HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB SPCSEP 10-03 Medicaid Managed Care
SPONSOR(S): Select Policy Council on Strategic & Economic Planning
TIED BILLS: PCB SPCSEP 10-04 **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Select Policy Council on Strategic & Economic Planning		Gormley	Bahl
1)				
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

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. The program's history is characterized by significant growth in caseload and expenditures. Federal health care reforms will increase the state's Medicaid burden.

The PCB creates part IV of Chapter 409, Florida Statutes, entitled "Medicaid Managed Care," comprised of new sections 409.961 through 409.992, Florida Statutes. The PCB 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 three 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 Managed Long-term Care for Persons with Developmental Disabilities 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 are excluded
- Competitive, negotiated selection of qualified managed care plans that meet strict selection criteria
- Regionalized plan selection to ensure coverage in rural areas
- Limited plan numbers to ensure stability but allow significant patient choice
- Varying models of managed care
- Strong plan accountability measures
- Risk-adjusted payment methods
- Enhanced benefits to incentivize healthy behaviors
- 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.

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

The PCB takes effect upon becoming law.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Medicaid

Medicaid Overview

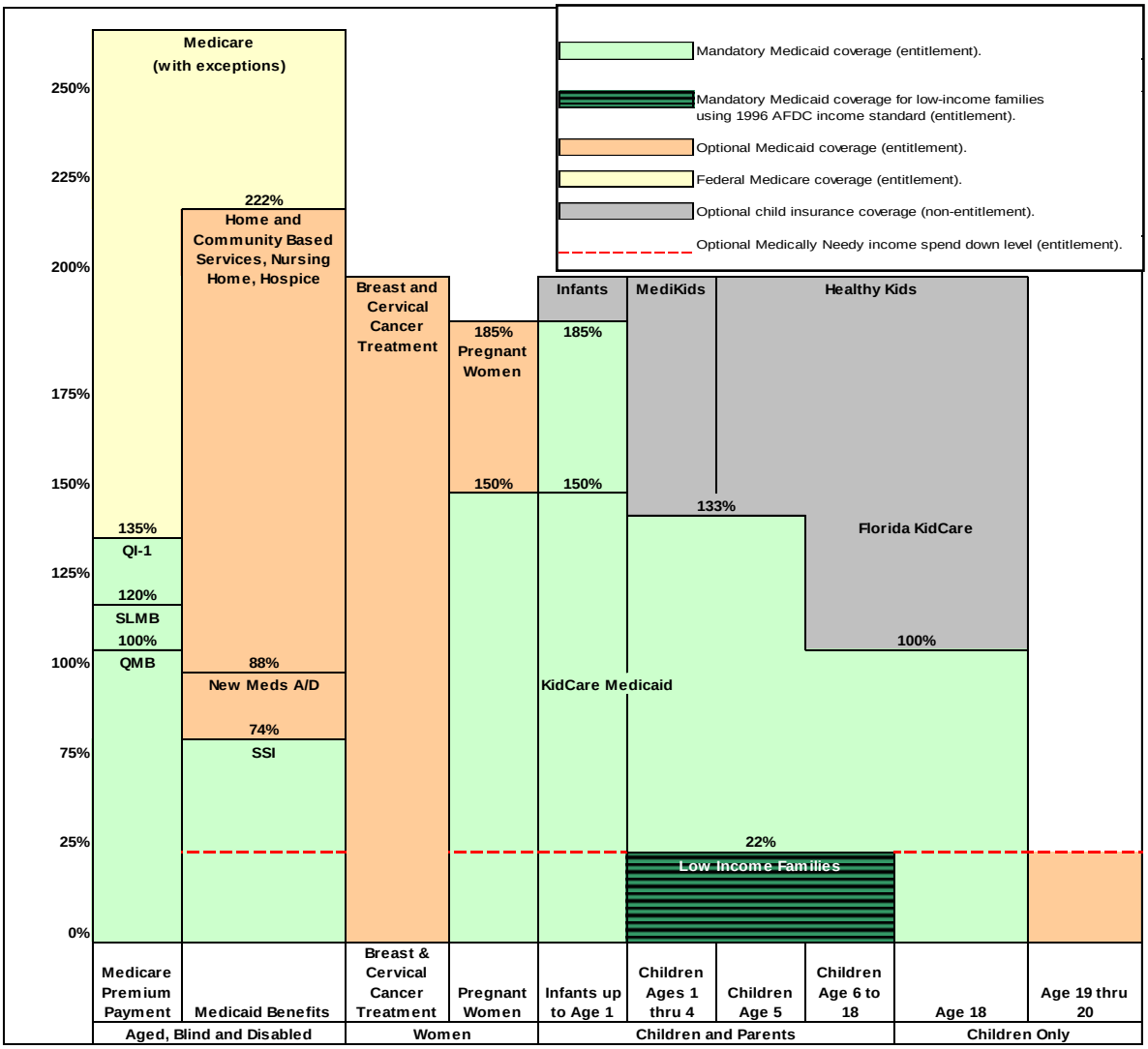
Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal 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 characteristics[1] of Florida's Medicaid program are as follows:

- 2.7 million enrolled recipients.
- $17.9 billion estimated spending in Fiscal Year 2009-2010.
- $6,625 estimated per recipient spending in Fiscal Year 2009-2010.
- 45 percent of all Medicaid expenditures cover:
    - Hospitals;
    - Nursing homes;
    - Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs); and,
    - Low Income Pool and Disproportionate Share supplemental payments.
- 1.9 million of the 2.7 million recipients are enrolled in some type of managed care.
- Over 80,000 providers participate in Medicaid as fee-for-service providers
- 23 managed care organizations, which includes 16 HMOs and 7 PSNs.

The structure of each state's Medicaid program what states must pay for are largely determined by the federal government, as a condition of receiving federal funds. Federal law creates requirements for 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.

[1] Florida Medicaid: Program Overview, Agency for Health Care Administration Presentation to the Medical Home Task Force, September 2009.

The federal government sets the minimum mandatory populations to be included in every state Medicaid program. In the chart below, the yellow and light green sections are mandatory populations by federal law. States can add eligibility groups, with federal approval. In the chart below, 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.



