HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 831 Medicaid Recipients with Developmental Disabilities
SPONSOR(S): Duggan
TIED BILLS: **IDEN./SIM. BILLS:** SB 1084

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	14 Y, 0 N	Calamas	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Florida Medicaid program provides health care coverage for low-income and disabled Floridians, in financial partnership with the federal government. Medicaid provides both acute care medical services, and long-term care services for elderly and disabled people at risk of nursing home admission. With few exceptions, Medicaid provides services through a comprehensive managed care model, which integrates acute care and long-term care.

The Florida home- and community-based services (HCBS) Medicaid waiver program, known as iBudget Florida, provides Medicaid-covered, non-acute, services for persons with developmental disabilities. iBudget services are designed to help people achieve the greatest potential for independent and productive living, while avoiding costly institutionalization. While most of the Medicaid program uses a managed care model, managed care is not used for HCBS; even for acute care services, iBudget enrollees may choose to enroll in a managed care plan, or remain in the traditional, fee-for-service, Medicaid system without acute care coordination.

Long-term care and HCBS services are not available in traditional Medicaid; they are authorized only by federally approved state waivers. Long-term care and HCBS services have some similarities; both are non-acute care, and both are intended to avoid institutionalization and assist people to remain in the community.

The iBudget federal waiver allows the state to limit the number of people served, as determined by state funding levels. The iBudget currently maintains a waitlist of people eligible for enrollment, but beyond the level of funding for the waiver program.

HB 831 directs the Agency for Health Care Administration (AHCA) to establish a pilot program in Miami-Dade County for a managed care model of service delivery for persons with developmental disabilities. The Agency must contract with a Medicaid managed long-term care plan to provide the services, which must be a provider service network owned in part by health care practitioners with experience serving persons with developmental disabilities. The plan must provide comprehensive, integrated, care, including acute care and home- and community-based developmental disability services, rather than the current model of separate acute and HCBS care. The plan will be available, on a voluntary basis, for people on the iBudget waitlist; not for people currently served by the iBudget program.

The bill requires AHCA to contract for an independent evaluation of the model, and submit a report to the legislature by October 31, 2024.

The bill has an indeterminate, significant, negative fiscal impact on the AHCA, and no fiscal impact on local government.

The bill provides an effective date of July 1, 2023.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

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 (DCF), the Department of Health, the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

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.[1] 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. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also 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 have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[4] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[5]

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.

The Florida Medicaid program covers over 5.5 million low-income individuals, including approximately 2.5 million children, or 54%, of the children in Florida.[6]

Statewide Medicaid Managed Care (SMMC)

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] Id.
[6] Agency for Health Care Administration, Presentation to the House Healthcare Regulation Subcommittee, Jan. 18, 2023.

Florida delivers medical assistance to most Medicaid recipients – approximately 78% - using a comprehensive managed care model, the SMMC program.[7] The SMMC program was intended to provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure provider participation and quality performance impossible under the former, federally prescribed, fee-for-service delivery model.

The SMMC program has three components: the integrated Managed Medical Assistance (MMA) program that provides primary care, acute care and behavioral health care services; the Long-Term Care (LTC) program[8] that provides long-term care services, including nursing facility and home and community-based services; and the dental component.

Services in SMMC are delivered by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations, such as HMOs, are reimbursed as prepaid plans – they are risk-bearing entities that are paid capitated rates (prospective, per-member, per-month payments) by AHCA. PSNs are managed care plans controlled by health care providers, such as physician groups or hospitals. Because health care practitioners and facilities did not previously operate managed care plans or use capitated payment arrangements, SMMC allowed an alternative risk-bearing arrangement for PSNs.

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: 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.

AHCA began the next procurement process in 2022 for implementation in the 2025 plan year, and plans to issue the procurement solicitation documents imminently.

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-based 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.

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

[7] *Supra*, FN 6.

