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 Committee on Health Policy

BILL:	SB 1084
INTRODUCER:	Senator Trumbull
SUBJECT:	Long-term Managed Care Program
DATE:	April 2, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 1084 amends s. 409.981, F.S., to create a Medicaid long-term care managed care pilot program in Miami-Dade County to integrate Medicaid's health care services, long-term care services, and home and community-based services for persons with developmental disabilities, under one package, to be delivered by one managed care plan that must be a provider service network meeting certain qualifications. The bill requires an evaluation of the pilot program to be submitted by October 1, 2024.

The bill is likely to have a significant negative fiscal impact. The Agency for Health Care Administration (AHCA), which operates the state's Medicaid program, has not submitted an estimate of the bill's potential fiscal impact. See Section V. of this analysis.

The bill takes effect upon becoming law.

II. Present Situation:

The Florida Medicaid Program

Florida Medicaid is the health care safety net for low-income Floridians. The national Medicaid program is a partnership of federal and state governments established to provide coverage for health services for eligible persons. Florida's program is financed through state and federal funds.[1]

The AHCA is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare

[1] Section 20.42, F.S.

& Medicaid Services (CMS) and maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed under the Florida Statutes,[2] the General Appropriations Act (GAA), and other legislation accompanying the GAA.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request from CMS a formal waiver of the requirements codified in the SSA. Federal waivers give states flexibility not afforded through their Medicaid state plan.

Statewide Medicaid Managed Care

In Florida, a large majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[3] Other recipients who are not eligible for managed care, are not subject to mandatory managed care enrollment, or are not yet enrolled in a plan, are provided services directly from health care practitioners or facilities, and in those cases, providers are paid on a fee-for-service basis.

SMMC has three components:

- Managed Medical Assistance (MMA), under which the AHCA makes payments for primary and acute medical treatments and related services using a managed care model;
- Long-term Care Managed Care (LTCMC), under which the AHCA makes payments for long-term care, including home and community-based services, using a managed care model; and
- The Medicaid Prepaid Dental Health Program (Prepaid Dental), under which the AHCA makes payments for dental services for children and adults using a managed care model.

SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S. SMMC benefits cover primary, acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services.

Florida Medicaid does not cover all low-income Floridians. Current eligibility prioritizes low-income children, disabled persons, and elders, and sets income eligibility by reference to the annual federal poverty level. For some groups, clinical eligibility provisions apply, as well.

[2] *See* parts III and IV of ch. 409, F.S.
[3] As of January 31, 2023, Florida Medicaid's total enrollment comprised 5,696,638 persons. Eighty-seven percent were enrolled in a Medicaid managed care plan. *See:* https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_202301.xls (last visited March 9, 2023).

The Florida Medicaid program covers:[4]

- More than 5.5 million low-income individuals, including approximately 2.5 million children, or 54 percent of the children in Florida;
- More than 54 percent of the births occurring in Florida in calendar year 2020; and
- More than 60 percent of the nursing home days in Florida.

Types of Comprehensive Medicaid Managed Care Plans

Comprehensive services in SMMC are managed by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations are usually health insurers or health maintenance organizations (HMOs). PSNs are managed care plans that are owned or are majority-controlled by health care providers, such as physician groups or hospitals.

All managed care plans in SMMC, including PSNs, are reimbursed as prepaid plans. That is, they are paid capitated rates (prospective, per-member, per-month payments) by the AHCA in advance for any particular month and are expected to provide medically necessary services to their respective members during that month, using the dollars within that month's capitation. Medically necessary services are required to be provided regardless of whether the capitation includes all the dollars necessary to provide those services.[5]

The AHCA contracts with managed care plans on a statewide and regional basis, in sufficient numbers to ensure choice. The cyclical Medicaid procurement process ensures plans offer competitive benefit designs and prices. In addition, plans compete for consumer choice. That is, while Medicaid requires a basic benefit package, and regulates the adequacy of plans' provider networks, plans can add to their benefit packages and offer provider networks attractive to Medicaid recipients when choosing a plan.

The AHCA began the next procurement process in 2022 for implementation in the 2025 plan year and intends to issue the procurement solicitation documents imminently.[6]

Medicaid Long-Term Care

Federal Medicaid law establishes coverage for institutional care, such as nursing home care and residential institutions for people with developmental disabilities, but does not allow federal dollars to be spent on alternatives to such care. Those alternatives include home and community-based services designed to keep people in their homes and communities instead of going into an institution when they need higher levels of care. This federal spending limitation creates a bias toward institutional care, and toward acute care, rather than allowing the non-acute supports that prevent institutionalization.

