The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Budget Subcommittee on Health and Human Services Appropriations

BILL:	CS/SB 730
INTRODUCER:	Health Regulation Committee and Senator Flores and Others
SUBJECT:	Medicaid Managed Care Plans
DATE:	January 20, 2012 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Stovall	HR	**Fav/CS**
2.	Brown	Hendon	BHA	**Favorable**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill changes the statewide Medicaid managed care program (the managed medical assistance program and the long-term care managed care program) with respect to the role that Medicare Advantage plans will play in the program, for recipients who are dually eligible for Medicaid and Medicare. The bill requires the Agency for Health Care Administration (AHCA) to establish a per-member, per-month payment for dually eligible individuals enrolled in any Medicare Advantage coordinated care plan, not just in a Medicare Advantage special needs plan.

The definition of "eligible plan" for the statewide Medicaid managed care program and various other statutory references to eligible plans in the program are amended to include additional Medicare Advantage organizations and plans, for purposes of providing coverage to individuals who are dually eligible for Medicaid and Medicare and who are to be enrolled in the managed medical assistance program and the long-term care managed care program.

The bill exempts a Medicare Advantage coordinated care plan from the procurement requirements and regional plan limits of the new Medicaid managed medical assistance program, if the plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible for Medicaid and Medicare. Also, the bill requires the AHCA to

automatically enroll Medicaid managed medical assistance program recipients who have not voluntarily selected a plan, who are dually eligible, and who are currently receiving Medicare services from a Medicare Advantage coordinated care plan to that Medicare Advantage plan, if the plan is currently under contract with the AHCA.

The bill modifies the existing exemption from the procurement requirements of the Medicaid long-term care managed care program for Medicare Advantage plans serving dually eligible recipients. The bill specifies that the exemption from the procurement requirements applies only if the Medicare Advantage plan's Medicaid enrollees consist exclusively of its current Medicare enrollees.

The bill reduces the penalty imposed on certain managed care plans that leave a region before the end of the term of their contract with the AHCA.

The bill has no direct fiscal impact on government.

This bill substantially amends the following sections of the Florida Statutes: 409.9122, 409.962, 409.967, 409.974, 409.977, 409.981, and 409.984.

The bill has an effective date of July 1, 2012.

II. Present Situation:

Medicaid

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. The AHCA is responsible for administering the Medicaid program. Medicaid serves approximately 3.19 million people in Florida, with over half of those being children and adolescents 20 years of age or younger. Estimated Medicaid expenditures for FY 2011-2012 are approximately $20.3 billion.

Medicaid Managed Care

Part III of ch. 409, F.S., provides the statutory requirements for the Florida Medicaid program. Sections 409.9121 – 409.9124, F.S., contain provisions relating to managed care in Medicaid.

In 1993, the Legislature passed legislation declaring its intent that the Medicaid program require, to the maximum extent practicable and permitted by federal law, that all Medicaid recipients be enrolled in a managed care program.[1] This intent language was codified in s. 409.9121, F.S., and has remained in effect and unchanged since 1993. Section 409.9122, F.S., which was also created in 1993, set Florida on the path of mandatory enrollment of Medicaid recipients in managed care by providing for the statewide expansion of the primary care case management program known as MediPass and for the growth of health maintenance organizations and prepaid health plans for Medicaid recipients. Section 409.9122, F.S., has been amended almost every year since 1993 to expand the role of managed care in Medicaid as managed care has evolved.

[1] *See* s. 50 of ch. 93-129, L.O.F.

In 2005, the Legislature directed the AHCA to seek federal Medicaid waivers pursuant to s. 1115 of the Social Security Act to create a Medicaid managed care pilot program in five counties in the State. Under the pilot program, most Medicaid recipients have been moved from Medicaid fee-for-service and the MediPass program into capitated managed care systems. As of December 15, 2011, the pilot program waiver was extended for three years, through June 30, 2014. This coincides with implementation of the new statewide Medicaid managed care program established in 2011 and codified in pt. IV of ch. 409, F.S. (s. 409.961 – 409.9841, F.S.).[2]

Part IV of ch. 409, F.S., requires all Medicaid recipients to enroll in a managed care plan unless they are specifically exempted. The statewide Medicaid managed care program includes the long-term care managed care program and the managed medical assistance program. The law directs the AHCA to begin implementation of the long-term care managed care program by July 1, 2012, with full implementation in all regions of the State by October 1, 2013. By January 1, 2013, the AHCA must begin implementation of the managed medical assistance program, with full implementation in all regions of the State by October 1, 2014.