[8] The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) provided in a recipient's home, an assisted living facility, or an adult family care home. Enrollment in the LTC program is based on a clinical priority system and includes a wait list. The state is approved for 62,000 recipients in the HCBS portion of LTC. In order to be eligible for the program, a recipient must be both clinically eligible under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

SMMC Long-Term Care Mandatory Benefits	
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 not services that will not cure or mitigate the underlying diagnosis, or social services. 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.[9] 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[10] 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.[11]

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.[12]

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. The HCBS services are not integrated with acute medical services or behavioral health services, as those Medicaid services are administered by AHCA (usually through the fee-for service model, not the managed care model).

Historically, despite the utilization management tools authorized in 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.[13]

In 2019, the legislature directed the agency to implement better monitoring and accounting procedures, and to take corrective action when deficits are projected to develop. In addition, APD was required to develop a plan to redesign the program if a deficit were to re-occur in the 2018-2019 fiscal year.[14] 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.[15]

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[9] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.

[10] 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.

[11] S. 393.063(12), F.S.

[12] 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 March 19, 2023).

[13] For example, the legislature made retroactive appropriations to address APD deficits that occurred in FY 17-18 ($56,895,137), FY 18-19 ($107,848,988), and FY 19-20 ($133,505,542). See Sections 30, 30, and 29, respectively, of the respective General Appropriations Acts in those years.

[14] Ch. 2019-116, s. 26, L.O.F.

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

For FY 22-23, the legislature appropriated $1,871,531,214 to APD for the iBudget waiver program,[16] of which $742,997,892 are state funds. Currently, the program serves over 35,300 enrolled people.[17]

iBudget Waiver Waitlist

The waiver serves over 33,000 persons with disabilities, consistent with the funding level provided by the legislature. However, 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.[18]

As new funding becomes available, APD enrolls people from the waitlist in a statutory order of priority in seven categories, described below.[19]

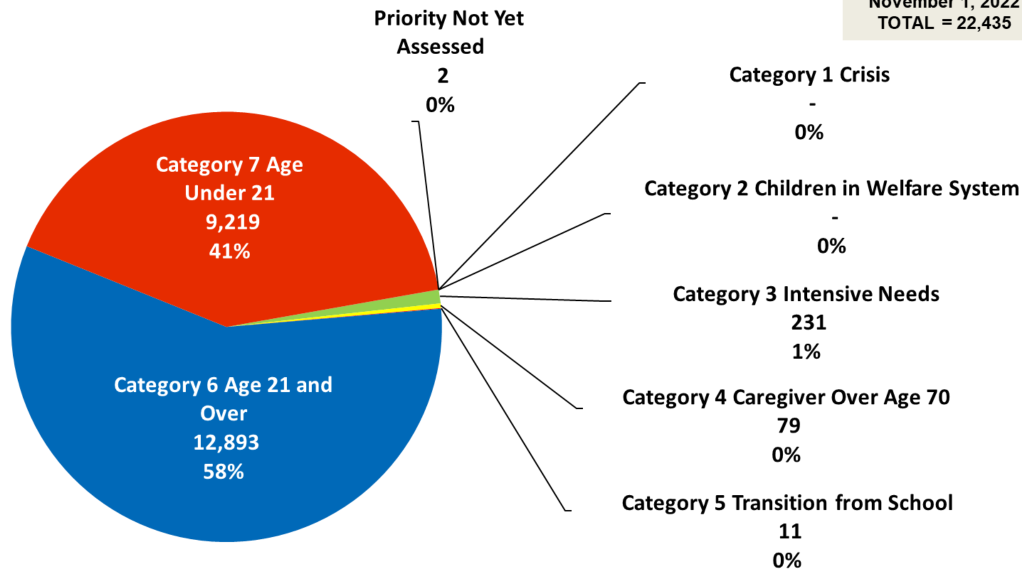
Category	Description
1	Crisis, as defined by APD

2	Individuals:
	• From the child welfare system with an open case who are either:
	  o Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or
	  o At least 18 years but not yet 22 years of age and who need both waiver services and extended foster care services; or
	• 18-21 years old who chose not to remain in extended foster care

3	Individuals: • 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 • 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 or whose caregiver is unable to provide the care needed.
4	Individuals whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available
5	Individuals expected to graduate from high school within the next 12 months who need support to obtain a meaningful day activity, maintain competitive employment, or attend postsecondary education
6	Individuals age 21 or older who do not meet the criteria for Categories 1-5
7	Individuals under age 21 who do not meet the criteria for Categories 1-4

The chart below indicates the percent of people in each category on the current waitlist.