[4] Agency for Health Care Administration, Presentation to the Senate Health Policy Committee, Jan. 23, 2023.
[5] *See* s. 409.968(1) and (2), F.S.
[6] *Supra* note 4.

Florida obtained a federal waiver to allow the state Medicaid program to cover other kinds of long-term care services for elders and people with disabilities, to prevent admission into a nursing home. Those non-institutional, often non-acute, long-term care benefits are listed below.

SMMC Long-Term Care Mandatory Benefits	
Services provided in an ALF	Physical therapy
Hospice services	Intermittent and skilled nursing
Adult day care	Medication administration
Personal care	Medication management
Home accessibility adaption	Nutritional assessment and risk reduction
Behavior management	Caregiver training
Home-delivered meals	Respite care
Case management	Personal emergency response system
Occupational therapy	Transportation
Speech therapy	Medical equipment and supplies
Respiratory therapy	

Medicaid Home and Community-Based Waiver for Persons with Developmental Disabilities

Under federal law, fee-for-service Medicaid provides coverage for health care services to cure or ameliorate diseases. Generally, Medicaid does not cover services that will not cure or mitigate a medical diagnosis. However, people with developmental disabilities, while certainly requiring traditional medical services, need other kinds of services to maintain their independence and avoid institutionalization. Home and community-based services (HCBS) are an alternative to institutionalizing people with developmental disabilities.

To obtain federal Medicaid funding for HCBS, Florida obtained a Medicaid waiver.[7] This allows coverage of non-medical services to avoid institutionalization and allows the state to limit the scope of the program to the number of enrollees deemed affordable by the state. In this way, the HCBS waiver is not an entitlement; it is a first-come, first-served, slot-limited program.

Under the HCBS waiver, known as iBudget Florida, serves eligible[8] persons with developmental disabilities. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[9]

[7] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[8] The HCBS waiver retains the Medicaid requirement that enrollees be low-income, but measures only the developmentally disabled person's income; not the income generated by the whole household.
[9] Section 393.063(12), F.S.

The Agency for Persons with Disabilities (APD) administers the iBudget program, offering 27 supports and services delivered by contracted service providers to assist individuals to live in their community. Examples of waiver services are residential habilitation, behavioral services, companion, adult day training, employment services, and physical therapy.[10]

While providers and individual support coordinators each have a role in helping the iBudget enrollee assess and coordinate their care, the program essentially operates as a fee-for-service program, with no comprehensive care management in the traditional sense. HCBS services are not integrated with Medicaid acute medical services or behavioral health services, as those services are administered for iBudget enrollees by the AHCA, usually through the fee-for service model, not through SMMC.

Historically, despite the utilization management tools authorized by law and the entitlement flexibilities provided by the federal waiver, and despite legislative funding increases, APD has frequently been unable to manage the waiver program within the budget appropriated by the legislature, resulting in significant deficit spending.[11]

In 2019, the Legislature directed the APD to implement better monitoring and accounting procedures and to take corrective action when deficits are projected to develop. Additionally, APD was required to develop a plan to redesign the program if a deficit were to reoccur in the 2018-2019 fiscal year.[12] The APD did generate a deficit that year; however, the submitted redesign plan promised to stay within the appropriated budget only if that budget were significantly increased.[13]

For FY 2022-2023, the Legislature appropriated $1,871,531,214 to APD for the iBudget waiver program, of which $742,997,892 are state funds. [14] Currently, the program serves over 35,300 enrolled people.[15]

iBudget Waiver Waitlist

The APD maintains a waitlist of people who would like to enroll in the waiver. Currently, the waitlist includes 22,535 people. About 660 of those receive other, limited, services from APD, and over 9,000 people on the waitlist are otherwise eligible for, and receive, Medicaid coverage for medical care. About 13,500 people on the waiver waitlist receive no APD or Medicaid services.[16]

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[10] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).

[11] For example, the legislature made retroactive appropriations to address APD deficits that occurred in FY 17-18 ($56,895,137), FY 2018-2019 ($107,848,988), and FY 2019-2020 ($133,505,542). *See* Sections 30, 30, and 29, respectively, of the respective General Appropriations Acts in those years.