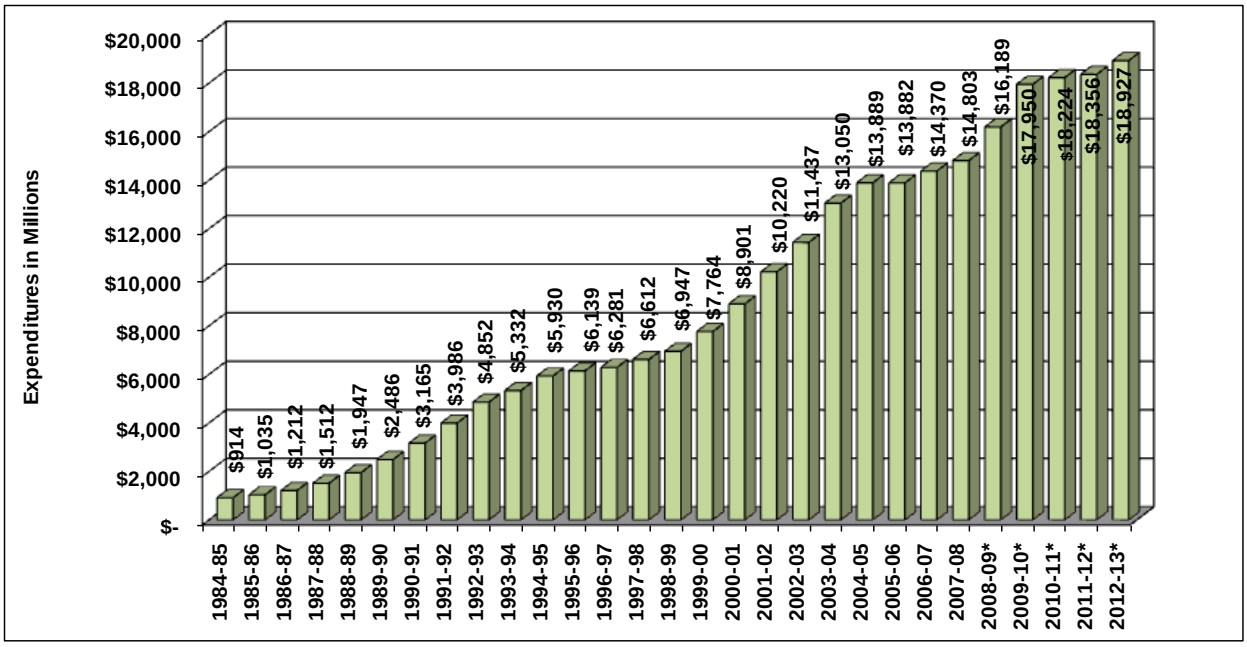
The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including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

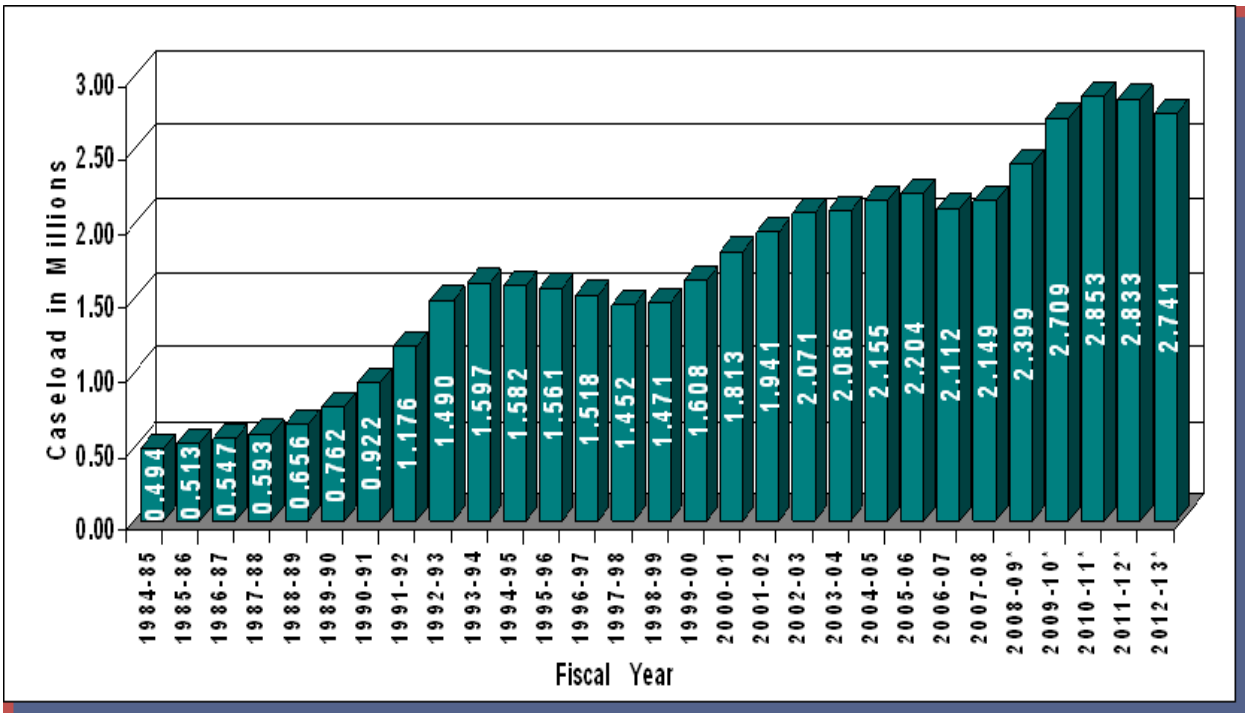
States do have some flexibility. States can ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. Florida has 20 separate waiver programs for distinct populations, services and service delivery models.

Florida Medicaid is the second largest single program in the state behind public education, representing 26.3 percent of the total FY 2009-10 budget. Medicaid general revenue expenditures represent 12.1 percent of the total General Revenue funds appropriated in FY 2009-10. Florida's program is the 4th largest in the nation, and the 5th largest in terms of expenditures.

[2] S. 409.905, F.S.
[3] S. 409.906, F.S.

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 figures below.[4]





Current estimates indicate the program will cost $19.2 billion in FY 2010-2011. By FY 2013-2014, the estimated program cost is $22.1 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.

[4] *Supra*, note 1.
[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.