[16] Supra, note 12.
[17] Id.
[18] Id.
[19] S. 393.065(5), F.S.



Category 1--Individuals in crisis--are enrolled onto the waiver and therefore are not considered to be waiting for services.

APD rarely moves beyond Category 1 in enrolling people off the wait list. In FY 20-21, for example, APD enrolled a total of 2,646 new enrollees in the waiver program. Of those, 1,841 (70%) were Category 1 – crisis – enrollees.[20]

Medicaid Coverage for iBudget Enrollees

iBudget waiver benefits include Medicaid coverage for medical services, administered by 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 – including HMOs and PSNs – to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees; not a requirement. iBudget participants can opt use the traditional fee-for-service model of service delivery.[21]

Because clinical services and home- and community-based services are provided by two different programs in two different state agencies, these services are not integrated or managed as a whole service for the individual.

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 using 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 – acute care, behavioral health and long-term care (HCBS) services. Tennessee takes a similar approach, but its managed care plans do not bear risk.[22]

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[20] Supra, note 15. 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] S. 409.972(1)(e), F.S.

[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 March 21, 2023).

New York obtained a federal waiver to transition the Medicaid developmental disability population into managed care in a phased model, beginning with integrated care coordination under a single, comprehensive plan. In addition, New York offers operates a service delivery model which fully integrates with Medicare coverage (for people with dual eligibility), offering 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 acute care 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 the individual enrollee.

Effect of Proposed Changes

The bill would create a pilot program to test a managed care model for integrating medical care and home- and community-based services for persons with developmental disabilities. To implement the pilot program, AHCA will need to modify the current SMMC waiver and obtain federal approval.

The bill requires AHCA to contract with a long-term care plan in Miami-Dade County to integrate medical services and HCBS in one coverage plan. Benefits would include traditional Medicaid medical benefits, long-term care benefits provided in the current Medicaid managed long-term care program, and the HCBS benefits currently provided through the iBudget waiver. AHCA will need to develop a comprehensive, actuarially sound, capitation rate to pay the managed care plan.

Participation in the pilot project would be voluntary, and would only be offered to people on the iBudget waitlist, not to those currently enrolled in the iBudget waiver.

The contracted long-term care plan must be a provider service network whose owners include health care providers with experience serving iBudget enrollees; this ensures the PSN has experience with this unique population, not only traditional long-term care (with its focus on elderly people). The bill requires the plan to establish an individualized care plan for each enrollee, evaluate and update it at least quarterly, and provide services in accordance with that care plan.

The bill requires the managed care plan to submit financial reports, and requires the plans to participate in the achieved savings rebate program[25] like other Medicaid managed care plans.

Finally, the bill requires AHCA to contract for an independent evaluation of the pilot project to measure the plan's performance based on specific metrics of access to care, care quality, and cost. AHCA must submit the evaluation to the legislature by October 1, 2024.

The bill provides an effective date of July 1, 2023.

B. SECTION DIRECTORY:

Section 1: Creates s. 409.9812, F.S., related to integrated plan for persons with developmental disabilities pilot program.

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[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 21, 2023).

[24] Supre, note 22.

[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.

Section 2: Providing an effective date of July 1, 2023.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The pilot program created by the bill will require a significant, indeterminate, recurring appropriation to fund care for currently wait-listed persons with disabilities. The number of waiver enrollees necessary to adequately test a valid managed care model is currently unknown.

   AHCA may require additional contracted services funds for the evaluation required by the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES