \$23.6 billion. Florida has made numerous and repeated efforts to control costs in the program.⁵ Since 1996, the Legislature has reduced \$5.2 billion from the program through rate reductions, utilization limits, fraud and abuse efforts, and other cost control initiatives. For example, approximately 40 percent of the Medicaid prescription drug budget is funded by manufacturer rebates.

Medicaid and Federal Health Care Reform

The U.S. Congress passed the Patient Protection and Affordable Care Act⁶ and President Barack Obama signed the bill into law on March 23, 2010.⁷ Key policy areas of reform include: mandated

⁵ See, Florida Medicaid Budget Reduction History, presented by staff of the House Health Care Appropriations Committee in the Select Council on Strategic and Economic Planning, October 7, 2009.

⁶ Pub. L. No. 111-148, 124 Stat. 119 (2010)

⁷ The act is currently being challenged as unconstitutional by Florida and 25 other states. The law was declared unconstitutional by the court in State of Florida, et al. v. United States Department of Health and Human Services, et al., ---

individual coverage; mandated employer offers of coverage; expansion of Medicaid; individual cost-sharing subsidies and tax penalties for non-compliance; employer tax penalties for non-compliance; health insurance exchanges; expanded regulation of the private insurance market; and revision of the Medicare and Medicaid programs. Several of these changes will affect the Florida Medicaid program.

Medicaid currently focuses on covering low-income children, pregnant women, and adults who are elderly or have a disability. The federal reform act increases the mandatory population to all adults, regardless of whether they are disabled or elderly, up to 133 percent of the poverty level. The reform law would finance the expansion by raising the federal match rate for the new groups. States would still have to pay a share for the new groups, but it would be smaller than for existing groups. However, the additional federal match is time-limited.

In addition, the federal reform law imposes a mandate on individuals to buy insurance, or pay a penalty. Currently, many uninsured individuals are eligible for Medicaid coverage, but are not enrolled. The existence of the federal mandate to purchase insurance will result in many eligibles coming forward and enrolling in Medicaid who had not previously chosen to do so. While these eligibles are currently entitled to Medicaid coverage, their participation will result in increased costs and would not likely have occurred without the catalyst of the federal mandate.

Element	Affordable Care Act ⁸
Mandatory Expansion	Expand eligibility to 133% FPL (\$29,326 for a family of 4), including non-disabled adults in 2014.
FMAP/Expansion	Enhanced federal matching funds for expansion population: 100% CY 2014 100% CY 2015 100% CY 2016 57.44% + 34.3 = 91.74% CY 2017 57.44% + 33.3 = 90.74% CY 2018 57.44% + 32.3 = 89.74% in CY 2019 and beyond
FMAP/Current Eligibility Level	Regular FMAP (57.44%)
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program 1/1/2015 (through regular annual eligibility redetermination process).
FMAP/CHIP Transition	Anticipated enhanced FMAP for CHIP Population begins 10/1/2015 (134% Federal Poverty Level and above). 10/1/2015: 70.21+23.0=93.21%.
Increased Rate for Practitioners	100% federal funded increase to select codes for primary care providers for 2013 and 2014. This impacts approximately 35% of primary care codes under the Florida Medicaid Program.

The costs of federal reform to Florida Medicaid will be significant. Florida is expected to have over 379,000 new enrollees from the expanded federal reform population in 2014, at a cost of \$1.5 billion (of which \$142 million will be paid by the state), bringing the total cost of Medicaid that year to \$25 billion.

F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.) However, the ruling was stayed and the matter is on appeal to the United States Court of Appeals for the Eleventh Circuit, Case No. 11-11021-HH.

⁸ Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 13, 2010.

By 2019, Florida Medicaid will have 1.9 million additional enrollees, at an additional cost of over \$7.7 billion (of which \$1 billion will be paid by the state).⁹ In subsequent years, the state share may increase.

Federal reform will create additional costs unrelated to caseload expansion. For example, the law increases the minimum federal rebate for brand drugs from 15.1 percent to 23.1 percent and requires that 100 percent of this portion of rebates be withheld by the federal government rather than the current procedure of sharing rebate revenue with the states. This provision will cost Florida approximately \$37 million annually at current levels.¹⁰ The FY 2010-2011 impact is estimated to be a loss in rebate general revenue of \$39.8 million. This will be a recurring loss.¹¹ Additionally, when the federal enhanced payments to primary care providers expire in 2014, it is estimated that continuing the payments will cost the state \$247.9 million in 2015.

Medicaid Managed Care

Florida, like other states, turned to managed care for improving access to care, containing costs and enhancing quality. As of March 1, 2011, 67 percent of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models. Florida uses at least 16 different managed care models, including prepaid health plans, Health Maintenance Organizations (HMOs), primary care case management (MediPass)¹², provider service networks (PSNs)¹³, MediPass disease management, prepaid mental health plans, and prepaid dental health plans.

The Florida Medicaid Program pays for services in three ways: (1) fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; (2) per-member, per-month payments to certain managed care organizations which bear full risk for recipient care; and (3) fee-for-service reimbursement to PSNs which must meet and share savings targets or reimburse the Medicaid program for failure to meet the target.

Medicaid uses a per-member, per-month, or capitated, payment model for HMOs, capitated PSNs, 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. The Medicaid reform pilot (see

⁹ Agency for Health Care Administration, Overview of Federal Affordable Care Act, August 13, 2010; State of Florida Long-Range Financial Outlook Fiscal Year 2011-12 through 2013-14, Fall 2010 Report.

¹⁰ Agency for Health Care Administration, Patient Protection and Affordable Care Act Overview of Medicaid Prescribed Drug Changes, October 21, 2010.

¹¹ Agency for Health Care Administration, Impact of Patient Protection and Affordable Health Care Act, PPACA (P.L. 111-148) and changes made by the corrections measure through the Health Care and Education Reconciliation Act (H.R. 4872) approved by the House and Senate on March 25, 2010, March 31, 2010, on file with the Select Policy Council on Strategic & Economic Planning.

¹² MediPass is the Florida Medicaid primary care case management program. Services to MediPass members are reimbursed on a fee-for-service basis, and MediPass primary care providers (PCPs) are paid a \$2.00 per member per month case management fee. PCPs are responsible for providing primary care and authorizing the specialty care provided to their enrollees. PCPs do not bear risk for their patients but do have requirements in place for case management, care coordination, and preventive care.

¹³ S. 409.912(4)(d), F.S.

below) 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 PSNs, including MPNs. PSNs 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.

Federal regulations require Medicaid beneficiaries to have a choice of managed care 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. 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.

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 federal 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.

In 2005, with federal approval, Florida expanded managed care for mental health coverage under capitated Medicaid managed care plans throughout the state to serve Medicaid recipients not enrolled in HMOs. Current law requires Medicaid to competitively procure a single prepaid behavioral health plan in each AHCA area, with a few exceptions.¹⁴ AHCA has competitively procured a single prepaid behavioral health plan in each non-reform AHCA area. Those single plans currently exist in each AHCA area, with some exceptions and variances.¹⁵

¹⁴ S. 409.912(4)(b), F.S.

¹⁵ In AHCA Area 11, AHCA contracts with several managed care organizations. While many of these organizations provide comprehensive health care that includes physical and behavioral health, there are two prepaid mental health plans that provide comprehensive behavioral health care. One of the prepaid mental health plans is a public hospital-operated PSN providing behavioral health services to a minimum of 50,000 MediPass and PSN recipients. Initially, in AHCA Area 6, the comprehensive behavioral health providers already under contract with AHCA were used and their contracts were later amended to include substance abuse treatment services. For children enrolled in Home SafeNet, Florida Safe Families

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized 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.

Reform is characterized by:

- A managed, coordinated system of care
- Choices and new options for recipients:
 - Different managed care plans, which can offer additional and varying benefits
 - Different models of managed care - between a traditional HMO model and a new provider-based model
 - Opt-out – Opportunity to use Medicaid dollars to purchase employer-based insurance
 - Enhanced benefits - Opportunities to be rewarded for healthy behaviors
- Financing: actuarially sound, risk-adjusted, capitated premiums based on encounter data, with comprehensive and catastrophic components.
- Low-Income Pool

The five-year waiver expires June 30, 2011, unless renewed by AHCA. In 2010, the Legislature directed AHCA to seek an extension of the waiver from the Centers for Medicare and Medicaid Services. The Agency for Health Care Administration is currently negotiating for the extension.

Provider Service Networks

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. PSNs are networks owned and operated by providers to deliver comprehensive health care to their enrolled population. By statute, providers in PSNs must have a controlling interest in the governing body of the PSN, and may make arrangements with physicians or other health care professionals, health institutions, or any combination thereof, to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians, by other health professionals, or through the institutions.¹⁶

In Medicaid reform counties, PSNs may be paid one of two ways: PSNs may receive the capitated, risk-adjusted payment used by the HMOs; or, for the first five years and at the PSN's option, PSNs may be reimbursed on a fee-for-service basis which includes the savings reconciliation element required for non-reform areas.¹⁷ In Medicaid reform, current law requires all managed care organizations to bear risk; however, PSNs may choose to be reimbursed on a fee-for-service basis, with a savings settlement mechanism consistent with non-reform requirements. The ability for PSNs to be reimbursed on a fee-for-service basis was originally intended to apply to the first three years of reform; however, the deadline was subsequently extended to 2011.¹⁸

Network comprehensive behavioral health services are provided through a specialty prepaid plan operated by a community based lead agency pursuant to s. 409.912(8), F.S.

¹⁶ S. 409.912(4)(d), F.S.

¹⁷ S. 409.91211(3)(e), F.S.

¹⁸ S. 409.91211(3)(e), F.S.

In non-Medicaid reform counties, PSNs provide comprehensive health care to enrollees; however, except for one PSN in Miami-Dade County, PSNs are not authorized to manage community behavioral health and targeted case management (see “Managed Behavioral Health Care in Florida” above).¹⁹ Instead, when a PSN enrollee requires comprehensive behavioral health care,²⁰ enrollees are referred by the PSN to a prepaid behavioral health plan for services.

