Committee on Health Regulation

CS/HB 7107 — Medicaid Managed Care

by Appropriations Committee; Health and Human Services Committee; and Rep. Schenck (CS/CS/CS/SB 1972 by Budget Committee; Budget Subcommittee on Health and Human Services Appropriations; Health Regulation Committee; and Senators Negron, Gaetz, Garcia, and Hays)

The bill establishes the Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. The Agency for Health Care Administration (AHCA) is directed to apply for and implement amendments to the Medicaid state plan or waivers of applicable federal laws and regulations by August 1, 2011, necessary to implement the program. The AHCA is directed to provide public notice and seek public comment before applying for such waivers and is required to include public feedback in waiver applications.

The new Medicaid program consists of two components:

- **Managed Medical Assistance**
  Provides medically-necessary primary and acute health care services such as doctor's visits, hospitalization, pregnancy care, prescription drugs, etc.
- **Managed Long-Term Care**
  Provides individuals who are aged and/or disabled, and who meet additional acuity levels, with additional services beyond routine health care needs such as adult day care, home delivered meals, personal care, case management, etc.

All Medicaid recipients will be enrolled in managed care plans unless specifically exempt. Recipients who are exempted include persons with limited eligibility or benefits and persons with developmental disabilities.

A variety of managed care plans may participate in the program. A recipient has a choice of plans and plan types that are contracted by the AHCA in the recipient's region of residence. Recipients may choose between insurers, exclusive provider organizations, health maintenance organizations (HMOs), and other managed care plans run by health care providers or groups of providers, such as provider service networks (PSNs) or accountable care organizations (ACOs). Recipients may also choose specialty plans with expertise in specific medical conditions.

Plans will compete for Medicaid contracts via an invitation-to-negotiate process based on specified qualifications, such as price, provider network adequacy, accreditation, community partnerships, additional benefit offerings, and performance history.

- Specific factors are identified for the AHCA to use in selecting bidders to participate in negotiations. Critical factors include:
  - Accreditation and experience
  - Sufficient primary and specialty physicians in the network
  - Community partnerships
  - Commitment to quality improvement

  - Coverage of additional benefits including dental care and disease management
  - Evidence of established relationships with providers
  - Input from providers
  - Documentation of policies to prevent fraud and abuse
- Plans must reveal their business relationships so that one company cannot dominate a region and prevent Medicaid recipients from having a real choice among plans.
- Preference will be given to plans that demonstrate:
  - Signed contracts with primary and specialty physicians and with essential providers;
  - Well-defined programs for recognizing patient-centered medical homes and accountable care organizations;
  - Ability to produce a greater economic benefit by being headquartered in Florida and employing Floridians to meet contract terms;
  - Provider networks in which over 10 percent of providers use electronic health records;
  - A contract with AHCA to provide managed long-term care services in the same region;
  - Contracts or other arrangements for cancer disease management programs;
  - Contracts or other arrangements for diabetes disease management programs;
  - A process for prompt payment of claims.

There will be a limited number of plans in each of eleven regions to promote plan stability but also provide choices to recipients.

Insurers and HMOs will be prepaid on a full-risk basis via a monthly capitated rate designed to represent the costs needed to provide all medically necessary services in the aggregate during any month-long period. Capitation rates will be risk-adjusted based on patient encounter data. Risk-adjusted rates will ensure plans are paid more for sicker patients in order to allocate resources appropriately.

Provider service networks will have the option of assuming risk immediately or being paid on a fee-for-service basis for the first 2 years of operation, after which a PSN that initially opted to be paid via fee-for-service must convert to a full-risk capitation payment.

During the first year of the first contract term, managed care plans, including prepaid plans and PSNs paid via fee-for-service, must guarantee a savings of at least 5 percent from the amount they would have been paid in the previous year based on service area and population.