[12] Chapter 2019-116, s. 26, Laws of Fla.

[13] Agency for Persons with Disabilities and Agency for Health Care Administration, 2029 iBudget Waiver Redesign, Sept. 30, 2019.

[14] Chapter 2022-156, Laws of Fla., Specific Appropriation 245.

[15] *Supra*, note 10.

[16] *Id*.

As new funding becomes available, APD enrolls people from the waitlist in a statutory order of priority in seven categories:[17]

- Category 1 – Clients deemed to be in crisis.
- Category 2 – Specified children from the child welfare system.[18]
- Category 3 – Includes, but is not limited to, clients:
  - Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;
  - Who are at substantial risk of incarceration or court commitment without supports;
  - Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or
  - Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.
- Category 4 – Includes, but is not limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available;
- Category 5 – Includes, but is not limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.
- Category 6 – Clients 21 years of age or older who do not meet the criteria for categories 1-5.
- Category 7 – Clients younger than 21 years of age who do not meet the criteria for categories 1-4.[19]

APD rarely moves beyond Category 1 in enrolling people off the wait list. In Fiscal Years 2020-2021 and 2021-2022, for example, APD enrolled a total of 2,646 new enrollees in the waiver program. Of those, 1,841 (70%) were Category 1 enrollees.[20]

Medicaid Coverage for iBudget Enrollees

iBudget waiver benefits include Medicaid coverage for medical services, administered by the AHCA. The vast majority of full-coverage Medicaid recipients receive services through the SMMC managed care model, in which the recipient can choose from different health plans to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees – not a requirement. iBudget participants may opt to use the traditional fee-for-service model of service delivery.[21]

Because clinical services and HCBS are provided by two different programs in two different state agencies, these services are not integrated or managed holistically for enrollees.

[17] Section 393.065(5), F.S.
[18] *See* s. 393.065(5)(b), F.S., for specific criteria.
[19] Section 393.065(5), F.S.
[20] *Supra* note 10. Of the 2,646 new enrollees, 182 were in Category 2 (children aging out of the child welfare system); the remainder were in special categories authorized by the legislature to jump the queue (military dependents, people with Phelan-McDermid Syndrome, and people in ICFs or nursing facilities), *see* s. 393.064(6), (7), F.S.
[21] Section 409.972(1)(e), F.S.

HCBS and Managed Care Models

Some states use managed care models for HCBS for persons with developmental disabilities, in varying forms.

Iowa and Kansas use a long-term care managed care model to provide developmental disability services. These states use a single, risk-bearing, managed care plan to coordinate all services for this population, including primary care, acute care, behavioral health, and long-term care services. Tennessee takes a similar approach, but its managed care plans do not bear risk.[22]

New York obtained a federal waiver to transition the Medicaid developmental disability population into managed care based on a phased-in model, beginning with integrated care coordination under a single, comprehensive plan. In addition, New York operates a service delivery model that fully integrates with Medicare coverage, for persons eligible for both programs, offering primary, acute, long-term care, and habilitation services.[23]

Using managed care for the developmental disability population requires careful adaptation of acute care models to address factors that differentiate this population from a typical long-term care population. These factors include: the longer length of time individuals will require these services, often for a lifetime; the role of community services and supports and the need to integrate them into the model; and the unique developmental disability provider community, composed of smaller organizations exclusively dependent on government funding and inexperienced at navigating a managed care environment; among other differentiating factors.[24]

Florida does not use a risk-based managed care model for HCBS services, and the Medicaid managed care model is rarely used by iBudget enrollees. Medicaid acute care services and HCBS services are not integrated, or coordinated, by any single entity for individual enrollees.

III. Effect of Proposed Changes:

SB 1084 amends the LTCMC statutes in s. 409.981, F.S., to create a pilot program in Miami-Dade County, establishing a managed care model for integrating medical care and long-term care services with HCBS for persons with developmental disabilities who volunteer to participate and are selected to do so.