Medicaid and Federal Health Care Reform

The U.S. Congress spent the last year debating an extensive overhaul of the national health care system with particular focus on access to affordable coverage in the private market and a reorganization of public programs. On March 21, 2010, the House passed the Senate version of federal health care reform (H.R. 3590) and President Barak Obama signed the bill into law on March 23, 2010. Key policy areas of reform include: mandated 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 tax. 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	Senate Patient Protection and Affordable Care Act
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 federal matching funds for current populations and currently non-enrolled eligibles (upon enrollment): 57.44%
CHIP Transition	Children under 133% FPL move from Title XXI CHIP Program to Title XIX Medicaid program in 2015
FMAP/ CHIP Transition	Enhanced FMAP for CHIP Population begins in 2013 (134% FPL and above) October 2013 - 70.21% + 23.0 = 93.21%

The costs of federal reform to Florida Medicaid will be significant. Florida is expected to have over 708,000 new enrollees from the expanded federal reform population in 2014, at a cost of $2.8 billion (of which $150 million will be paid by the state), bringing the total cost of Medicaid that year to $24.9 billion. By 2019, Florida Medicaid will have over 1.7 million additional enrollees, at an additional cost of over $7 billion (of which $1 billion will be paid by the state).[6] 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

[6] Agency for Health Care Administration, Overview of National Reform Legislation, March 23, 2010.

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 $33-$35 million annually at current levels. The current year impact will be a deficit in anticipated rebate general revenue of approximately $16,568,320. The FY 2010-2011 impact will be a loss in rebate general revenue of $34,893,412.11.[7]

Medicaid Managed Care

Florida, like most other states, turned to managed care for improving access to care, containing costs and enhancing quality. As of 2006, more than 65 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 (HMOs), primary care case management (MediPass)[8], provider service networks (PSNs)[9], minority physician networks[10] (MPNs), MediPass disease management, prepaid mental health plans, prepaid dental health plans and pediatric emergency room diversion[11].

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 Health Maintenance Organizations (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 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

[7] 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.
[8] 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.
[9] S. 409.912(4)(d), F.S.
[10] Minority Physician Networks (MPNs) networks of primary care physicians predominantly owned by minorities. Services to MPN members are reimbursed on a fee-for-service basis, and primary care providers are paid a $2.00 per-member per-month case management fee. MPNs are also paid an administrative fee and may share in savings. MPNs bear limited financial risk as they must repay administrative fees if savings targets are not reached.
[11] 2009-2010 Florida Medicaid Summary of Services, Agency for Health Care Administration.

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.[12] 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.[13]

Medical Homes

The term "medical home" was first coined by the American Academy of Pediatrics in 1967. A medical home is a patient-centered model of care that provides a home base—a personal health care professional, usually a physician, who coordinates and facilitates access to medical care. The personal provider is the patient's first contact as well as his continuing contact throughout the delivery of a comprehensive range of services. Medical homes are characterized by use of health information technology, the coordination of specialty and inpatient care, preventive services, disease management, behavioral health care, patient education, and the diagnosis and treatment of acute illness. A variety of studies have validated the model and indicated that this approach to services results in lower hospitalization rates, lower rates of death for heart disease, cancer and stroke, and reduced rates of medical errors. The model is supported by the American Academy of Family Physicians and the American College of Physicians. The National Committee for Quality Assurance (NCQA) released standards in January 2008 for patient-centered medical homes.

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

[12] s. 409.912(4)(b), F.S.

[13] 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 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.

law sets a goal of statewide expansion by 2011. The five-year waiver expires June 30, 2011, unless renewed by AHCA.[14]

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

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.[15]

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 three 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.[16] 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.[17]

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).[18] Instead, when a PSN enrollee requires comprehensive behavioral health care[19], 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 three 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.[20]

---

[14] According to AHCA, it must submit the renewal request by June 30, 2010. The federal Centers for Medicare and Medicaid Services must approve or deny the request within six months of receiving it.
[15] S. 409.912(4)(d), F.S.
[16] S. 409.91211(3)(e), F.S.
[17] Section 409.91211(3)(e), F.S.
[18] *See* s. 409.912(4)(b); Medicaid 2007-2008 Summary of Services, *available at* http://ahca.myflorida.com/Medicaid/pdffiles/SS_07_070701_SOS.pdf.
[19] "Comprehensive behavioral health care" refers to covered mental health and substance abuse treatment services. See s. 409.912(4)(b), F.S.
[20] S. 409.91211(3)(e), F.S.

In reform, AHCA is currently authorized to contract with specialty plans for certain populations,[21] 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.

The five-year Medicaid Reform Waiver will expire in October, 2011.

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 current risk adjustment methodology relies on claims data for prescription drug use. 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 requires at-risk plans to report encounter data, for use in evaluating plan quality and in setting risk-adjusted rates, and set a three-year process for establishing the new system.[22] 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, and expects to be able to use 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.[23] 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.[24] Voluntary plan choice (as opposed to automatic assignment by AHCA) has increased.

---

[21] S. 409.91211(3)(bb)-(dd), F.S.
[22] In the interim, risk-adjusted rates in reform are achieved using clinical data from recipient pharmacy records.
[23] S. 409.91211(4)(a), F.S.
[24] 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).

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 highly satisfied.

Customized Benefits

Reform allows plans to design vary the amount, duration and scope of benefits to 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. Recipient can save their credits for larger purchases.

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.[25] 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:[26]

- 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;

[25] 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.
[26] S. 409.91211(c), F.S.

- Promote measures to avoid preventable hospitalizations;
- Account for hospital efficiency; and
- Contribute to a community's overall health system.

In 2009, $1 billion in LIP payments were made to hospitals and other providers. The LIP expires in 2011, unless renewed.

Reform Objectives

Reform has five objectives:

1. To ensure there is an increase in the number of plans from which an individual may choose and an increase in the different type of plans.
2. To ensure that there is access to services not previously covered and improved access to specialists.
3. To improve enrollee outcomes.
4. Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).
5. To ensure that patient satisfaction increases.

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 nine HMOs and five PSNs for a total of fourteen health plans in Broward County; and four HMOs and three PSNs for at total of seven health plans in Duval County.

Reform met the second objective. By allowing plans to customize their benefit designs, and by making recipient choice the driving factor of plan enrollment, reform encouraged plans 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 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 (2009) surveys found 99 percent and 100 percent of the providers listed by plans actually had contracts with them.[27] These efforts resulted in the discovery that plans did not consistently maintain up-to-date provider files.

For Objective 3, AHCA measured enrollee outcomes based on national standards developed by the National Committee for Quality Assurance.[28] 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. The most recent 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.

	Non-Reform			Reform			
Measure	2008	2009	Difference	2008	2009	Difference	National Mean
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%

[27] Florida Medicaid Reform Year 3 Annual Report July 1, 2008 – June 30, 2009, Agency for Health Care Administration, *available at* http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).
[28] *See*, National Committee for Quality Assurance, http://www.ncqa.org/tabid/675/Default.aspx.

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, 61 individuals have enrolled in the Opt Out Program. Of those, 40 individuals have disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance. In 2009, there were 21 individuals enrolled in the Opt Out Program. 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.[29]

For Objective 5, AHCA contracted with the University of Florida to measure recipient satisfaction. The most recent report[30] 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 will 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.[31] 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; twenty states have over 80 percent managed care enrollment.[32] Currently, seventeen states have implemented statewide mandatory managed care programs for Medicaid recipients under the 1115 waiver.[33] There is great differentiation between states in what payment structure is used 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."[34] In particular, Arizona, Texas and Georgia represent three distinct approaches to Medicaid managed care serving multiple eligible populations with great geographic variety.

Arizona

[29] Florida Medicaid Reform Year 3 Annual Report July 1, 2008 – June 30, 2009, Agency for Health Care Administration, *available at* http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml (last viewed April 8, 2010).
[30] Duncan, Paul, et al. Medicaid Reform Enrollee Satisfaction Year One Follow-On Survey, March 20, 2009, Department of Health Services Research, Management and Policy, University of Florida, *available at* http://mre.phhp.ufl.edu/publications/ (last viewed April 8, 2010).
[31] 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.phhp.ufl.edu/publications/ (last viewed April 8, 2010)
[32] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: key Data, Trends, and Issues* (February 2010).
[33] *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.
[34] The Pacific Health Policy Group, *Medicaid Managed Care Study*, Prepared for the Florida House of Representatives (March 2010).

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.

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.[35]

Managed care enrollment is at 93 percent of the Medicaid eligible recipients.[36]

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.[37] 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.[38]

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.[39]

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.[40]

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.[41]

Medicaid Long-Term Care

Long-term care is currently provided to elderly and disabled Medicaid recipients though 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.

[35] *Id*.
[36] Pacific, *supra* note 32.
[37] The Lewin Group, *Medicaid managed Care Cost Savings – A Synthesis of Fourteen Studies* (July 2004).
[38] *Id*.
[39] Pacific, *supra* note 32.
[40] Pacific, *supra* note 32.
[41] Pacific, *supra* note 32

Medicaid Long-Term Care Waivers

Home and Community Based services are provided through six Medicaid Waiver programs and one State Plan administered by the Department of Elderly Affairs (DOEA) in partnership with AHCA. These waiver programs are administered through contracts with the 11 Aging Resource Centers[42] 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[43]	Services	Area
Adult Day Health Care[44] (2004)	Adults age 75 years or older with functional or cognitive impairments and live with a caregiver	33	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)	• 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	9,656	Adult companion, attendant care, caregiver training, case management, consumable medical supplies and others.	Statewide
Alzheimer's Disease[45] (2005)	Medicaid eligible adults age 60 or older with a diagnosis of Alzheimer's disease who meet Nursing Home Level of Care and live with a caregiver in a private residence	273	Adult day health care, behavioral assessment and intervention, caregiver training, incontinence supplies, personal care, respite care, wanderer alarm systems, wanderer identification and location programs and other services.	Broward, Miami-Dade, Palm Beach, Pinellas
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	2,650	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	1,489	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	16,500	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

[42] Aging Resources Centers are discussed below.
[43] 2009-2010 Florida Medicaid Summary of Services; *Profile of Florida's Medicaid Home and Community-Based Services Waivers*, Report No. 10-10, January 2010, Office of Program Policy Analysis & Governmental Accountability
[44] 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.
[45] S. 430.502(9), F.S., provides that the Alzheimer's Disease Waiver will expire on April 30, 2010. The Department of Elderly Affairs is transitioning enrollees into other waivers. Contained in correspondence on file with the Elder & Family Services Policy Committee from the Department of Elderly Affairs.

Waiver	Population	Enrolled[43]	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 Center[46] 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:[47]

- 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 (CARES) 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.[48] CARES is operated by ACHA through an inter-agency agreement with DOEA.[49]

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.[50]

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 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.[51]

---

[46] Ch. 2004-386, Sec. 8, L.O.F.
[47] S. 430.2053(5), F.S.
[48] S.409.912(15), F.S.
[49] *Id*.
[50] S. 409.912(15)(a), F.S.
[51] *Id*.

During Fiscal Year 2008-09, CARES program staff conducted 77,508 assessments.[52]

Medicaid Long-Term Care for Persons with Developmental Disabilities

Long-term care services to persons with developmental disabilities[53] 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.[54] APD currently serves 29,903[55] people in the four- tier system and has a waitlist of over 18,800[56] people for the program. 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 28 home and community based services including therapies, adult day training, behavioral services, residential habilitation services, respite, nursing services, employment and supported living services.[57] 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.[58]

APD has had some success in controlling spending through the implementation of the four-tier waiver system. When the tier legislation was passed 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 tier caps and other legislative actions.[59] Delays have occurred in fully implementing the tiers as a result of 5,500 people in the waiver program requesting a hearing on their tier assignment. This delay in assigning people to tiers has partially resulted in continued deficits in the waiver program including a $26.7 million deficit for FY 2008-2009 and projected deficit of $36 million for FY 2009-10.[60]

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.[61]

The appropriation for Medicaid waiver services to persons with developmental disabilities for FY 2009-10 is $849.6 million.[62]

Licensed Residential Services

There are 7,364 Medicaid recipients with developmental disabilities living in 1,683 licensed residential settings which are alternatives to intermediate care facilities for the developmentally disabled (ICF/DDs).[63] Most of these facilities are licensed by APD and include group homes, foster homes, residential habilitation centers

---

[52] *CARES Diversion, 2009 Report,* Department of Elderly Affairs
[53] 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.
[54] S.393.0661, F.S.
[55] Tier Waiver Enrollment Summary by Year and Month, December 2009.
[56] APD Quarterly Report to the Legislature on Agency Services, February 2010
[57] 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
[58] S. 393.0661(3), F.S.
[59] APD Medicaid Expenditure ,Social Services Estimating Conference, , January 29, 2010
[60] Email from Susan Chen, APD, dated 2-5-10, on file with the Health Care Services Policy Committee.
[61] Florida Questionnaire for Situational Information, version 4.0, Agency for Persons with Disabilities.
[62] FY2009-2010 General Appropriations Act, line 243.
[63] Email from Logan McFaddin, APD, dated 2-5-10, on file with the Health Care Services Policy Committee.

and comprehensive transitional education programs.[64] 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.[65]

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, 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.[66]

The largest of these facilities are the public facilities operated by APD, which are Sunland Center in Marianna, Tacachale Center in Gainesville and Gulf Coast Center in Lehigh Acres.[67] The appropriation for FY 2009-10 for public institutions is $153.4 million.[68] The private facilities provide the majority of institutional care for persons with developmental disabilities. There are 88 private facilities in the state of which 21 facilities are "cluster facilities" which specialize in services to medically complex individuals.[69] The appropriations for Intermediate Care Facilities for the Developmentally Disabled for FY 2009-10 total 220.8 million. This is projected to increase to $264 million in FY 2010-11.[70]

Effect of the Bill: Statewide, Integrated Managed Care Program

The bill creates part IV of Chapter 409, Florida Statutes, entitled "Medicaid Managed Care." New sections 409.961 through 409.992, Florida Statutes, comprise the Medicaid Managed Medical Assistance Program, the Long-Term Care Managed Care Program, and the Managed Long-term Care for Persons with Developmental Disabilities Program.