Managed care plans will be held accountable:

- Payment to physicians must be equal to or exceed Medicare rates after 2 years of continuous plan operation.
- Prescription drug formularies or preferred drug lists must be accessible on the plan's website.
- Prior authorization requests must be accepted electronically.
- Provider networks must meet specific adequacy standards, and plans must maintain an online database of network providers that can be used by consumers and the AHCA.

- Valid encounter data must be submitted on time.
- Plans must provide quality data measures on their websites to allow recipients to compare plans.
- Plans must be accredited by a nationally recognized accrediting body or seek accreditation by such a body within one year of plan operation.
- Performance must continuously improve based on specific standards that are raised over the term of the contract.
- Active systems must be used to reduce the incidence of fraud and abuse.
- All recipients must have access to a grievance process.
- Financial penalties will be imposed and contracts will be terminated for reducing enrollment or withdrawing prior to the end of a contract term.
- Financial penalties will be imposed on plans that fail to comply with encounter data reporting requirements. If the plan does not comply within 90 days, its contract will be terminated.

Limits will be placed on how much profit can be earned by managed care plans to ensure that plans are not overspending on administration or earning profit at the expense of patient care. This system of "achieved savings rebates" will require plans that exceed an appropriate profit threshold to pay dollars back to the state, thereby eliminating an incentive to withhold appropriate spending on health care services:

- Administrative fees are restricted to actuarially appropriate levels.
- Effective management of care will achieve savings that will be shared with the state.
- Plans may retain a reasonable profit of up to a 5 percent margin. Plans must pay back a portion of profits above that threshold and must pay back all profits above a 10 percent margin.
- Plans can earn an additional one percent profit if they demonstrate exceptional performance.
- Plans will be required to perform and submit detailed audits to verify the achieved savings rebates.

Intergovernmental Transfer Process:

- Local funding sources may contribute funds to the state Medicaid program.
- Specific conditions apply to the local contributions.
- The Low Income Pool is restructured to function within a managed care environment.
- The Access to Care Partnership is created as a single organization representing all providers designated by local funding sources as eligible to receive support through the Low Income Pool.
- Any additional resources generated by the local contributions may be used to enhance hospital payment rates through a specific formula for hospitals classified in three tiers. All hospitals will receive some benefit from tiered rate increases.

Medicaid recipients will have an opportunity to choose among plans in their region. Those who do not choose a plan will be automatically enrolled, with a preference for enrollment in specialty

plans if there is one available to serve their particular condition. This will ensure recipients are served by plans with expertise in their specific disease states.

The AHCA is directed to develop a process to enable a recipient with access to employer-sponsored coverage to opt-out of all Medicaid managed care plans and use Medicaid financial assistance to pay the recipient's share of the cost for the employer-sponsored coverage, and the AHCA is directed to seek federal approval to require such recipients to opt-out of Medicaid managed care in favor of their employer-sponsored coverage. The AHCA is also directed to seek federal approval to enable recipients with access to other insurance or related products that provide access to health care services, including products available under the Florida Health Choices program or any health exchange, to opt-out. The amount of financial assistance provided for any such recipient may not exceed the amount the Medicaid program would have paid to a Medicaid managed care plan for that recipient.

Participation in the Medicaid managed care medical assistance component by the Children's Medical Services Network will be under a single, statewide contract with the AHCA that is not subject to the program's procurement process or the regional limitation on the number of plans. However, the Children's Medical Services Network must meet all other plan requirements for the managed medical assistance component.

Managed Medical Assistance

The bill creates the managed medical assistance component for primary and acute care services. Implementation of the medical assistance component begins January 1, 2013, and is scheduled to be fully implemented by October 1, 2014. All mandatory and optional primary and acute care services are covered in the program, and plans can offer additional benefits.

Plans contracted for the medical assistance component must:

- Maintain adequate provider networks
- Monitor quality and performance standards of their providers
- Contract with Healthy Start Coalitions to improve outcomes for pregnant women and infants.
- Ensure at least 80 percent of their enrolled children receive their well-child screening by the end of the second year in pursuit of proper preventive care and treatment.