The AHCA is required to separately procure long-term care managed care plans and managed medical assistance plans in each of the 11 regions of the state, which coincide with the existing Medicaid areas. The AHCA is required to select a limited number of eligible plans to participate in the program using Invitations to Negotiate. Each Medicaid recipient must have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.

Section 409.967(4)(h)1., F.S., requires plans that reduce enrollment levels or withdraw from an area of operation before a contract term is over to reimburse the AHCA for the cost of enrollment changes and other transition activities. If more than one plan leaves an area, the plans are required to split the cost proportionate to their enrollment. In addition to payment of costs, departing provider services network plans must pay a penalty of up to 3 months' payment and departing health maintenance organization plans must pay a penalty of 25 percent of the minimum surplus which they are required to maintain under s. 641.225(1), F.S.

Dual Eligibles

Dual eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage. Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing, and—for those below certain income and asset thresholds—long-term care services and, until 2006, prescription drugs, among other services. The term "dual eligible" encompasses all Medicare beneficiaries who receive Medicaid assistance, including those who receive the full range of Medicaid benefits and those who receive assistance only with Medicare premiums or cost sharing.

Currently, dual eligibles cannot be mandatorily assigned to managed care. The AHCA is seeking authority to mandatorily assign dual eligibles to long-term care managed care plans and managed medical assistance plans.

[2] *See* ch. 2011-134, L.O.F.

Medicare Advantage Plans

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services.

Medicare has four different parts that cover specific services.

- *Part A* (Hospital Insurance) helps cover inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.
- *Part B* (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps cover some preventive services that help people maintain their health and keep certain illnesses from getting worse.
- *Part C* (Medicare Advantage Plans) covers Part A, Part B, and usually Part D services provided by Medicare-approved private insurance companies.
- *Part D* (Prescription Drug Coverage) helps cover the cost of prescription drugs through Medicare-approved private insurance companies.

The Balanced Budget Act of 1997 established a new Part C of the Medicare program, known then as the Medicare+Choice program, effective January 1999. The act authorized the CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans, Medicare Medical Savings Account plans, private-fee-for-service plans, and Religious Fraternal Benefit plans. These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the original Medicare program.

The Medicare+Choice program in Part C of Medicare was renamed the Medicare Advantage Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which was enacted in December 2003. This act updated and improved the choice of plans for beneficiaries under Part C. Beneficiaries may now choose from additional plan options, including regional preferred provider organization plans and special needs plans. The act also established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most Medicare Advantage plans to offer prescription drug coverage.

Coordinated care plans are plans that include a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by the CMS. They may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. Coordinated care plans include plans offered by any of the following:

- Health maintenance organizations (HMOs);
- Provider-sponsored organizations (PSOs);

- Regional or local preferred provider organizations (PPOs);
- Other network plans, except for private-fee-for-service plans; and
- Specialized Medicare Advantage plans for special needs individuals, which include any type of coordinated care plan that exclusively enrolls special needs individuals.[3] Special needs individuals are Medicare Advantage eligible individuals who are institutionalized, have severe or disabling chronic conditions, or qualify both for Medicare and Medicaid benefits (dual eligibles).[4]

Specialized Medicare Advantage plans for special needs individuals must provide Part D benefits. They must be designated by the CMS as meeting the requirements of a Medicare Advantage special needs plan as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

Medicare Advantage organizations seeking to offer a special needs plan serving beneficiaries eligible for both Medicare and Medicaid must have a contract with the State Medicaid agency (the AHCA).[5] Medicare Advantage plans wishing to offer a special needs plan are required to meet additional requirements set forth by federal law, including approval by the National Commission on Quality Assurance, effective January 1, 2012.

The Medicare Advantage program also provides for a "*fully integrated* dual eligible special needs plan." The fully integrated plan is a CMS-approved Medicare Advantage/Prescription Drug dual eligible special needs plan that:

- Enrolls special needs individuals entitled to medical assistance under Medicaid;
- Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;
- Has a capitated contract with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services;
- Coordinates the delivery of covered Medicare and Medicaid health and long-term care services using aligned care management and specialty network methods for high-risk beneficiaries; and
- Employs policies and procedures approved by the CMS and the State to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.[6]

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[3] 42 C.F.R. part 422.4, Types of MA plans. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6458b5363e3fed66ddaf309b5baa0b31&rgn=div8&view=text&node=42:3.0.1.1.9.1.5.3&idno=42> (Last visited on January 17, 2012).

[4] 42 C.F.R. part 422.2, Definitions. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div8;view=text;node=42%3A3.0.1.1.9.1.5.2;idno=42;cc=ecfr> (Last visited on January 17, 2012).

[5] 42 C.F.R. part 422.107, Special needs plans and dual-eligibles: Contract with State Medicaid Agency. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr#42:3.0.1.1.9.3.5.8> (Last visited on January 17, 2012).

[6] 42 C.F.R. part 422.2, Definitions. Found at: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=92c8e79ce6a6a52e4b60a4251b9a8745;rgn=div8;view=text;node=42%3A3.0.1.1.9.1.5.2;idno=42;cc=ecfr> (Last visited on January 17, 2012).

Health Maintenance Organization Minimum Surplus Requirement

Subsection 641.225(1), F.S., requires each health maintenance organization to maintain at all times a minimum surplus in an amount that is the greater of $1,500,000, 10 percent of total liabilities, or 2 percent of total annualized premium. The surplus account requirement is not specific to a certain line of business. Companies that operate or own multiple plans are only required to hold one surplus account.

III. Effect of Proposed Changes:

Section 1 amends s. 409.9122, F.S., relating to mandatory Medicaid managed care enrollment, to require, rather than to authorize, the AHCA to establish a per-member, per-month payment for enrollees of a Medicare Advantage coordinated care plan who are also eligible for Medicaid. The existing statutory provision applies only to members of Medicare Advantage special needs plans who are also eligible for Medicaid. The AHCA currently contracts with 12 Medicare Advantage special needs plans and has established a per-member, per-month payment. By using the term Medicare Advantage coordinated care plans, plans other than Medicare Advantage special needs plans would receive a per-member, per-month payment for enrollees who are dual eligibles. This will have an impact on enrollment levels of the existing contractees.

Section 2 amends s. 409.962, F.S., which provides definitions for the recently enacted Medicaid managed care program, to modify the definition of "eligible plan." The bill clarifies that, for purposes of dual eligibles, the term "eligible plan" includes all Medicare Advantage coordinated care plans. The term is also expanded to include dual eligibles enrolled in the managed medical assistance program, not just enrollees in the long-term care managed care program.

According to the AHCA,[7] there are 87,000 Medicaid recipients residing in a nursing home or participating in a waiver program who will be required to participate in the long-term care managed care program. Of these, 82,000 are dual eligibles who are eligible for full Medicaid services and Medicare services. The AHCA does not currently know the number of these individuals who are enrolled in Medicare Advantage plans or the Medicare Advantage plans in which they are enrolled. In order to implement this provision, the AHCA may need to obtain information from Medicare Advantage plans and may need to make systems changes.

There will be 5,000 who are not dual eligibles who will be eligible for both the long-term care managed care program and the managed medical assistance program. These individuals would not qualify for enrollment in a Medicare Advantage plan.

Section 3 amends s. 409.967, F.S., relating to managed care plan accountability, to clarify that, for plans, other than provider services networks, only the *departing* plans must pay the penalty of 25 percent of the minimum surplus required under s. 641.225(1), F.S. The bill also reduces the penalty on departing plans, other than provider services networks, to 25 percent of the minimum surplus which is attributable to the provision of coverage to Medicaid enrollees, not all plan enrollees. This change may potentially reduce the payment a departing plan must make.

[7] *See* Agency for Health Care Administration 2012 Bill Analysis and Economic Impact Statement for SB 730 – on file with the Health Regulation Committee.

Section 4 amends s. 409.974, F.S., relating to eligibility of plans for participation in the Medicaid managed medical assistance program, to exempt a Medicare Advantage coordinated care plan from the procurement requirements or regional plan limits applicable to other managed care plans, if the Medicare Advantage coordinated care plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible. Participation by such plans would be pursuant to a contract with the AHCA. If a plan's Medicaid enrollees are not exclusively its current Medicare enrollees who are dually eligible, the plan must meet all procurement requirements. The bill corrects an incorrect cross-reference.

If Medicare Advantage plans are allowed to become Medicaid managed medical assistance plans and are not subject to procurement requirements, the AHCA will need to develop an open application document and process in addition to the competitive procurement documents and process specified in current law. The application would be necessary to ensure that Medicare Advantage plans meet or have the ability to meet all statutorily required and agency-defined contract requirements.

Section 5 amends s. 409.977, F.S., relating to enrollment of Medicaid managed medical assistance program recipients into managed care plans, to specify that, if a Medicaid recipient has not voluntarily selected a plan, is a dual eligible, and is currently receiving Medicare services from a Medicare Advantage coordinated care plan, the AHCA must automatically enroll the recipient in that plan for Medicaid services, if the plan is under contract with the AHCA.

The dual-eligible population makes up a large portion of the long-term-care population available for enrollment in Medicaid health plans. Under the provisions of this section, a health plan selected by the AHCA for the managed medical assistance program that is not also a Medicare Advantage plan may not have as many enrollments as a plan that does have a Medicare Advantage plan. Existing Medicare Advantage plans would have the advantage in enrolling dual eligibles for Medicaid services.

Section 6 amends s. 409.981, F.S., relating to eligibility of long-term care plans for participation in the Medicaid long-term care managed care program, to expand the list of Medicare Advantage plans to include all the Medicare Advantage coordinated care plans. The law currently includes only Medicare Advantage preferred provider organizations, Medicare Advantage provider-sponsored organizations, and Medicare Advantage special needs plans. The bill also limits the existing statutory exemption for such plans from the procurement requirements to plans whose Medicaid enrollees consist exclusively of its current Medicare enrollees who are dually eligible.

Section 7 amends s. 409.984, F.S., relating to enrollment of Medicaid recipients into long-term care managed care plans, to expand the list of Medicare Advantage plans to include all the Medicare Advantage coordinated care plans. The law currently includes only Medicare Advantage preferred provider organizations, Medicare Advantage provider-sponsored organizations, and Medicare Advantage special needs plans. This will potentially increase the number of plans available and potentially reduce enrollment in each plan.

Section 8 provides an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill has no discernable fiscal impact on government. The number of persons enrolled, the scope and extent of services, and the costs associated with the services will remain the same under the changes contained in the bill.[8]

VI. Technical Deficiencies:

The term "Medicare Advantage coordinated care plan" is the federal Medicare term that encompasses a variety of plans that are offered by various organizations. It may be sufficient to refer to "Medicare Advantage coordinated care plans" as section 1 of the bill does, rather than listing all the types of organizations and plans within that broader category throughout the bill.

VII. Related Issues:

Section 1 of the bill requires the AHCA to establish a per-member, per-month payment for enrollees of a Medicare Advantage coordinated care plan who are also eligible for Medicaid. There are currently Medicare Advantage special needs plans that have entered into Coordination of Benefits Agreements with the AHCA. Under these agreements, the plan coordinates care for its members and the AHCA pays any cost sharing. Cost-sharing includes deductibles,

[8] *Id.*

coinsurance, and co-payments, but does not include any premiums. The AHCA does not pay a per-member, per-month payment to the plans that have a Coordination of Benefits Agreement with the AHCA.

Implementation of the requirement on lines 86-87 to split the minimum surplus requirement for health maintenance organizations into Medicaid and non-Medicaid business will be dependent on the ability of the AHCA to obtain the necessary data to develop a methodology for calculating the penalty on only the Medicaid-related surplus requirement. The AHCA has indicated that it is currently unable to identify what portion of the surplus requirement is related to Medicaid recipients.[9]

VIII. Additional Information:

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

CS by Health Regulation on January 19, 2012:
The CS exempts Medicare Advantage plans from the procurement requirements for the managed medical assistance program and the long-term care managed care program only if their Medicaid enrollees consist exclusively of their current Medicare enrollees.

B. Amendments:

None.

[9] *Id.*