Under Medicaid reform, PSNs participate as managed care organizations in the pilot counties and compete with HMOs for recipient enrollment. PSNs may choose to be reimbursed on a fee-for-service basis or on a risk-adjusted capitated basis for the initial five years of the program, and then must convert to risk-adjusted capitated methodology used by HMOs in reform at the end of the third year of operation.²¹

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,²² and the fully risk-adjusted payment methodology of reformed Medicaid will create the ability to adequately compensate and incentivize the development of these and other specialty PSNs. The 1115 Medicaid Reform Waiver approved by the Centers for Medicare and Medicaid Services mandates that the State review and approve specialty plans pursuant to criteria that includes the appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population.

Risk-Adjusted Rates

The pilot program administers all health care services through managed care organizations, reimbursed using actuarially sound, risk-adjusted, capitated rates.

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. The initial risk adjustment methodology relied on claims data for prescription drug use. AHCA is in the process of transitioning to data as the basis for determining rates. In the future, encounter data will provide the clinical history for managed care enrollees. 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.

Encounter Data

Prior to reform, Florida law did not require Medicaid managed care plans to report patient diagnosis and service information, or encounter data, about their recipients. For the first time in Medicaid, reform required at-risk plans to report encounter data, for use in evaluating plan quality and in setting risk-

¹⁹ See s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, available at http://ahca.myflorida.com/Medicaid/pdf/SS_07_070701_SOS.pdf.

²⁰ “Comprehensive behavioral health care” refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.

²¹ S. 409.91211(3)(e), F.S.

²² S. 409.91211(3)(bb)-(dd), F.S.

adjusted rates, and set a three-year process for establishing the new system.²³ AHCA created the Medical Encounter Data System (MEDS) to track this information. Both the plans and AHCA encountered difficulties in generating, reporting, and receiving the encounter data. However, all historical encounter data was received by AHCA by the end of 2009, and plans are continuing to submit current data. AHCA is reviewing and validating the data to ensure completeness and accuracy. AHCA used the encounter data as part of the rate-setting process for FY 2010-2011.

Plan Choice and Opt Out Program

Upon enrollment in Medicaid, recipients in reform counties have 30 days to voluntarily select a managed care plan. For those who do not make a choice, current law requires AHCA to assign the recipient to a plan “based on the assessed needs of the recipient as determined by the agency.” 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.²⁴ Recipients in reform counties may receive choice counseling through telephone, face-to-face counseling, mailings and outreach activities.

Evaluation by the University of Florida found the most common bases for recipient plan choice are primary care physicians in the network, and the prescription drugs covered by the plan.²⁵ Voluntary plan choice (as opposed to automatic assignment by AHCA) has increased.

Making Medicaid premiums available to help recipients purchase private insurance is a key component of Medicaid reform. The reform waiver allows recipients with access to employer-sponsored insurance to use their Medicaid dollars to purchase coverage through the employer. While few recipients currently use the Opt Out program, those who do are generally satisfied.

Customized Benefits

Reform allows plans to vary the amount, duration and scope of benefits and develop customized benefit packages for the general population or to meet the needs of specific groups. A variety of plan choices allows recipients to select a plan that best meets their needs. The customized plans must provide coverage for all mandatory and optional services required by plan enrollees, and may cover services not traditionally covered by Medicaid. As a result of this flexibility, reform plans have expanded certain services above current levels and have added services not currently covered.

Enhanced Benefits

Personal responsibility for health is a primary goal of Medicaid reform. Medicaid reform creates a flexible approach to meeting those needs within comprehensive systems of care that compete to improve the health of Medicaid recipients. AHCA establishes a list of activities for which recipients can earn credits. Recipients can spend their funds at community pharmacies on health care products and supplies, such as over-the-counter medication, vitamins, diapers, and first aid supplies. Recipients can save their credits for larger purchases.

²³ In the interim, risk-adjusted rates in reform are achieved using clinical data from recipient pharmacy records.

²⁴ S. 409.91211(4)(a), F.S.

²⁵ Florida Medicaid Reform Quarterly Progress Report April 1, 2009 – June 30, 2009, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).

For example, recipients can earn enhanced benefits with preventive health care visits like child dental and vision checkups, and participation in exercise programs, disease management programs, and smoking cessation programs. In FY 2009-2010, over 82,000 recipients in reform earned and spent over \$3 million in enhanced benefits.

Low Income Pool

The terms and conditions of the Medicaid reform waiver created a Low Income Pool (LIP) 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.²⁶ 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.

Florida law provides that distribution of the Low-Income Pool funds should:²⁷

- Assure a broad and fair distribution of available funds based on the access provided by Medicaid participating hospitals, regardless of their ownership status, through their delivery of inpatient or outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Assure accessible emergency inpatient and outpatient care for Medicaid beneficiaries and uninsured and underinsured individuals;
- Enhance primary, preventive, and other ambulatory care coverages for uninsured individuals;
- Promote teaching and specialty hospital programs;
- Promote the stability and viability of statutorily defined rural hospitals and hospitals that serve as sole community hospitals;
- Recognize the extent of hospital uncompensated care costs;
- Maintain and enhance essential community hospital care;
- Maintain incentives for local governmental entities to contribute to the cost of uncompensated care;
- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

In 2010, \$1 billion in LIP payments were made to hospitals and other providers. The LIP expires in 2011, unless renewed. Per the Legislature's directive in 2010, AHCA is currently negotiating the extension of the reform waiver, including the LIP funding.

Reform Objectives

Reform has five objectives:

1. To increase the number of plans and enhance individual choice, including having different types of plans.

²⁶ 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.

²⁷ S. 409.91211(c), F.S.

2. To ensure access to services not previously covered and improve access to specialists.
3. To improve enrollee outcomes.
4. To enable individuals to opt out and obtain private coverage.
5. To increase patient satisfaction.

Reform met the first objective. Pre-reform, AHCA contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, and two MPNs, for a total of twelve managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. AHCA currently has contracts with eight HMOs and five PSNs for a total of thirteen health plans in Broward County; and three HMOs and two PSNs for a total of five health plans in Duval County.

Reform met the second objective by allowing customized benefit designs and making recipient choice the driving factor of plan enrollment, plans were encouraged to offer new and additional services at no extra cost to the state. Currently, plans offer several services not previously covered:

- Over-the-counter drug benefit from \$20 to \$25 per household, per month;
- Adult preventive dental care;
- Acupuncture;
- Additional adult vision services - up to \$125 per year for upgrades such as scratch resistant lenses;
- Additional hearing services – up to \$500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition therapy.

Reform is also meeting the second objective. The figure below shows the Year One data on the numbers of certain specialists in Duval County pre- and post-reform, compared to national adequacy standards. After factoring in estimates of need for each specialty, AHCA concluded that access to care for the five identified specialties in Duval County either improved under reform or is more than adequate to meet recipient needs based on national benchmarks.

Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

	Pre-Reform (June 2006)					Post-Reform (June 2007)		Adequacy Benchmarks		
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	Specs per 100K	Health Plan Count	Specs per 100K	Estimate of Need per 100k (Low)	Estimate of Need per 100k (High)
Pain Mgmt	2	4.9	143	351.3	145	178.1	58	84.0	1.2	10.6
Dermatology	3	7.4	3	7.4	6	7.4	9	13.0	0.7	2.9
Neurology	21	51.6	44	108.1	54	66.3	67	97.0	1.2	3.4
Orthopedics	32	78.6	31	76.2	48	58.9	64	92.7	1.5	7.7
General Dentistry	14	34.4	32	78.6	45	55.3	31	44.9	17.5	30.8
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

AHCA conducts quarterly network validation surveys to confirm that plans have active contracts with providers - particularly primary care physicians and specialists. The two most recent (2010) surveys found 97 of the providers listed by plans actually have current contracts with them.²⁸ These efforts continue to indicate that the plans are maintaining up-to-date provider files.

²⁸ Florida Medicaid Reform Year 4 Annual Report July 1, 2009 – June 30, 2010, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed March 15, 2011).

For Objective 3, AHCA measured enrollee outcomes based on national standards developed by the National Committee for Quality Assurance.²⁹ The Healthcare Effectiveness Data Information Set (HEDIS) is a tool used to measure health plan performance in patient care and service. The HEDIS allows policy-makers to compare varying plans with a standard measure. Results for reform plans indicate that more reform plans than non-reform plans exceed the national mean in HEDIS measures. The shaded areas in the table below indicate mean-exceeding measures.

Measure	Non-Reform			Reform			National Mean
	2008	2009	Difference	2008	2009	Difference	
Annual Dental Visit	n/a	n/a	n/a	15.2%	28.5%	13.3%	42.5%
Adolescent Well-Care	41.9%	46.0%	4.1%	44.2%	46.5%	2.3%	43.6%
Controlling Blood Pressure	52.7%	51.6%	-1.1%	46.3%	55.9%	9.6%	52.9%
Cervical Cancer Screening	56.6%	53.8%	-2.8%	48.2%	52.2%	4.0%	65.7%
Diabetes – HbA1c Testing	74.7%	75.1%	0.4%	78.9%	80.1%	1.2%	78.0%
Diabetes - HbA1c Poor Control INVERSE	48.5%	51.7%	3.2%	48.3%	46.8%	-1.5%	48.7%
Diabetes - Eye Exam	36.3%	41.9%	5.6%	35.7%	44.0%	8.3%	51.4%
Diabetes - LDL Screening	75.6%	76.3%	0.7%	80.0%	80.2%	0.2%	71.1%
Diabetes - LDL Control	29.5%	29.4%	-0.1%	29.3%	35.9%	6.6%	30.6%
Diabetes – Nephropathy	77.1%	76.1%	-1.0%	79.2%	80.3%	1.1%	74.6%
Follow-Up after Mental Health Hospital – 7 day	30.5%	37.2%	6.6%	20.6%	29.3%	8.7%	39.1%
Follow-Up after Mental Health Hospital – 30 day	47.0%	51.7%	4.8%	35.5%	46.6%	11.1%	57.7%
Prenatal Care	71.7%	69.1%	-2.6%	66.6%	67.4%	0.8%	81.2%
Postpartum Care	58.5%	50.1%	-8.4%	53.0%	51.5%	-1.5%	59.1%
Well-Child First 15 Months – Zero Visits INVERSE	2.8%	3.0%	0.2%	4.9%	1.6%	-3.3%	3.8%
Well-Child First 15 Months – Six Visits	44.0%	51.0%	7.0%	44.4%	49.3%	4.9%	55.6%
Well-Child 3-6 years	71.1%	72.5%	1.5%	71.3%	75.7%	4.4%	66.8%
Adults’ Access to Preventive Care – 20-44 Years	n/a	69.3%	n/a	n/a	71.8%	n/a	76.8%
Adults’ Access to Preventive Care – 45-64 Years	n/a	82.2%	n/a	n/a	84.7%	n/a	82.4%
Adults’ Access to Preventive Care – 65+ Years	n/a	74.7%	n/a	n/a	83.6%	n/a	78.8%
Antidepressant Medication Mgmt – Acute	n/a	45.6%	n/a	n/a	52.0%	n/a	42.8%
Antidepressant Medication Mgmt -- Continuation	n/a	31.2%	n/a	n/a	29.8%	n/a	27.4%
Appropriate Medications for Asthma	n/a	87.0%	n/a	n/a	83.6%	n/a	86.9%
Breast Cancer Screening	n/a	47.5%	n/a	n/a	51.4%	n/a	50.0%
Childhood Immunization Combo 2	n/a	61.8%	n/a	n/a	63.6%	n/a	72.3%
Childhood Immunization Combo 3	n/a	52.0%	n/a	n/a	53.8%	n/a	65.6%
Frequency of Prenatal Care	n/a	51.6%	n/a	n/a	52.6%	n/a	59.3%
Lead Screening	n/a	46.0%	n/a	n/a	54.8%	n/a	61.5%

²⁹ See, National Committee for Quality Assurance, <http://www.ncqa.org/tabid/675/Default.aspx>.

Similarly, AHCA compared quality outcomes and compared managed care performance in non-reform areas to reform areas.³⁰

2009 Reform Compared to Non-Reform			
Measure	2009 Non-Reform	2009 Reform	Difference
Adolescent Well-Care	46.0%	46.5%	0.5%
Controlling Blood Pressure	51.6%	55.9%	4.3%
Cervical Cancer Screening	53.8%	52.2%	*
Diabetes – HbA1c Testing	75.1%	80.1%	5.0%
Diabetes - HbA1c Poor Control INVERSE	51.7%	46.8%	-4.9%
Diabetes - Eye Exam	41.9%	44.0%	2.1%
Diabetes - LDL Screening	76.3%	80.2%	3.9%
Diabetes - LDL Control	29.4%	35.9%	6.5%
Diabetes – Nephropathy	76.1%	80.3%	4.2%
Follow-Up after Mental Health Hospital – 7 day	37.2%	29.3%	*
Follow-Up after Mental Health Hospital – 30 day	51.7%	46.6%	*
Prenatal Care	69.1%	67.4%	*
Postpartum Care	50.1%	51.5%	1.4%
Well-Child First 15 Months – Zero Visits INVERSE	3.0%	1.6%	-1.4%
Well-Child First 15 Months – Six Visits	51.0%	49.3%	*
Well-Child 3-6 years	72.5%	75.7%	3.2%
Adults ³¹ Access to Preventive Care – 20-44 Years	69.3%	71.8%	2.5%
Adults ³¹ Access to Preventive Care – 45-64 Years	82.2%	84.7%	2.5%
Adults ³¹ Access to Preventive Care – 65+ Years	74.7%	83.6%	8.9%
Antidepressant Medication Mgmt – Acute	45.6%	52.0%	6.4%
Antidepressant Medication Mgmt -- Continuation	31.2%	29.8%	*
Appropriate Medications for Asthma	87.0%	83.6%	*
Breast Cancer Screening	47.5%	51.4%	3.9%
Childhood Immunization Combo 2	61.8%	63.6%	1.8%
Childhood Immunization Combo 3	52.0%	53.8%	1.8%
Frequency of Prenatal Care	51.6%	52.6%	1.0%
Lead Screening	46.0%	54.8%	8.8%

For Objective 4, AHCA established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. Since 2006, 86 individuals have enrolled in the Opt Out Program. Of those, 65 individuals have disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance. There are currently 26 individuals enrolled in the Opt Out Program.³¹ AHCA analysis indicates recipients choose the Opt Out Program because the desired primary care physician was not enrolled with a Medicaid Reform health plan or recipients elected to use the Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.³²

³⁰ Florida Medicaid Reform Year 4 Annual Report July 1, 2009 – June 30, 2010, Table 42, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed March 12, 2011).

³¹ Florida Medicaid Reform Year 3 Annual Report July 1, 2009 – June 30, 2010, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed March 12, 2011).

³² Florida Medicaid Reform Year 4 Annual Report July 1, 2009 – June 30, 2010, Agency for Health Care Administration, available at http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed March 12, 2011).

For Objective 5, AHCA contracted with the University of Florida to measure recipient satisfaction. The most recent report³³ indicates satisfaction was generally high. Most enrollees in Broward and Duval Counties indicated:

- It was “not a problem” to get a doctor or a nurse they were happy with;
- They communicate well with their providers;
- They chose their health plan; and
- Their overall satisfaction rating was at the highest level (9 or 10).

Approximately 85 percent of surveyed recipients said it was not difficult to get an appointment with a physician, and about 50 percent said it was easy to get an appointment with a specialist. Ratings by enrollees in rural counties (Baker, Clay and Nassau) were similar to those in Broward and Duval. Generally, there were no statistically significant differences between patient satisfaction pre- and post-reform, with a couple of exceptions in Broward County.

In addition to the five objectives, Medicaid reform was intended to reduce the rate of growth to a more sustainable rate and improve the financial predictability of the program in the long term. In the most recent fiscal evaluation report by the University of Florida, researchers reported that expenditures have been reduced by shifting patients from unmanaged, fee-for-service care to managed care.³⁴ Expenditures in Broward and Duval Counties were lower (on a per-member, per-month basis) in the first two years of reform than they would have been in those counties without reform.

Other States’ Experiences with Medicaid Managed Care

Forty-eight states have some portion of their Medicaid population enrolled in managed care; 20 states have over 80 percent managed care enrollment.³⁵ Seventeen states have implemented statewide mandatory managed care programs for Medicaid recipients under the 1115 waiver.³⁶ There are many differences among states regarding payment structure and what specific populations are served through managed care. Generally, “states have chosen this model for the savings it can achieve and the added fiscal predictability.”³⁷ In particular, Arizona, Texas and Georgia represent three distinct approaches to Medicaid managed care serving multiple eligible populations with great geographic variety.

Arizona

Arizona has implemented statewide managed care providing comprehensive services for children and pregnant women as well as behavioral services for all eligible recipients. The state selects plans through a competitive procurement process and plans service specific geographic regions statewide. A total of 14 private health plans serve Medicaid recipients, with a minimum of two plans serving each geographic region. The plans are capitated and the rates are established through competitive bid.

³³ Duncan, Paul, et al. Medicaid Reform Enrollee Satisfaction Year One Follow-Up Survey, March 20, 2009, Department of Health Services Research, Management and Policy, University of Florida, available at <http://mre.php.ufl.edu/publications/> (last viewed March 12, 2011).

³⁴ Duncan, Paul, et al. An Analysis of Medicaid Expenditures Before and After Implementation of Florida’s Medicaid Reform Pilot Demonstration, Department of Health Services Research, Management and Policy, University of Florida, June 2009, available at <http://mre.php.ufl.edu/publications/> (last viewed March 12, 2011)

³⁵ Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: key Data, Trends, and Issues* (February 2010).

³⁶ *Id.* The seventeen states are: Arkansas, Arizona, Delaware, Florida Hawaii, Indiana, Kentucky, Massachusetts, Maryland, Minnesota, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah and Vermont.

³⁷ The Pacific Health Policy Group, *Medicaid Managed Care Study*, Prepared for the Florida House of Representatives (March 2010).

Arizona also uses a managed care model to provide home and community-based long-term care for elderly, blind and developmentally disabled Medicaid recipients. However, eligibility for long-term care is tightly controlled; it is estimated that 75 percent of applicants are denied.³⁸

Managed care enrollment is at 93 percent of the Medicaid eligible recipients.³⁹

In the first eight years of statewide managed care, Arizona cut the growth in Medicaid expenditures to 6.8 percent compared to a 9.9 percent growth in fee-for-service.⁴⁰ From 1983 to 1993, the state achieved cost savings of 11 percent for medical services (or seven percent in total cost savings with plans' administrative costs and operating margins factored in).⁴¹

Georgia

The Georgia Medicaid managed care program serves TANF and TANF-related population through fully capitated plans. The state selects plans through a competitive procurement process and the selected plans serve six geographic regions statewide. Only three health plans serve Medicaid recipients. Georgia provides for elderly, blind and developmentally disabled Medicaid recipients through a traditional fee-for-service system, rather than through managed care. Managed care enrollment is at 84 percent of Medicaid eligible recipients.⁴²

To fund the managed care program, Georgia implemented an assessment on premiums for health plans serving the Medicaid population. It is estimated that the state saved between \$132.6 and \$194.9 million over the first three years of the program.⁴³

Texas

The Texas Medicaid program serves children, low-income families, and pregnant women. Managed care also provides long-term care for SSI and SSI-related populations, but with a carve-out for inpatient hospital services which are provided on a fee-for-service basis. The state selects plans through a competitive procurement and the selected plans serve specific portions of the state. The plans are fully capitated. The state also utilizes a capitated arrangement to provide behavioral health services to eligible recipients.

Managed care enrollment is at 70 percent of the Medicaid eligible recipients. It is estimated that the Texas long-term care program saved \$123 million over its first two years.⁴⁴

Medicaid Long-Term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients through nursing home placement and through home and community based services. Home and community based services provide care in a community setting instead of a nursing home or other institution.

³⁸ *Id.*

³⁹ Pacific, *supra* note 36.

⁴⁰ The Lewin Group, *Medicaid managed Care Cost Savings – A Synthesis of Fourteen Studies* (July 2004).

⁴¹ *Id.*

⁴² Pacific, *supra* note 32.

⁴³ Pacific, *supra* note 32.

⁴⁴ Pacific, *supra* note 32.

Home and Community Based services are provided through six Medicaid Waiver programs and one State Plan program administered by the Department of Elderly Affairs (DOEA) in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers⁴⁵ and local service providers, and provide alternative, less restrictive long-term care options for elders who qualify for skilled nursing home care. These waivers and the state program are described below.

Waiver	Population	Enrolled ⁴⁶	Services	Area
Adult Day Health Care⁴⁷ (2004)	Adults age 75 years or older with functional or cognitive impairments and live with a caregiver	24	Intake and assessment, case management and other direct care services such as transportation, medication management, rehabilitation and services which allow frail elders to remain in their home or community instead of going to a nursing facility.	Palm Beach, Lee
Aged and Disabled Adult (1982)	<ul style="list-style-type: none"> • Frail adults over age 60 or older • Adults with disabilities ages 18-59 • Adults over age 20 who age out of Children's Medical Services 	10,142	Adult companion, attendant care, caregiver training, case management, consumable medical supplies and others.	Statewide
Assisted Living for the Frail Elderly (1995)	Frail elders age 65 or older or disabled elders age 60 to 64 who reside in Assisted Living Facilities	2,919	Attendant call system, attendant care, behavior management, case management, companion services, intermittent nursing, medication administration, therapeutic social and recreational activities and other services.	Statewide
Channeling (1985)	Frail elders age 65 or older	1,233	Adult day health care, adult companion, case management, chore services, family training, financial assessment, personal care, respite care, special drug and nutritional assessment, home delivered meals, medical equipment and supplies, therapies and other services	Miami-Dade Broward
Nursing Home Diversion Program (1998)	Frail elders age 65 or older at risk for nursing home placement	21,031	Under this program, applicants can choose to continue living in their own homes or a community setting such as an assisted living facility. Coordinated acute and long-term care services to frail elders in the community, including acute medical services such as dental, community mental health, inpatient hospital, outpatient hospital emergency, physicians and prescribed drugs and long-term care community services such as adult companion, assisted living, case management, chore, family training, home health care, nutritional assessment, personal emergency response system, nursing facility services, therapies and other services.	33 counties; authorized to expand to 27 additional counties

⁴⁵ Aging Resources Centers are discussed below.

⁴⁶ 2010-2011 Florida Medicaid Summary of Services; *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 11-03, January 2011, Office of Program Policy Analysis & Governmental Accountability

⁴⁷ This waiver includes the Consumer-Directed Care Plus (CDC+) Program. The CDC+ program allows participants to hire workers and vendors of their own choosing to help with daily needs such as housecleaning, cooking, and getting dressed. The program offers consultants to help individuals manage their budgets and make decisions. See, *Summary of Programs & Services*, Department of Elderly Affairs.

Waiver	Population	Enrolled ⁴⁶	Services	Area
PACE - All-Inclusive Care for the Elderly (2002)	Medicaid and Medicare eligible adults age 54 or older who qualify for nursing home care and live in a PACE service area *State plan service; not a waiver program	550	Managed care program providing a comprehensive range of medical and home and community-based services adult day health care, home care, prescription drugs, nursing home and inpatient care	Miami-Dade, Lee

Aging Resource Centers

The 2004 Legislature created the Aging Resource Center⁴⁸ initiative to reduce fragmentation in the elder services system. To provide easier access to elder services, the Legislature directed DOEA to establish a process to help the 11 area agencies on aging transition to Aging Resource Centers. The legislation required each area agency to transition to an Aging Resource Center by taking on additional responsibilities, while at the same time maintaining its identity as a local area agency on aging. All 11 area agencies on aging are now functioning as Aging Resource Centers. The Aging Resource Centers are intended to perform eight primary functions that are intended to improve the elder services system.⁴⁹

- Increase access to elder services;
- Provide more centralized and uniform information and referral;
- Increase screening of elders for services;
- Improve triaging and prioritizing of elders for services;
- Streamline Medicaid eligibility determination;
- Improve long-term care options counseling;
- Enhance fiscal control and management of programs; and
- Increase quality assurance.

The Comprehensive Assessment and Review for Long-Term Care Services Program

Individuals must meet both medical and financial eligibility criteria to receive Medicaid long-term care. The Comprehensive Assessment and Review for Long-Term Care Services (CARES) program is Florida's federally mandated pre-admission screening program for individuals seeking Medicaid long-term care either in a nursing home or through one of the long-term care waivers.⁵⁰ CARES is operated by ACHA through an inter-agency agreement with DOEA.⁵¹

A CARES assessor or a registered nurse assesses an applicant's physical and mental capabilities and limitations, health care needs, and social support systems. A consulting physician then reviews the assessment with CARES staff and makes a level of care determination about the applicant's medical eligibility for Medicaid. Only individuals requiring a nursing facility level of care are eligible to receive services.⁵²

If the individual meets the level of care standard for Medicaid, CARES staff makes a recommendation for the least restrictive placement that will meet the applicant's service needs. The recommendation

⁴⁸ Ch. 2004-386, Sec. 8, L.O.F.

⁴⁹ S. 430.2053(5), F.S.

⁵⁰ S. 409.912(15), F.S.

⁵¹ *Id.*

⁵² S. 409.912(15)(a), F.S.

may be to place the client in a nursing home; an assisted living facility; an adult family care home; or to provide needed services in the client's own home or the home of a caregiver. An emphasis is placed on enabling people to remain in their homes with the provision of in-home services or with alternative community placement such as an assisted living facility.

Additionally, CARES staff conducts reviews of nursing home residents to ensure that they continue to meet the level of care criteria.⁵³

During Fiscal Year 2008-09, CARES program staff conducted 77,508 assessments.⁵⁴

Medicaid Long-Term Care for Persons with Developmental Disabilities

Long-term care services to persons with developmental disabilities⁵⁵ are primarily provided through Medicaid waiver programs and Intermediate Care Facilities for the Developmentally Disabled (ICFDD).

Four-Tier Medicaid Waiver System

Currently, home and community based services for Medicaid recipients with developmental disabilities are provided by the Agency for Persons with Disabilities (APD) through a four-tier waiver system.⁵⁶ APD currently serves 30,062 people in the four- tier system and has a waitlist of over 19,000 people for the program.⁵⁷ The tier system was created by the 2007 Legislature to establish a predictable spending model for the program and help control over-utilization of services which has lead to significant program deficits in recent years. The program offers home and community based services including therapies, adult day training, behavioral services, residential habilitation services, respite, nursing services, employment and supported living services.⁵⁸ Each of the tier waivers target specific groups of people with certain service needs. Three of the four tier waivers have caps on annual expenditures per person and one of the tier waivers has no cap and is reserved for individuals with the most intense needs.⁵⁹

Program Deficits

When the four- tier Medicaid waiver legislation was passed in 2007, APD was projecting a deficit of over \$150 million for FY 2007-2008. This deficit was reduced to \$12 million for FY 2007-2008, in part by the implementing the tier caps, eliminating some services and other legislative budget actions.⁶⁰ However, due to delays in fully implementing the tiers as a result of hearing requests and litigation challenges to rules promulgated for the program, the savings lost over the 3 years since FY 08-09 is estimated to be \$129.2 million.⁶¹ As a result program deficits began to rise again to \$26.7 million for

⁵³ *Id.*

⁵⁴ *CARES Diversion, 2009 Report*, Department of Elderly Affairs

⁵⁵ S. 393.063(9), F.S. A developmental disability is defined in chapter 393, F.S., as "a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely),F.S.

⁵⁶ S. 393.0661, F.S.

⁵⁷ APD Monthly Report to the Governor's Office of Policy and Budget (OPB), January 2011.

⁵⁸ Developmental Disabilities Waiver Services Coverages and Limitations Handbook, *available at*

[https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_08_070701_Waiver_DevSev_ver1%203%20\(2\).pdf](https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/CL_08_070701_Waiver_DevSev_ver1%203%20(2).pdf)

⁵⁹ S. 393.0661(3), F.S.

⁶⁰ APD Medicaid Expenditure ,Social Services Estimating Conference, , January 29, 2010

⁶¹ APD presentation to HHS Access Subcommittee, February 9, 2011 and email from Susan Chen, APD dated 2-8-11, titled February 9th Committee meeting.(on file with committee staff)

FY 2008-2009 and \$45.1 million for FY 2009-2010.⁶² According to the Governor's office the program deficit for the current fiscal year will be even higher. APD is in the process of determining a final estimate for the current year deficit which is expected to be in excess of \$59 million in state funds.

APD conducts an assessment of need for each individual who receives services in the four-tier Medicaid waiver program. The assessment is conducted once every three years or more frequently when there is a significant life change for the individual. The assessment instrument used by APD is the Questionnaire for Situational Information (QSI). This instrument is designed to gather key information about a person that will describe his or her life situation for the purpose of planning supports over a 12 month period. These descriptions reflect a person's needs for assistance in key life roles and areas of daily activity.⁶³

The appropriation for Medicaid waiver services to persons with developmental disabilities for FY 2010-11 is \$805.8 million.⁶⁴

Individual Budgets (ibudget Florida)

The 2010 Legislature directed APD in consultation with AHCA to develop and implement individual budgets (also known as ibudget) as the basis for allocating funds to people enrolled in Medicaid waiver programs. The ibudget system uses an algorithm to allocate funds to individuals based on client characteristics and acuity which are reliable predictors of need. The ibudget sets a cap on each person's spending for a 12 month period. Exceptions to the capped expenditures are available for extraordinary needs. AHCA received approval to implement the ibudget system from federal CMS on March 4, 2011 with an effective date of March 15, 2011. APD estimates that the reallocation of funds to individuals through the ibudget formula could result in an increase in funding for 64 percent of recipients and reduction in funding for 36 percent of recipients.⁶⁵

Licensed Residential Services

APD licenses residential facilities for Medicaid recipients in over 1,600 residential settings which are alternatives to intermediate care facilities for the developmentally disabled (ICF/DDs).⁶⁶ Most of these facilities are licensed by APD and include group homes, foster homes, residential habilitation centers and comprehensive transitional education programs.⁶⁷ The primary fund source for these facilities is the Medicaid waiver program. Most people live in group home settings which provide residential habilitation services and 24 hour supervision of residents. The Department of Children and Families licenses group homes and foster care facilities which serve children under age 18 years with developmental disabilities who are also in the child welfare system.⁶⁸

Institutional Care Services

Institutional care service for Medicaid recipients is provided in public and private ICF/DDs. These facilities are licensed by AHCA and provide 24-hour support for personal care, habilitation,

⁶² Email from Susan Chen dated 2-4-11 titled "budget figures" (on file with committee staff)

⁶³ Florida Questionnaire for Situational Information, version 4.0, Agency for Persons with Disabilities.

⁶⁴ FY 2010-2011 home and community services budget, House Health Care Appropriations Subcommittee.

⁶⁵ Report to the Legislature on the Agency's Plan for Implementing Individual Budgeting, February 1, 2010.

⁶⁶ APD 211 transition materials.

⁶⁷ Email from Susan Chen, APD, dated 2-5-10, on file with the Health Care Services Policy Committee; S. 393.067, F.S.

⁶⁸ S. 409.175, F.S.

developmental and health services. The statewide capacity in public and private institutional care facilities is 2,908 beds, of which 837 are in public facilities and 2,070 in private facilities.⁶⁹

The largest of these facilities are the public facilities operated by APD, which are Sunland Center in Marianna, and Tacachale Center in Gainesville. The appropriation for FY 2010-11 for public institutions is \$126.4 million.⁷⁰ The private facilities provide the majority of institutional care for persons with developmental disabilities. There are 91 private facilities in the state of which 21 facilities are “cluster facilities” which specialize in services to medically complex individuals.⁷¹ The appropriations for Intermediate Care Facilities for the Developmentally Disabled for FY 2010-11 total 264.0 million. This is projected to increase to \$281.5 million in FY 2011-12.⁷²

Effect of Changes: Statewide, Integrated Managed Care Program

The bill creates part IV of Chapter 409, Florida Statutes, entitled “Medicaid Managed Care.” The bill provides that any conflicts between newly created Part IV control if there is any conflict with the other parts of Chapter 409. AHCA is given authority to adopt any rules necessary to administer the managed care programs and any rules necessary to comply with federal requirements. New sections 409.961 through 409.985, Florida Statutes, comprise the Medicaid Managed Medical Assistance Program and the Long-Term Care Managed Care Program. Sections 409.962 through 409.970, F.S., are general provisions that apply to both managed care programs.

The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The Agency for Health Care Administration is designated as the single state agency authorized to manage, operate, and make payments for the Medicaid managed care programs. AHCA shall apply for and implement state plan amendments or waivers of applicable federal laws necessary to implement the program by August 1, 2011.

Medicaid will consist of two managed care programs:

- The Medicaid Managed Medical Assistance Program – primary and acute care
- The Long-Term Care Managed Care Program – residential and home and community based care, alone or paired with primary acute care for comprehensive coverage

The statewide managed care program has the following characteristics:

- Care and services provided in a managed care model.
- Mandatory participation for most populations, voluntary participation for some, and some populations excluded
- Competitive, negotiated selection of qualified managed care plans that meet strict selection criteria
- Regionalized plan selection of a limited number of plans to ensure coverage in rural areas.
- Limited plan numbers in the 11 regions to ensure stability but allow significant patient choice.
- Varying models of managed care, including HMOs, PSNs, specialty plans, and medical home plans.

⁶⁹ Email from Kari Anderson, Agency for Persons with Disabilities, dated 4-6-10 on file with the Health Care Services Policy Committee.

⁷⁰ FY2010-2011 General Appropriations Act

⁷¹ Emails from S. Sewell, Florida ARF, dated 4-7-10 and 4-12-10, on file with the Health Care Services Policy Committee.

⁷² FY 2010-2011 General Appropriations Act

- Specific plan accountability measures, including network standards, achieved savings rebates, encounter data, performance measures, and fraud and abuse measures.
- Negotiated payments based on risk-adjusted rates.
- Customized benefits to allow meaningful recipient choice.
- Opt Out Program for recipients who would rather use their Medicaid dollars to purchase other forms of coverage.

Mandatory Enrollment

All Medicaid recipients shall receive covered services through a managed care program except for populations which receive limited Medicaid services, like emergency Medicaid for aliens and women who are only eligible for family planning services or for breast and cervical cancer services. The service range and duration is so limited for these groups that care management is impractical. Similarly, children receiving services in prescribed pediatric extended care centers are exempt from mandatory enrollment. The existing fee-for-service Medicaid program remains for these, limited populations.

In addition, persons with developmental disabilities on the home and community-based services waiver may voluntarily participate in the Managed Medical Assistance Program; otherwise, they remain in the fee-for-service program.

Eligible Plans

Medicaid managed care must be provided by an eligible plan. Eligible plans include health insurers, exclusive provider organizations, health maintenance organizations, and provider service networks. These organizations are required to meet relevant statutory solvency and regulatory requirements. A provider service network must be capable of providing all covered services or may limit the provision of services to a specific target population based on age, chronic disease, or medical condition.

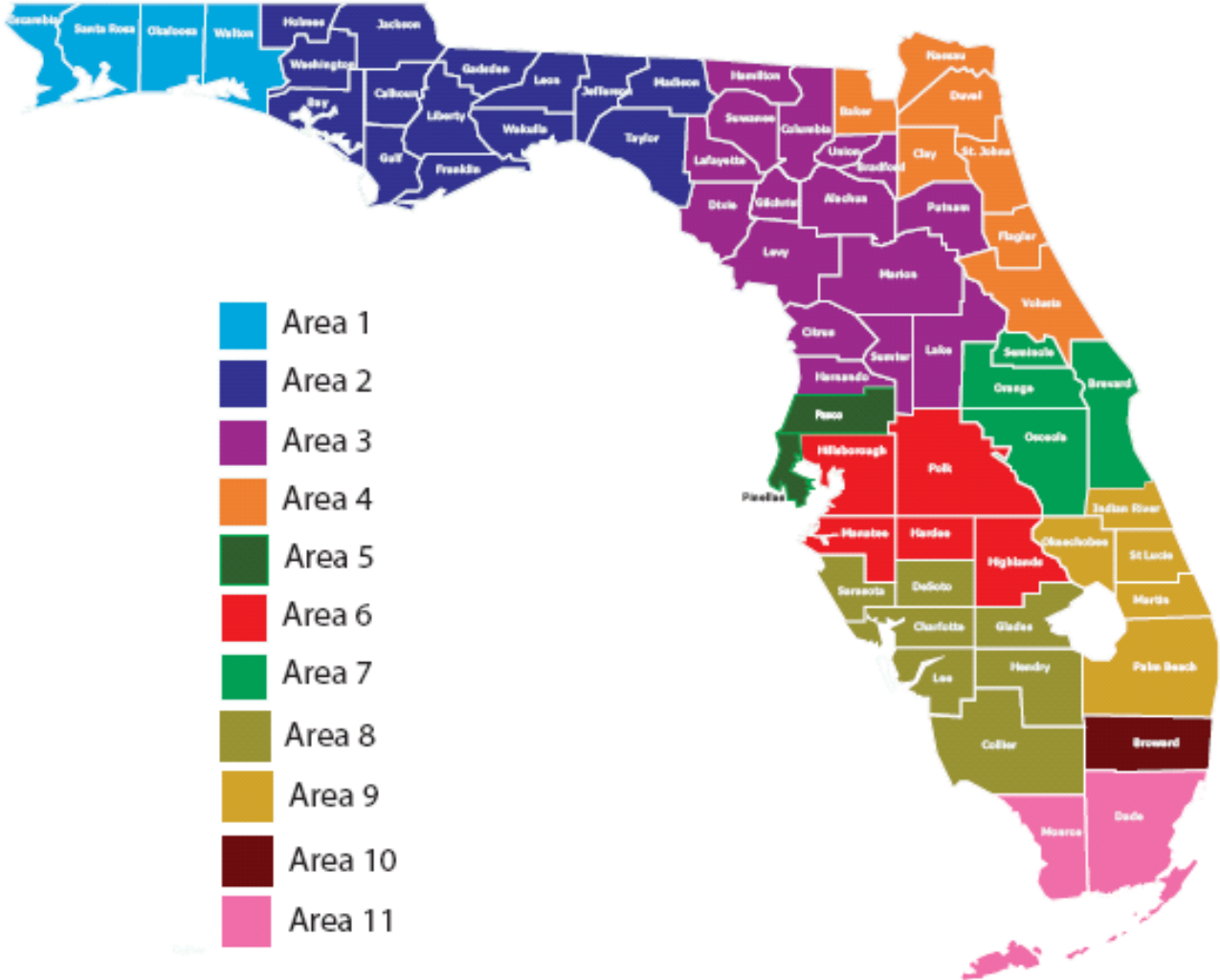
Eligible plans include accountable care organizations which meet federal requirements and qualify as provider service networks.

Qualified Plan Selection

AHCA shall select a limited number of qualified plans to participate in the Medicaid managed care program using invitations to negotiate (ITNs). The number of plans varies by region, and between the three programs. The bill divides the state into eleven regions by counties. Separate and simultaneous procurements shall be conducted in each of the regions. The regions are:

- **Region 1** - Escambia, Okaloosa, Santa Rosa, Walton.
- **Region 2** - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington.
- **Region 3** - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union.
- **Region 4** - Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia.
- **Region 5** - Pasco, Pinellas.
- **Region 6** -Hardee, Highlands, Hillsborough, Manatee, Polk.
- **Region 7** - Brevard, Orange, Osceola, Seminole.
- **Region 8** - Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota.

- **Region 9** – Indian River, Martin, Okeechobee, Palm Beach, St. Lucie.
- **Region 10** – Broward.
- **Region 11** – Miami-Dade, Monroe



Selection Criteria

AHCA shall specify in the ITNs the criteria and the relative weight of the criteria that will be used in the selection of organizations to engage in negotiations. In addition to criteria established by AHCA, AHCA must consider:

- Accreditation by the National Committee for Quality Assurance, The Joint Commission, or another nationally recognized accrediting body.
- Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.
- Availability and accessibility of primary care and specialty physicians in the provider network.

- Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.
- Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.
- Provision of additional benefits, particularly dental care and disease management, and other enhanced benefit programs.
- Evidence that the plan has contracts or has made substantial progress in obtaining contracts with needed providers.
- Comments by Medicaid providers relating to the plan.
- Fraud and abuse prevention policies and procedures.
- The business relationships the plan has with any other plan who responds to the invitation to negotiate.

AHCA is prohibited from selecting a plan that has a business relationship with another bidding plan in the same region. Plans which fail to disclose its business relationships with other bidders will be disqualified from participation in any region for the next full (five-year) contract period.;

At the conclusion of the negotiations, the agency shall select the plans that provide the best value to the state. If all other factors are equal, preference shall be given to plans that:

- Have signed contract with sufficient numbers of primary and specialty physicians
- Recognize and compensate medical homes or accountable care organizations
- Provide greater economic benefit to Florida through employment of or subcontracts with Floridians
- Have a cancer disease management program meeting certain criteria
- Have disease management programs meeting certain criteria
- Have prompt payment processes for provider claims

In order to ensure that the plans bid in Regions 1 and 2 (Panhandle), plans who are selected by AHCA in Region 1 or Region 2 will also be awarded a contract in another region in which they submit a bid, if the bid is responsive and the negotiated payment rate is acceptable to AHCA. However, if such a plan withdraws from Region 1 or 2, the agency must terminate its contract in the additional region.

Additional, program-specific, criteria applies to the ITN process for the two managed care programs.

A plan that participates in an ITN in multiple regions and is selected in at least one region may not begin serving Medicaid recipients in any region until all administrative challenges to procurements, to which the plan is a party, have been finalized. If the number of plans selected in the region is less than the maximum number of plans permitted, AHCA may contract with the other selected plans in the region that are not participating in the administrative challenge.

Plan Accountability and Contract Requirements

AHCA shall establish a 5-year contract with each selected plan. The contracts cannot be renewed except the agency may extend the terms of the contracts to cover delays in procurement. AHCA shall establish contract terms necessary for the operation of the managed care program. In addition to terms established by the agency, the contract must address:

- **Physician compensation.** Plans must increase physician payment to Medicare levels by redirecting savings generated by care management. AHCA may fine plans that do not meet this requirement.
- **Emergency services.** Plans shall pay for necessary emergency services rendered by a non-contracted provider within 30 days after receipt of a complete and correct claim.
- **Access.**
 - Plans must maintain a network adequate to meet the needs of its clients. AHCA is required to set network adequacy standards for both children and adults.
 - Plans may include providers located outside of the region.
 - Plans must maintain an on-line database of information about its physicians and other providers, and the database must have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients.
 - Plans must publish any preferred drug lists or formularies on their websites in a searchable format, and must update them within 24 hours of a change.
 - Plans must accept prior authorization requests electronically.
- **Encounter data.** The plans must comply with AHCA's encounter data system, and is subject to mandatory fines and contract termination, under certain circumstances, for failure to comply.
- **Continuous improvement.**
 - Plans must comply with established performance standards and expected milestones for improving performance over the term of the contract.
 - Plans must establish internal improvement systems which must include enrollee satisfaction surveys.
 - Plans must collect and submit HEDIS performance measures, which AHCA must use to monitor plan performance, and must publish the measures on their websites.
 - Each plan must be accredited by a national organization within 1 year, or be subject to suspension of automatic assignment after 18 months.
- **Program integrity.** The plans must establish program integrity functions and activities to reduce fraud and abuse.
- **Grievance resolution.** The plans must establish internal grievance procedures. Grievances not resolved by the plan's internal process shall be submitted to the subscriber assistance panel. Each plan must submit quarterly reports on grievances including number, description, and outcome.
- **Prompt payment.** The plans must comply with prompt payment provisions.⁷³
- **Electronic claims.** The plans must accept electronic claims.
- **Fair payment.** PSNs must ensure that a hospital provider with a controlling interest in the network does not charge another plan more than the amount paid to the provider by the PSN for the same service.
- **Itemized payment.** Claims payments to providers must be itemized, including specified information.
- **Provider dispute resolution.** Disputes between plans and providers may be resolved by the Subscriber Assistance Panel established in s. 408.7057, F.S.

The contract shall contain penalties for plans that reduce enrollment or leave a region prior to the end of the contract term: The plan shall reimburse the agency for the cost of enrollment changes and other transition activities, including the cost of additional choice counseling services. In addition, PSNs must pay a per-enrollee penalty of not to exceed three months' payment and continue to provide services for

⁷³ SS. 641.315, 641.3155, and 641.513, F.S. set forth the requirements for the prompt payment of health services claims.

90 days. All other plans must pay a penalty of 25 percent of their minimum surplus amount. The plan must provide the agency notice no less than 180 days prior to withdrawing from a region. In addition, AHCA is required to terminate all other contracts with a departing plan in other regions.

Four years after implementation of the program, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring.

Plan Payment

Except as discussed below, the plans shall receive prepaid risk-adjusted per-member, per-month payments which will be negotiated as part of the procurements. The risk-adjustment shall be based on historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area, and the clinical risk profile of the recipients. Plan requests for rate increases may only be approved if sufficient funds have been authorized in the General Appropriations Act.

PSNs may choose to bear full risk as a prepaid plan, and receive prepaid risk-adjusted per-member, per-month payments. Or, PSNs may choose to receive fee-for-service rates with a shared savings settlement. However, the fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation in a given region. AHCA shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled.

For the first year of the first contract term, the negotiated rates must reflect an aggregate savings of 5 percent.

Achieved Savings Rebate

The bill creates an Achieved Savings Rebate program to monitor plan expenditures and impose incentives and disincentives to ensure proper use of state funds. AHCA will establish a uniform method for the plans to use for annually reporting, premium revenue, medical and administrative costs, and income or losses.

To calculate whether the plans have achieved a savings for the reporting year and whether they may retain them or must pay a rebate to the state, plans must submit to AHCA an annual financial audit. Plans regulated by the Office of Insurance Regulation must also submit an annual statement pursuant to s. 624.424. In addition, AHCA must audit the plans' financial information. AHCA must contract with independent certified public accountants to conduct the audits, and plans must pay the costs.

The achieved savings rebate will be calculated by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

- 100% of the income up to and including 5% of the revenue will be retained by the plan.
- 50% of the income above 5% and up to 10% of the revenue will be retained by the plan with the other 50% refunded to the state.
- 100% of the income above 10% will be refunded to the state.

If the plan meets or exceeds quality measures defined by AHCA, then the plan may retain an additional 1% of revenue.

Rebates, bonuses, fines, lobbying expenses and reserves will not be included in the calculation. Additionally the agency will set maximums for administrative expenses, reinsurance, and outstanding

claims expenses. These maximums establish a mechanism within the achieved savings rebate program which is similar in effect to a medical loss ratio. Plans that incur a loss during the first contract year may carry the loss forward. No losses may be carried forward for subsequent contract years.

The reports will be due 270 days after the end of the reporting period to allow sufficient time for outstanding claims payment and the rebates will be due to the state within 30 days of the report.

Enrollment and Disenrollment

All Medicaid recipients must enroll in a managed care plan unless specifically exempted. Each recipient will have 30 days in which to choose from among the available plans.

After the initial enrollment, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, the recipient can only change plans for good cause which includes poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency shall monitor disenrollment for patterns of discrimination due to the health or a condition of the recipients.

After the 90 day period, Medicaid recipients must remain in their plans for the remainder of a 12 month period. After 12 months, the recipient may change plans. Recipients may change providers within the plan during the 12-month period.

Encounter Data

The agency shall maintain and operate the Medicaid Encounter Data System to collect, process, store, and report on covered services. The plans must submit encounter data electronically and certify that the data is accurate and complete, and AHCA must validate the data. In addition, AHCA must conduct data analyses to assess plan performance, particularly to identify inappropriate utilization.

State and Local Medicaid Partnerships

The bill authorizes state and local partnerships in order to encourage contributions from local funding sources that can enhance the quality and accessibility of services for Medicaid and uncompensated care patients. Intergovernmental transfers (IGTs) consist of qualified revenue from counties, municipalities, and tax districts. Currently, approximately \$900 million in contributions are received and used to fund the Low Income Pool, the Disproportionate Share Hospital program, and enhanced rates for certain hospitals. The bill creates a specific set of guidelines and conditions for the receipt of local contributions and the expenditure of any additional Medicaid resources. The bill establishes time limits for receiving contributions and including in a given fiscal year. IGTs received first are allocated to the Low Income Pool and implemented through a contract with the Access to Care Partnership.

The Access to Care Partnership is created by the bill as an administrative unit for allocation of LIP funds to all participating providers. Participating providers are designated by local funding sources and the net benefit to the jurisdiction contributing local funds is equal to the contribution plus a factor specified in the General Appropriations Act. Periodic payments from AHCA to the Access to Care Partnership will be paid to designated providers as specified in the contract between AHCA and the partnership.

To the extent funds are available, hospital rates may be increased through a tiered system. Tier 1, which is allocated 35 percent of the funds for rate increases, consists of statutory rural hospitals,

statutory teaching hospitals, and specialty children's hospitals. Tier 2 are community hospitals not included in Tier 1 with more than 9 percent of the hospital's total inpatient days used by Medicaid and charity patients. Thirty-five (35) percent of funds for increased rates are allocated to Tier 2. Tier 3 includes all community hospitals and receives 30 percent of the funding for rate increases. Rate increases will be built into the capitated payments to the prepaid plans.

Effect of Proposed Changes: Managed Medical Assistance Program

The bill creates section 409.971 through 409.977, Florida Statutes, – the statewide Medicaid Managed Medical Assistance Program (MMA program) - which provides managed primary and acute medical services to Medicaid recipients through a managed care delivery system. All of the general provisions created in sections 409.961 through 409.970 apply to the MMA program; in addition, the MMA program also includes specific requirements pertaining to managed acute and primary care.

The agency will begin implementing the MMA program by January 1, 2012, with full implementation statewide to be completed no later than October 1, 2013.

Enrollment

Mandatory Participants

All persons meeting applicable eligibility requirements of Title XIX of the Social Security Act must be enrolled in a managed care plan. For the first time, persons qualifying for the medically needy program will be included in the mandatory enrollment category as well. Subject to federal approval, medically needy recipients will be required to meet their share of cost by paying the plan premium up to the share of cost amount, with Medicaid covering the remaining cost of the premium. Medically needy participants become eligible for the MMS after their first month of qualifying for the program and will be enrolled in a plan – either by selecting a plan or assignment by AHCA – for 12 months. Plans must provide a grace period of up to 90 days before disenrolling a medically needy participant that fails to pay his or her share of the premium. The bill also clarifies that the plans are not responsible for any claims incurred by the medically needy recipient prior to enrollment in the plan.

The bill establishes a new eligibility requirement for Medicaid, subject to federal approval. Recipients enrolled in managed care plans must pay a share of the premium in the amount of \$10 per month.

Voluntary Participants

Several groups of Medicaid recipients are exempt from mandatory enrollment in the MMA program, but may voluntarily enroll, including recipients who:

- Have other creditable care coverage, excluding Medicare;
- Reside in a residential commitment facility operated through the Department of Juvenile Justice, a group care facility operated by the Department of Children and Families (DCF), or a treatment facility funded through the DCF Substance Abuse and Mental Health Program;
- Are eligible for refugee assistance; or
- Reside in a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

If they do not choose to participate in the program, these recipients shall be served in the Medicaid fee-for-service program.

Benefits

Plans selected to serve recipients in the MMA program must cover, at a minimum, the following benefits:

- Advanced registered nurse practitioner services
- Ambulatory surgical treatment center services
- Birthing center services
- Chiropractic services
- Dental services
- Early periodic screening diagnosis and treatment services for recipients under age 21
- Emergency services
- Family planning services and supplies
- Healthy start services
- Hearing services
- Home health agency services
- Hospice services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory and X-ray services
- Medical supplies, equipment, prostheses, and orthoses
- Mental health services
- Nursing care
- Optical services and supplies
- Optometrist services
- Physical, occupational, respiratory, and speech therapy services
- Physician services
- Podiatric services
- Prescription drugs
- Renal dialysis services
- Respiratory equipment and supplies
- Rural health clinic services
- Substance abuse treatment services
- Transportation to access covered services

Plans can customize the benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency must evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

Plans may opt out of providing family planning services on moral or religious grounds, pursuant to 42 C.F.R. s. 438.102. In such an instance, these services would be provided through fee-for-service payments.

Qualified Plan Selection

Using the plan selection process provided for in the general provisions, the agency must notice ITNs later than January 1, 2012. The number and types of plans that must be selected per Region is as follows:

- **Region 1** - Two plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 2** - Two plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 3** - At least 3, but no more than 5 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 4** - At least 3, but no more than 5 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 5** - At least 2 plans, but no more than 4 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 6** - At least 4, but no more than 7 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 7** - At least 3, but no more than 6 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 8** - At least 2, but no more than 4 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 9** - At least 2, but no more than 4 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 10** – At least 2, but no more than 4 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- **Region 11** - At least 5, but no more than 10 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.

These requirements are illustrated in the following chart:

Medical and Long Term Care Plans	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	Statewide Totals
Total Enrollees	96,365	113,027	251,892	280,501	184,448	380,476	334,845	191,176	234,709	229,399	544,224	2,841,062
Minimum plans	2	2	3	3	2	4	3	2	2	2	5	30
PSN plans, if responsive	1	1	1	1	1	1	1	1	1	1	1	11
Maximum plans	2	2	5	5	4	7	6	4	4	4	10	53

Specialty Plans

Specialty plans serve specific, targeted populations based on age, medical condition, or diagnosis. For example, a plan could serve children, diabetics, or persons with AIDS. Specialty plans may participate in the managed care program and are subject to the regional plan number limitations unless the plan’s target population is no more than 10% of the enrollees in a region. Then the agency may contract with a specialty plan in excess of the limitation if the plan otherwise meets the procurement requirements.

Children’s Medical Services Network

The Children’s Medical Services Network (CMS) is established as a qualified plan for the MMA program. The CMS network’s participation will be established through a single, statewide contract with the agency that is exempt from the ITN requirements or the limitations on the number of regional plans. CMS must meet all other plan requirements established for the MMA program.

Quality Selection Criteria

In addition to the quality selection criteria provided in the general provisions (s. 409.966, F.S.), the agency must consider evidence that qualified plans responding to the ITN have written agreements, signed contracts, or have made substantial progress in establishing relationships with providers prior to the plans' submission of a response to the ITN. The agency must evaluate and give special weight to evidence of signed contracts with essential providers pursuant to s.409.705 (2), F.S. The agency must also consider whether the organization has a contract to provide managed long-term care services in the same region and must exercise a preference for such plans.

Plan Accountability

Provider Networks

Managed care plans are required to develop and maintain adequate networks of providers in order to meet the medical needs of their enrollees. Plan networks must include all essential providers—hospitals, Federally Qualified Health Centers (FQHCs), and other providers classified as essential by the agency. Not all providers in these categories will meet the criteria to be identified as essential. To do so they must be the sole source of specific services, or must have historically provided a substantial amount of particular services that cannot be absorbed by other providers. AHCA will determine which providers are essential, and must make specific determinations about federally qualified health centers, teaching hospitals, trauma centers, and hospitals located at least 25 miles from another hospital with similar services. Practitioners may not be classified as essential providers.

If plans selected through the procurement process do not already have contracts with essential providers, they must negotiate with them for one year or until an agreement is reached. Payment rates during the negotiation process are set at 100 percent of the Medicaid rate in effect on the first day of the agency's contract with the plan. After one year, the plan may request agency approval of an alternative arrangement. If that alternative is approved, the new payment rate is 90 percent of the Medicaid rate. If that alternative is not approved, the new payment rate is 110 percent of the Medicaid rate.

Certain providers are identified as essential on a statewide basis. These include faculty of Florida medical schools, regional perinatal intensive care centers, specialty children's hospitals, and certain entities providing prescribed pediatric extended care services. Parameters for payment in the event no contract exists with these providers are identified as the Medicaid rate or, in the case of children's hospitals, the highest rate established in an existing Medicaid plan contract with that facility.

Florida Medical Schools Quality Network

The Florida Medical Schools Quality Network is created to provide supplemental payments to these physicians using certified public expenditures and earned federal funding. The network is responsible for an active and ongoing program to improve clinical outcomes in all managed care plans.

Performance Measurement

Each plan is required to monitor the quality and performance of each participating provider. Plans must notify the providers at the beginning of the contract period regarding the metrics that will be used by the plan for evaluating the provider's performance and determining continued participation in the network.

Primary Care Initiative

Each plan must establish an initiative to encourage enrollees to establish a relationship with a primary care provider. Plans must provide information to enrollees about how to select a primary care provider, and must assign a primary care provider to any enrollee who fails to do so. For new Medicaid recipients, plans must assist the recipient in scheduling an appointment with the primary care provider. Plans must report data on primary care assignments, enrollees who have not had a primary care appointment in their first year of enrollment, and on emergency room visits by those enrollees.

Healthy Behaviors

Each plan must establish a program to encourage healthy behaviors. At a minimum, plans must establish smoking cessation programs, weight loss programs, and an alcohol and substance abuse recovery program. Plans are required to identify enrollees who need these programs and establish agreements with them to participate in these programs.

MomCare Network

The agency is directed to contract with an administrative services organization representing all Healthy Start Coalitions in order to continue the MomCare waiver services of care coordination, and other services. The Coalitions will receive funding for these services based on certified public expenditures and earned federal revenue. All managed care plans must contract with the Healthy Start Coalitions in their regions in order to coordinate services provided to pregnant women and infants.

EPSDT Screening Rate

After the end of the second contact year, each plan must achieve an annual Early Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 80 percent for those recipients continuously enrolled for at least 8 months.

Provider Payment

Plans and hospitals must negotiate mutually acceptable rates, methods and terms of payment. For contracts with hospitals negotiated after the contracts with AHCA are awarded, the plans must pay hospitals at least the Medicaid rate, but payments cannot exceed 120 percent of the Medicaid rate unless specifically approved by the agency. The Medicaid rate is the rate the agency would have paid on the first day of the contract between the provider and the plan. Payment rates may be updated periodically.

The agency shall establish payment rates for statewide inpatient psychiatric programs. Payments to managed care plans shall be reconciled to reimburse actual payments to statewide inpatient psychiatric programs.

Plan Payment

In addition to the general payment provisions applicable to all managed care plans under the part, plans in the MMA program must negotiate prepaid payment rates with the agency as part of the ITN process.

Enrollment

Automatic Enrollment

The agency must automatically enroll recipients into a managed care plan when recipients do not voluntarily choose a plan. The agency must automatically enroll recipients in plans that meet or exceed the performance or quality standards established in the general section, and are prohibited from enrolling recipients in plans that are deficient in those standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. During the first contract period, if there is no applicable specialty plan available and the recipient is currently receiving services from a participating plan, the agency shall assign the recipient to that participating plan. The agency cannot otherwise engage in practices that favor one plan over another. When automatically enrolling recipients in plans, the agency must take into account:

- Whether the plan has sufficient network capacity to meet the needs of recipients.
- Whether the recipient has previously received services from one of the plan's primary care providers.
- Whether the primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

In addition, newborns will be automatically enrolled in their mothers' plans, and are deemed enrolled in those plans upon birth. Mothers may choose other plans for their infants within 90 days of birth.

Opt-Out Option

The agency must develop a process to enable recipients in the MMA program with access to employer-sponsored health insurance to opt out of the plans and use Medicaid financial assistance to pay their share of cost in such plans. Subject to federal approval, the agency must also allow recipients with access to other insurance or related products providing access to health care services created pursuant to state law, such as Cover Florida plans, any products available in the Florida Health Choices Program, or any health exchange. The amount of financial assistance cannot exceed the amount of the Medicaid premium that would have been paid to the plan for that recipient.

Effect of Changes: Long-term Care Managed Care Program

AHCA is responsible for administering the Long-term Care Managed Care Program, but may delegate specific duties to DOEA and other state agencies. Implementation of the program shall begin July 1, 2012 with full implementation by October 1, 2013.

DOEA is directed to assist AHCA in the development of the ITNs and of contracts with plans, determining clinical eligibility, monitoring plans, assisting families and clients in addressing complaints with plans, and facilitating working relationships between the plans and the providers.

Eligibility

Medicaid recipients who are 65 years old or older or who are eligible for Medicaid by reason of a disability will be eligible for the long-term care program, subject to a wait-list prioritization and availability of funds. Additionally, the recipients must be determined by the CARES Program to require a nursing facility level of care. A nursing facility level of care means the individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24 hour period and requires care to be performed on a daily basis under the direct supervision of a health professional of medically complex services because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24 hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

Additionally, as the long-term care managed care plans become available in each region, everyone who is enrolled in one of following the long-term care waivers will be eligible on that date. This population will be “grandfathered in” even if they fail to meet the specific age requirements and will be “grandfathered in” for 24 months if they fail to meet the level of care requirements of the long-term care managed care program. These waivers are:

- The Assisted Living for the Frail Elderly Waiver
- The Aged and Disabled Adult Waiver
- The Adult Day Health Care Waiver
- The Consumer-Directed Care Plus Program (CDC+)
- The Program of All-inclusive Care for the Elderly (PACE)
- The Long-Term Care Community-Based Diversion Pilot Project
- The Channeling Services Waiver for Frail Elders

Benefits

Participating managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans will be free to customize and offer additional serves. The minimum benefits include:

- Nursing home
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing
- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care

- Transportation
- Personal emergency response system

Eligible Plans

In addition to the types of plans that are generally qualified to participate in the long-term care managed care program, the bill provides that additional specific types of plans that may participate such as plans that offer managed care for Medicare recipients are qualified plans. These plans include Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans. Also, the bill specifies that a provider services network must be a long-term care provider service network. Specifically, a long-term care provider service network must have a controlling interest owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, Community Care for the Elderly Lead Agencies, or hospices.

PACE plans shall be considered qualified plans. Their participation shall be by contract with AHCA and their enrollment and benefits shall be subject to specific appropriation in the General Appropriations Act. PACE plans shall not count toward the regional plan number limits.

Regions and Number of Plans

The long-term care managed care program shall use the regions described in the general Medicaid managed care provisions and have the same upper and lower limits on plans participating as the managed medical assistance program.⁷⁴

Qualified Plan Selection

AHCA shall use the previously explained general procurement process. The agency shall notice the ITNs no later than July 1, 2012.

In addition to the general selection criteria, the agency shall consider whether the plan has executive managers with expertise and experience in serving aged and disabled clients who require long-term care' whether the plan has an adequate network of home and community based service providers; whether the plan offers consumer-directed care services; whether the plan is proposing to offer comprehensive medical services; and whether the plan offers home and community based services in addition to the minimum required services.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) may participate as a qualified plan, but is not subject to the procurement process or regional plan number limits of the bill. PACE may participate through a contract with AHCA, pursuant to the requirements of the General Appropriations Act.

Medicare Plans

Medicare managed care plans (Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-Sponsored Organizations, and Medicare Advantage Special Needs Plans) may participate as qualified plans. If their enrollees are exclusively Medicaid recipients also eligible for

⁷⁴ *Supra*, p. 27.

Medicare, these plans are not subject to the procurement process or regional plan number limits of the bill.

Plan Accountability

The long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in home and community based waivers. If after 12 months of participation these providers do not meet the plan's quality standards, then the plan may exclude them. In general providers do not have to participate in plans; however, nursing homes and hospices must participate in all selected plans that offer them contracts.

The long-term care managed care plans must offer a network contract to nursing homes, hospices, and aging network providers who previously participated in home and community based waivers. If after 12 months of participation these providers do not meet the plan's quality standards, then the plan may exclude them. In general, providers do not have to participate in plans; however, nursing homes and hospices must participate in all selected plans that offer them contracts.

Each long-term care managed care plan's network must include the following:

- Adult Day Center Centers
- Adult Family Care Homes
- Assisted Living Facilities
- Health Care Services Pools
- Home Health Agencies
- Homemaker and Companion Services
- Hospices
- Community Care for the Elderly Lead Agencies
- Nurse Registries
- Nursing Homes

Plan Payment

In general, the plans and provider shall negotiate mutually acceptable payment terms and rates. However, both nursing homes and hospices shall receive a "pass-through" rate set by AHCA.

Prepaid payment rates shall be negotiated between AHCA and the plans for long-term care services. Plans that are comprehensive long-term care plans that provide both medical assistance and long-term care services shall receive a combined rate for all services.

Rates will be adjusted to reflect the level of care profile for enrollees of each plan. The rates will be adjusted to provide an incentive for reducing nursing home placement and increasing placement in home and community based care. The expected change in the unitization mix toward home and community based care will be a 2 percentage point shift in the first rate setting period; a 2 percentage point shift in the second rate setting period, as compared to the first period; and 3 percentage point shift thereafter, as compared to the immediately preceding period. The incentive adjustment will continue until the plan reaches a unitization mix where no more than 35% of the plan's enrollees are in institutional settings.

The initial assessment of each enrollee's level of care needs will be done by the CARES Program. First, the CARES staff will determine if the individual is medically eligible to receive Medicaid by

needing a nursing facility level of care. If the CARES staff determines that the individual is medically eligible, then CARES shall assigned each individual to one of three levels of care. These levels of care are:

- Level 1 – The individual is in a nursing home or requires immediate nursing home placement.
- Level 2 – The individual is at risk of immediate nursing home placement and as evidenced by the need for the constant availability of routine care with extensive needs for related services because of medical or physical incapacity.
- Level 3 – The individual is at risk of immediate nursing home placement and as evidenced by the need for the constant availability of routine care and a limited need for related services because of mild medical or physical incapacity.

The agency shall periodically adjust payment rates to account for changes in the care needs of the client profile of each plan.

Enrollment

In a recipient fails to choose a plan, the agency shall assign the recipient to a plan. The agency shall assign individuals to plans that meet or exceed quality standards. A recipient who is dually eligible for Medicaid and Medicare shall be assigned to a plan that provides both Medicaid and Medicare services if the recipient is currently receiving Medicare services from that plan. In making assignments, the agency shall also consider network capacity, whether the recipient has previously received services from one of the plan's providers, and whether the plan's providers are near the recipient's home.

When a recipient is referred for hospice services, the recipient shall have a 30-day period in which the recipient may select a different plan to access a hospice provider preferred by the recipient.

Technical Advisory Workgroup

Before August, 1, 2011, AHCA must establish a long-term care managed care technical advisory workgroup to assist in developing:

- Methods for the CARES program to determine medical eligibility for the long-term care managed care program
- The requirements for implementing pass-through payments by plans to nursing homes
- The method for managing non-payment of Medicare co-insurance crossover claims
- Uniform requirements for claims submission and payments, including electronic funds transfers and claims processing
- The process for the enrollment of and making payments for individuals pending determination of Medicaid eligibility

The workgroup must include, but is not limited to, representatives of providers and plans who could potentially participate in the long-term care managed care program. Members will serve without compensation, but may be reimbursed for per diem and travel expenses. The workgroup will expire on June 30, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Counties may continue local contributions to the Medicaid program through the inter-governmental transfers. Counties are permitted to designate the providers that should benefit from the Low Income Pool. The amounts available are subject to legislative direction and contacts with AHCA.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Because of the limitations on the number of plans selected in each region, plans selected will have the opportunity to serve more Medicaid recipients; however, current plans participating in the program that are not selected in one or more regions may experience a reduction their plan enrollment. Plans that are selected but do not meet performance and quality standards established in the bill will experience a reduction in enrollment opportunities.

D. FISCAL COMMENTS:

With the expansion of additional lives in managed care programs, the state may realize additional savings and efficiencies in the Medicaid program, particularly with the expansion of long-term care service delivery into additional managed care programs. The exact savings are indeterminate but are expected to be significant.