The bill requires medical assistance plans to contract with certain "essential providers," which include:

- Federally qualified health centers;
- Statutory teaching hospitals;
- Hospitals that are trauma centers;
- Hospitals located at least 25 miles from any other hospital with similar services;
- Faculty plans of Florida medical schools;
- Regional perinatal intensive care centers;
- Specialty children's hospitals;

- Accredited and integrated systems serving medically complex children that comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and prescribed pediatric extended care.

The bill sets reimbursement mandates for plans that are unable to contract with essential providers.

The bill brings the Medically Needy population into managed care under certain conditions that are contingent on federal approval. After being deemed eligible for the Medically Needy program, recipients will be enrolled in managed care plans and pay a portion of the managed care plan premium, based on their income and share of cost as determined by the Department of Children and Families. The state will pay the remaining portion of the premium to the managed care plan.

Managed Long-term Care

The bill creates the managed long-term care component for Medicaid recipients eligible for long-term care services. Implementation of the long-term care component will begin July 1, 2012, and is scheduled to be fully implemented in all regions by October 1, 2013.

The managed long-term care component covers:

- Medicaid recipients who are age 65 or older, or age 18 or older and eligible for Medicaid by reason of a disability; and
- Determined by the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES) program to require nursing facility care.

Medicaid recipients who, on the date long-term care plans become available in their region, reside in a nursing home facility or are enrolled in certain long-term care Medicaid waiver programs, are eligible to participate in the long-term care component for up to 12 months without being reevaluated for their need for nursing facility care.

There will be two types of long-term care plans:

- Comprehensive long-term care plans that combine medical assistance and long-term care services
- Long-term care plans that provide only long-term care services

Selection preference will be given to comprehensive plans so seniors can receive all services from one plan. Plans will provide residential care in nursing facilities or assisting living facilities. The plans also must offer a comprehensive range of home and community based services for the care of seniors or the disabled who need assistance but not round-the-clock nursing care. Eligible plans must have specialized staffing with experience in serving elders and the disabled.

Long-term care plans must provide a complete range of services throughout their regions and must have needed providers such as nursing homes, assisting living facilities, and hospices in their networks.

A long-term care plan's network must include all of 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
- Lead Agencies
- Nurse Registries
- Nursing Homes

Long-term care recipients who are referred to nursing homes or assisted living facilities will be informed of facilities within the plans that are associated with specific religious or cultural affiliations, and a reasonable effort must be made to place the recipient in the facility of their choice.

The bill provides an additional choice for hospice patients. When a senior is referred for hospice services, the senior will have a 30-day period in which to change plans if a preferred hospice provider is only available through another plan.

When a recipient does not choose a long-term care plan, auto-assignment will be based on the quality measures of plans in the region. Members of certain Medicare Advantage plans who are also Medicaid-eligible and who do not choose a Medicaid plan will be assigned to their Medicare Advantage plan for applicable Medicaid services if their Medicare Advantage plan has contracted with the AHCA for the Medicaid long-term care component.

Medicare Advantage plans that serve only individuals who are dually eligible (qualify for both Medicare and Medicaid) may enter into a contract with the AHCA and will not be subject to the procurement requirements contained in the bill. All other Medicare plans will be subject to competitive procurement.

Program for All Inclusive Care for the Elderly (PACE) plans are eligible plans and are not subject to the procurement process or region limits. They may continue to serve recipients at the enrollment caps set by the Legislature.

The bill focuses on keeping seniors in their homes as long as possible. Home and community based care is both required and rewarded. Payment rates for long-term care plans will be adjusted to create incentives for keeping individuals out of nursing homes when in-home accommodations and care can be arranged instead of nursing home care.

Long-term care plans are required to pay nursing homes and hospices at payment levels established by the AHCA.

If approved by the Governor, these provisions take effect July 1, 2011.
Vote: Senate 28-11; House 79-39