[22] National Association of States United for Aging and Disabilities, MLTSS Institute, "MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success (2018), available at: http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success_0.pdf (last viewed Mar. 24, 2023).
[23] Center for Health Care Strategies, "Enrolling Individuals in Intellectual/Developmental Disabilities in Managed Care: A strategy for Strengthening Long-Term Services and Supports", March 2019, available at: https://www.chcs.org/media/Integration-Strategy-3-Strengthening-LTSS-Toolkit_032019.pdf (last viewed March 24, 2023).
[24] *Id.*

The bill requires the AHCA to contract with one long-term care managed care plan, which must be a PSN meeting certain criteria, in Miami-Dade County to integrate medical services and HCBS, under the same coverage umbrella. Benefits are to include health care benefits described in s. 409.973, F.S., LTCMC benefits described in s. 409.98, F.S., and the HCBS benefits typically provided through the iBudget waiver.

The bill requires the AHCA to utilize the "invitation to negotiate" (ITN) process under s. 287.057(1)(c), F.S., to procure a single managed care plan for the pilot project and requires that the entity awarded a contract must be a PSN, the owners of which must include licensed health care providers with experience serving iBudget clients. Other types of managed care plans with experience serving iBudget clients are not eligible for the contract.

The bill requires the PSN that wins the contract to establish an individualized care plan for each enrollee, evaluate and update it at least quarterly, or as changes in conditions and circumstances warrant, and provide services in accordance with that care plan.

The selected PSN is to be compensated based on a risk-adjusted capitated rate. The bill requires the PSN to submit financial reports and requires the PSN to participate in the achieved savings rebate program,[25] consistent with the SMMC requirements for other Medicaid managed care plans.

Under the bill, the maximum number of voluntary enrollees who may be selected to participate will be limited to the amount specified in the GAA, if any.

Finally, the bill requires the AHCA to contract for an independent evaluation of the selected PSN's performance based on specific metrics of access to care, care quality, and cost. The AHCA must submit the evaluation to the President of the Senate and the Speaker of the House of Representatives by October 1, 2024.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[25] The achieved savings rebate program requires plans to share savings with the state, and authorizes plans to retain statutorily-defined portions of savings, some increments of which are tied to achieving AHCA-defined quality measures. S. 409.967(3)(f), F.S.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons who enroll in the pilot will experience an increase in HCBS and/or traditional Medicaid benefits.

A PSN awarded a contract under the pilot program will benefit financially from the bill's implementation, if that PSN is able to successfully manage services rendered to the program's enrollees. The AHCA has not provided an analysis of the bill; therefore, the number of PSNs, if any, who currently meet the bill's qualifications, or could potentially be created to meet those qualifications, is unknown.

C. Government Sector Impact:

The bill limits enrollee participation in the Miami-Dade pilot program to individuals on the waitlist for iBudget waiver services. The bill provides that enrollee participation is limited to the maximum number of enrollees specified in the GAA, but the AHCA has not provided an estimate of the number of potential enrollees who might be eligible in that county under the bill nor an estimate of how many dollars would be necessary to provide such enrollees with all the services required under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill provides that enrollee participation in the Miami-Dade pilot is voluntary and that participants "will be selected" from individuals who are on the waitlist for iBudget waiver services. However, the bill does not specify who will do the selecting.

The bill also provides that participation is limited to the maximum number of enrollees specified in the GAA, if any. In the event that the number of the volunteers exceeds the GAA's maximum number of enrollees, the bill does not provide a process or criteria to determine which individuals will be selected and which will be excluded. The bill also does not grant the AHCA rulemaking authority to develop selection criteria.

In terms of benefits, it is unclear whether the PSN that wins the contract under the pilot program will be required to provide coverage for dental services. The bill requires coverage to include benefits "described in" s. 409.973, F.S. SMMC dental services are provided under s. 409.973(5), F.S., but are usually provided under the Prepaid Dental Health Program, separate from other health care services. The bill references s. 409.973, F.S., but is silent on whether the AHCA should include dental services in the pilot's PSN contract.

It is unclear how quickly the pilot program will be operational. It is not unusual for procurements conducted via the ITN process to take a significant amount of time to be concluded. For example, as reported earlier in this analysis, the AHCA began the next SMMC procurement process in 2022 for implementation in the 2025 plan year. It is unclear whether the bill's evaluation of the pilot which is required to be submitted by October 1, 2024, will have any meaningful data or results worthy of being evaluated. The bill does not provide for any evaluations to be submitted beyond October 1, 2024, in the event the pilot program endures past that date.

VIII. Statutes Affected:

This bill substantially amends section 409.981 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.