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.

Sections 409.962 through 409.970, F.S., are general provisions that apply to all three 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.

Medicaid is created as three 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 Managed Long-term Care for Persons with Developmental Disabilities 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:

[64] Email from Susan Chen, APD, dated 2-5-10, on file with the Health Care Services Policy Committee; S.393.067,F.S.
[65] S. 409.175, F.S.
[66] Email from Kari Anderson, Agency for Persons with Disabilities, dated 4-6-10 on file with the Health Care Services Policy Committee.
[67] Gulf Coast Center will close in June 2010 and most residents have already left the facility.
[68] FY2009-2010 General Appropriations Act, lines 259-268A.
[69] Email from S. Sewell, Florida ARF, dated 4-7-10, on file with the Health Care Services Policy Committee.
[70] Email from E. Pridgeon, House Health Care Appropriations Committee, dated 2-7-10, on file with the Health Care Services Policy Committee.

- 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 to ensure coverage in rural areas
- Limited plan numbers to ensure stability but allow significant patient choice
- Varying models of managed care – HMOs, PSNs, specialty plans, and medical home plans
- Strong plan accountability measures, including network standards, medical loss ratios, encounter data, performance measures, and fraud and abuse measures
- Risk-adjusted payment methods
- Enhanced benefits to incentivize healthy behaviors
- 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 only eligible for breast and cervical cancer services. The service range and duration is so limited for these groups that care management is impractical. The existing fee-for-service Medicaid program remains for these, limited populations.

Qualified Plans

Medicaid managed care must be provided by a qualified plan. Qualified 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 qualified plan may request that the agency designate the plan as a medical home network if it meets the criteria for becoming a medical home[71]. 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.

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 six regions by counties. Separate and simultaneous procurements shall be conducted in each of the regions. The regions are:

- **Region I** - Panhandle: Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington
- **Region II** - North Central and Northeast: Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, and Volusia.
- **Region III** - West Central: Charlotte, DeSoto, Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota.
- **Region IV** - Central: Brevard, Indian River, Lake, Orange, Osceola, Seminole, and Sumter.
- **Region V** - Southeast: Broward, Glades, Hendry, Martin, Okeechobee, Palm Beach, and St. Lucie.
- **Region VI** - South: Collier, Dade, and Monroe.

Selection Criteria

[71] The specific requirements for designation as medical home are set forth in PCB SPCSEP 10-04 (s. 409.91207, F.S.)

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:

- 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.
- History of voluntary or involuntary withdrawal from any state Medicaid program or program area.
- Evidence that the plan has contracts or has made substantial progress in obtaining contracts with needed providers.

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 medical home networks, networks containing primary care physicians who are recognized as patient-centered medical homes, and networks that reflect recruitment of minority physicians and providers. Additional, program-specific, criteria applies to the ITN process for the three 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.

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:

- **Emergency services.** Plans shall pay for necessary emergency services rendered by a noncontracted 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.
    - Plans must maintain an on-line database of information about its physicians and other providers.
    - The database shall have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients.
- **Encounter data.** The plans must comply with AHCA's encounter data system.
- Continuous improvement. The plans must comply with established performance standards and expected milestones for improving performance over the term of the contract. The plans shall establish internal improvement systems which must include enrollee satisfaction surveys.
- **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.

The contact 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, and must pay a per-enrollee penalty not

to exceed 5 percent of one month's payment. The plan must provide the agency notice no less than 180 days prior to withdrawing from a region.

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.

Beginning September 1, 2010, the agency shall update the rate setting methodology by initiating a transition to rates based on statewide encounter data submitted by Medicaid managed care plans. The transition shall be implemented within 3 years or less, and shall utilize data sources as necessary and reliable to make appropriate adjustments during the transition. The agency shall establish a technical advisory panel to obtain input from the prepaid plans regarding the incorporation of encounter data in the rate setting process.

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 5 years of the plan's operation in a given region, or until the contract year beginning in October 2015, whichever is later. 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.

Enrollment, Disenrollment, and Choice Counseling

All Medicaid recipients must enroll in a managed care plan unless specifically exempted. Each recipient will have 30 days in which to choose among the available plans. All recipients will be offered choice counseling services provided by AHCA.

The agency may enter into 5-years contracts for choice counseling and the contracts may be renewed for an additional 5-year period. The agency may extend the contracts to cover any delays in transition to a new contractor. Choice counseling shall be offered in the native or preferred language of the recipient, consistent with federal requirements. The choice counseling shall include:

- An explanation that each recipient has the right to choose a managed care plan at the time of enrollment in Medicaid and again at regular intervals set by the agency, and that if a recipient does not choose a plan, the agency will assign the recipient to a plan.
- A list and description of the benefits provided in each plan.
- An explanation of benefit limits.
- A current list of providers participating in the network, including location and contact information.
- Plan performance data.

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.

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 their primary care 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 shall submit encounter data electronically and certify that the data is accurate and complete.

Managed Medical Assistance Program

The PCB 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 60 days before disenrolling a medically needy participant that fails to pay his or her share of the premium.

Voluntary Participants

Medicaid recipients who: have other creditable care coverage, excluding Medicare; reside in residential commitment facilities operated through the Department of Juvenile Justice, group care facilities operated by the Department of Children and Families (DCF), and treatment facilities funded through the DCF Substance Abuse and Mental Health Program; are eligible for refugee assistance; residents of a developmental disability center including Sunland Center in Marianna and Tacachale in Gainesville, may voluntarily enroll in the MMA program. 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.

Enhanced Benefits

Each plan must establish an incentive program that rewards specific healthy behaviors with credits in a flexible spending account. Recipients can use their credits to purchase otherwise uncovered health and related services during the entire period of their Medicaid eligibility and for up to three years thereafter, whether or not the recipient remains continuously enrolled in the plan in which the credits were earned. Enhanced benefits must be structured to provide greater incentives for those diseases linked with lifestyle and conditions or behaviors associated with avoidable utilization of high-cost services. Credits are funded from a plan's reserve account, which must hold up to two percent of the plan's Medicaid premium revenue or benchmark premium revenue in the case of PSNs, based on an actuarial assessment of the value of the enhanced benefits program.

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 I: At least 3 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- Region II: 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 III: At least 5, but no more than 10 plans, at least 2 of which shall be PSNs if any 2 PSNs submit a responsive bid.
- Region IV: At least 4, but no more than 8 plans, at least 1 of which shall be a PSN if any PSN submits a responsive bid.
- Region V: At least 4, but no more than 7 plans, at least one of which shall PSN if any PSN submits a responsive bid.
- Region VI: At least 5, but no more than 10 plans, at least 2 of which shall be PSNs if any PSNs submit a responsive bid.

These requirements are illustrated in the following chart:

Medical / Long Term	Region I	Region II	Region III	Region IV	Region V	Region VI	Total Statewide
Total Enrollees	203,337	433,428	692,564	370,747	426,008	552,024	2,678,108
Minimum plans	3	4	5	4	4	5	25
PSN plans if responsive	1	1	2	1	1	2	8
Maximum plans	3	7	10	8	7	10	45
DD plans Min – Max (1 PSN each)	2	2– 5	3– 6	3– 6	3– 6	3– 6	16– 31

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 providers of critical services pursuant to s. 409.975(3)(a)-(d), 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.

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.

Plan Accountability

Medical Loss Ratio

In addition to the plan accountability requirements in the general provisions, the PCB establishes a medical loss ratio for plans participating in the MMA program. Plans are required to us uniform methods of accounting for and reporting medical, direct care management, and nonmedical costs. Beginning 2 full years after each plan's operation in, the agency must begin annual spending pattern evaluations and implement the following thresholds and consequences:

Medical Loss Ratios and Risk Corridors

Percent of Medicaid Revenues	Consequences
More than 92%	AHCA evaluation to determine effectiveness of care management
85% or less	Pay back up to 85%
Less than 75%	Loss of auto-assignments and pay back up to 85%

Provider Networks

Plans can limit providers in their network based on credentials, quality indicators, and price. However, in the first contract period for which a plan is selected in a region, the plan must offer a contract to the following providers in the region:

- Federally qualified health centers;
- Primary care providers certified as medical homes;
- Statutory teaching hospitals and their medical staff who are employees or under contract and are essential for the delivery of the teaching hospital's specialty and subspecialty services;
- Hospitals that are trauma centers as defined in s. 395.4001(14) and their medical staff who are employees or under contract and are essential for the delivery of the hospital's trauma services;
- Hospitals that are regional perinatal intensive care centers as defined in s. 383.16(2) and their medical staffs who are employees or under contract and are essential for delivery of the hospital's perinatal services; and

- Hospitals licensed as specialty children's hospitals pursuant to s. 395.002(28) and their medical staff who are employees or under contract and are essential for the delivery of the hospital's specialty children's services.

After one full year of active participation in a plan's network, the plan may exclude any of these providers from the plan for failure to meet quality or performance criteria.

Select Provider Participation

Providers can limit the plans they join; however, after AHCA has selected a limited number of plans in a region, certain providers are obligated to participate:

- Statutory teaching hospitals and their medical staff who are employees or under contract and are essential for the delivery of the teaching hospital's specialty and subspecialty services;
- Trauma centers and their medical staff who are employees or under contract and are essential for the delivery of the hospital's trauma services;
- Regional perinatal intensive care centers (RPICCs) and their medical staffs who are employees or under contract and are essential for delivery of the hospital's perinatal services;
- Specialty children's hospitals and their medical staff who are employees or under contract and are essential for the delivery of the hospital's specialty children's services; and
- Providers with both an active Medicaid provider agreement and a Certificate of Need (CON).

Statutory teaching hospitals, trauma centers and RPICCs hold special statutory status under Florida law, and are recognized by the state as holding special qualifications to receive special benefits in the Medicaid program.[72] To capture the capabilities of these institutions which are inherent in their statutory designation, Medicaid plans would need contract with the medical staff that allow these institutions to earn and maintain that designation. Providers which hold a CON enjoy state-granted market protection. Those CON-holders that have already decided to participate in the Medicaid program, as evidenced by their active Medicaid provider agreement, would participate as a plan provider.

Because plans responding to ITNs are given preference for having active agreements or contracts with providers that evidence the adequacy of the plan's network, these providers are not deprived of bargaining power with the plans, as any contract or agreement with the plans could be drafted in such a way to ensure the agreed-upon payment amount cannot be modified after a plan is selected in any given region. Failure by a plan to honor these contractual arrangements in good faith after being selected would not reflect well on the plans and could affect their ability to establish network adequacy in future plan selection processes, as providers will be unwilling to enter into agreements or contracts with the plans prior to the deadline to respond to an ITN.

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.

Pregnancy and Infant Health

Each plan must establish specific programs and procedures to improve pregnancy outcomes and infant health, including coordination with the Healthy Start and immunizations programs, and referrals to the Special Supplemental Nutrition Program for Women, Infant's and Children and CMS. Each plan must achieve an annual Early Periodic Screening, Diagnosis, and Treatment Service screening rate of at least 60 percent for those recipients continuously enrolled for at least 8 months.

Provider Payment

[72] These benefits include disproportionate share funds, low-income pool funds, and a more advantageous Medicaid payment base.

Plans and hospitals must negotiate mutually acceptable rates, methods and terms of payment. At a minimum, plans must pay hospitals the Medicaid rate, but payments cannot exceed 150 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.

Conflict Resolution

For those providers that are obligated to participate by contracting with selected plans, the agency must establish a process for resolving disputes between qualified plans and inpatient hospitals or the medical staff of specified hospitals when the agency is notified by either party of irreconcilable differences and the agency determines that the dispute jeopardizes access to, or quality of, services. The agency can contract with an outside entity for any portion of that process, and the agency is authorized to establish payment rates, contract terms, and other conditions on either or both parties. The process cannot be used to review and reverse any plan decision to exclude any provider that fails to meet quality standards, and any administrative costs associated with the process must be paid by the entities invoking it in equal parts.

Managed Care 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. Additionally, the agency must establish a methodology to ensure the availability of intergovernmental transfers (IGTs) to support providers that have historically served Medicaid recipients, such as safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed or under contract with a medical school in the state. The agency is also authorized to develop a supplemental capitation rate, risk pool, or incentive payment to plans that contract with these providers.

The supplemental payment is only available to plans if there are sufficient IGTs available from allowable sources and the plan can demonstrate that it pays a reimbursement rate not less than the equivalent fee-for-service rate. If necessary to ensure access and supported by funds provided by the locality, the agency can develop the supplemental capitation rate to consider rates higher than the fee-for-service rates. The agency must evaluate the development of the rate cell to accurately reflect the underlying utilization to the maximum extent possible. This may include interim rate adjustments as permitted under federal regulations. Any such methodology will preserve federal funding to these entities and must be actuarially sound.

Choice Counseling and Enrollment

In addition to the general choice counseling provisions, the agency must make available information about earning credits in the plan's enhanced benefits program and information about cost sharing requirements for each plan.

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 is prohibited from enrolling recipients in plans that are deficient in those standards. The agency cannot 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.
- The recipient's medical condition or diagnosis, and the availability of a plan to accommodate the condition or diagnosis.

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 the Bill: 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, 2011 with full implementation by October 1, 2012.

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. 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 the constant availability of routine medical and nursing care and requires extensive health-related care because of mental or physical incapacitation; or
- Requires the constant availability of routine medical and nursing care, has a limited need for health-related care, is mildly medically or physically incapacitated, and has a priority score[73] of five or above.

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 or 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
- Assisted living facility
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies

[73] A priority score is assigned by the CARES staff based on the individuals need for immediate services. The higher the score, the greater the need for services. Client frailty adds to the score, client resources, especially having a caregiver, subtract from the score.

- 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

Qualified 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.

Plan Selection

AHCA shall use the previously explained general procurement process. The agency shall notice the ITNs no later than July 1, 2011.

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. The agency shall also consider whether the plan has an adequate network of home and community based service providers.

Preference shall be given to plans who are proposing to be a comprehensive long-term care plan that provides both medical assistance services and long-term care and the plan already has a contract to provide managed medical assistance services in the region. Additionally, special weight will be given to whether the plans have contracts in place or pending with nursing homes, hospices, and aging network services providers.

If all other factors are equal, preference shall be give to plans that are designated as medical homes and to plans that provide consumer directed care services.

Plan Accountability

In addition to the general accountably measures, the long-term care managed care plans must use a uniform method of accounting and reporting established by AHCA. The agency shall evaluate the data on spending patterns received from the plans. The plans will be subject to the same medical loss ratios and consequences as the managed medical assistance services plans.

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 toward increasing home and community based care will be not less than five percent each year.

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 requires constant availability of routine care with extensive needs for related services.
- Level 3 – The individual requires constant availability of routine care and a limited need for related services with a priority score of 5 or above.

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

Choice Counseling and Enrollment

Before contracting with a vendor to provide choice counseling for the long-term care managed care program, the agency shall offer to contract with the Aging Resource Centers for choice counseling services. If an Aging Resource Center does not wish to be a choice counseling vendor, the agency must establish a memorandum of understanding with the Aging Resource Center to coordinate staffing and collaborate with the choice counseling vendor.

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. Recipients who are dually eligible for Medicaid and Medicare shall be assigned to a plan that provides both Medicaid and Medicare services. 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.

Effect of the Bill: Long-term Managed Care for Persons with Developmental Disabilities Program

The bill provides authority and direction to AHCA to administer a long-term managed care program for persons with developmental disabilities. Two types of plans are to be offered which include:

- Comprehensive plans that combine medical assistance and home and community based services, and
- Long-term care plans that only provide home and community based services.

AHCA is to begin implementation of the long-term care plans on January 1, 2014 and complete implementation statewide by October 1, 2015. The bill directs the Agency for Persons with Disabilities (APD) to assist with implementation and ongoing monitoring of the managed care program.

Eligibility

The eligibility for the program is the same as the current four-tier Medicaid waiver and the Intermediate Care for the Developmental Disabilities program. All current Medicaid recipients of these programs will be eligible to enroll in the plans.

The bill requires all Medicaid recipients with developmental disabilities to enroll in a managed care plan unless specifically excluded. The residents of two developmental disabilities centers, Sunland Center at Marianna and Tacachale Center in Gainesville, are exempt from participation but may enroll voluntarily.

Benefits

Each plan must provide a specific list of home and community based and institutional care services which are detailed in the bill. These required services are substantially the same as those currently offered under the four-tier Medicaid waiver program and the Intermediate Care Facility for Developmental Disabilities program. Plan may customize services and offer additional services to meet the needs of enrollees. The services include:

- Intermediate care for developmentally disabled
- Alternative residential services, including, but not limited to:
    - Group homes and foster care homes licensed pursuant to chapters 393 and 409
    - Comprehensive transitional education programs licensed pursuant to chapter 393
    - Residential habilitation centers licensed pursuant to chapter 393

    - Assisted living facilities, and transitional living facilities licensed pursuant to chapters 400 and 429
- Adult day training
- Behavior analysis services
- Companion services
- Consumable medical supplies
- Durable medical equipment and supplies
- Environmental accessibility adaptations
- In-home support services
- Therapies, including occupational, speech, respiratory, and physical therapy
- Personal care assistance
- Residential habilitation services
- Intensive behavior residential habilitation services
- Behavior focus residential habilitation services
- Residential nursing services
- Respite care
- Case management
- Supported employment
- Supported living coaching
- Transportation

Qualified Plans

The bill provides that qualified plans offering comprehensive long-term care programs must offer medical assistance as well as long-term care benefits. A qualified long-term care plan must offer home and community based services and intermediate care facility for the developmentally disabled services. The Children's Services Network authorized under chapter 391 is a qualified plan for both comprehensive and long-term care plans.

Provider service networks offering plans must include at least one owner which is a licensed residential facility pursuant to s.393.067, F.S., or s.409.988, F.S., with at least 10 years experience working with persons with developmental disabilities.

The bill directs AHCA to consider specific factors in the selection of qualified plans including the following:

- Plan employment of executive managers with experience working with persons with developmental disabilities;
- Plan networks must be adequate and accessible throughout the region being served;
- Whether the plan has proposed to be a comprehensive long-term care plan and has a contract for medical assistance services in the region and;
- Whether the plan offers consumer directed care services pursuant to s.409.221,F.S.

The bill also specifies that a selected plan must:

- Comply with specific medical loss ratios, to ensure certain amounts of paid premiums are used for direct services;
- Include consumer and family involvement in design and oversight of the plan.
- Contract with all residential providers upon implementation of the new program to ensure there is no disruption is living situations. This includes alternative residential providers specified in the bill and intermediate care facilities for the developmentally disabled. Further, the bill requires all intermediate care facilities for the developmentally disabled to agree to participate with qualified plans selected in their region.

After 12 months plans may exclude any of the residential providers for failure to meet performance or quality standards.

Regions and Number of Plans

The developmental disabilities managed long-term care program shall operate in the same 6 regions as the other plans in the bill. However, the limit on numbers of developmental disabilities plans per region is different from the plans offered to other populations. A minimum and maximum number of plans are specified for each region. A provider services network must be selected for each region.

Plan Payment

The bill directs AHCA to pay developmental disabilities long-term care plans based on five specific levels of care for enrolled individuals. APD will perform the initial assessment and assignment of persons into levels of care. The bill specifies that the levels of care will be based on information from the Questionnaire for Situational Information and encounter data. The levels of care include:

- Level of care 1 consists of individuals receiving services in an intermediate care facility for the developmentally disabled.
- Level of care 2 consists of individuals with intensive medical or adaptive needs and that are essential for avoiding institutionalization, or who possess behavioral problems that are exceptional in intensity, duration, or frequency and present a substantial risk of harm to themselves or others.
- Level of care 3 consists of individuals with service needs, including a licensed residential facility and a moderate level of support for standard residential habilitation services or a minimal level of support for behavior focus residential habilitation services, or individuals in supported living who require more than 6 hours a day of in-home support services.
- Level of care 4 consists of individuals requiring less than moderate level of residential habilitation support in a residential placement, or individuals in independent or supported living situations, or who live in their family home.
- Level of care 5 consists of individuals requiring minimal support services while living in independent or supported living situations and individuals who live in their family home.

The rates for intermediate care for the developmental disabilities facilities will be determined by AHCA and must be based on adjusted facility cost and other factors. AHCA is to periodically adjust payment rates to account for changes in the level of care profile of plan enrollees.

Auto Enrollment

Individuals who do not voluntarily choose a plan will be enrolled automatically into a plan. Enrollment will be based on criteria including network capacity of the plan; if the recipient has previously received services from the plan's home and community based providers and geographic accessibility of the providers to the Medicaid recipient.

B. SECTION DIRECTORY:

Section 1: Designates ss. 409.961 through 409.992 as part IV of Chapter 409, F.S., entitled "Medicaid Managed Care."
Section 2: Creates s. 409.961, F.S., relating to statutory construction, applicability and rules.
Section 3: Creates s. 409.962, F.S., relating to definitions.
Section 4: Creates s. 409.963, F.S., relating to a single state agency.
Section 5: Creates s. 409.964, F.S., relating to the Managed Care Program; state plan; and waivers.
Section 6: Creates s. 409.965, F.S., relating to mandatory enrollment.
Section 7: Creates s. 409.966, F.S., relating to qualified plans and qualified plans selection.
Section 8: Creates s. 409.967, F.S., relating to managed care plan accountability.
Section 9: Creates s. 409.968, F.S., relating to managed care plan payment.
Section 10: Creates s. 409.969, F.S., relating to enrollment; choice counseling; automatic assignment; and disenrollment.
Section 11: Creates s. 409.970, F.S, relating to encounter data.

Section 12: Creates s. 409.971, F.S., relating to the managed medical assistance program.
Section 13: Creates s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 14: Creates s. 409.973, F.S., relating to benefits.
Section 15: Creates s. 409.974, F.S., relating to qualified plans.
Section 16: Creates s. 409.975, F.S., relating to managed care plan accountability.
Section 17: Creates s. 409.976, F.S., relating to managed care plan payment.
Section 18: Creates s. 409.977, F.S., relating to choice counseling and enrollment.
Section 19: Creates s. 409.978, F.S., relating to managed care plan authority.
Section 20: Creates s. 409.979, F.S., relating to managed care plan eligibility.
Section 21: Creates s. 409.980, F.S., relating to managed care plans covered benefits.
Section 22: Creates s. 409.981, F.S., relating to qualified plans.
Section 23: Creates s. 409.982, F.S., relating to managed care plan accountability.
Section 24: Creates s. 409.983, F.S., relating to managed care plan payment.
Section 25: Creates s. 409.984, F.S., relating to choice counseling and enrollment.
Section 26: Creates s. 409.985, F.S., relating to comprehensive assessments and reviews for long-term care services programs.
Section 27: Creates s. 409.986, F.S., relating to authority of long-term managed care programs.
Section 28: Creates s. 409.987, F.S., relating to eligibility for long-term managed care programs.
Section 29: Creates s. 409.988, F.S., relating to benefits of managed care plans.
Section 30: Creates s. 409.989, F.S., relating to qualified plans.
Section 31: Creates s. 409.990, F.S., relating to managed care plan accountability.
Section 32: Creates s. 409.991, F.S., relating to managed care plan payment.
Section 33: Creates s. 409.992, F.S., relating to enrollment and choice counseling.
Section 34: Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The agency will earn $1,651,093 in federal Medicaid matching funds for the administrative costs associated with the implementation of the provisions of this bill in FY 2010-2011.

2. Expenditures:

ESTIMATED NON-RECURRING EXPENDITURES	**Amount FY 10-11**	**Amount FY 11-12**
Expense	$31,000	$0
Contracted Services	$645,000	
TOTAL Non-Recurring Expenditures	**$676,000**	**$0**

ESTIMATED RECURRING EXPENDITURES	**Rate**	**Amount FY 10-11**	**Amount FY 11-12**
Total Salary & Benefits (8.0 FTE)	399,750	$412,450	$541,480
OPS		$88,502	$88,502
Expense		$89,760	$112,200
Human Resources Services		$3,474	$3,474
Contracted Services		$2,032,000	$2,032,000
TOTAL RECURRING EXPENDITURES	**399,750**	**$2,626,186**	**$2,777,656**

	Amount FY 10-11	Amount FY 11-12
Non-Recurring Expenditures	$676,000	$0
Recurring Expenditures	$2,626,186	$2,777,656
TOTAL EXPENDITURES	**$3,302,186**	**$2,777,656**
General Revenue Fund	**$1,651,093**	**$1,388,828**
Medical Care Trust Fund	**$1,651,093**	**$1,388,828**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Counties that continue the current level of contributions for inter-governmental transfers should continue to receive the same level of funding through their local health systems, contingent upon approval of a methodology developed by AHCA to continue supplemental payments.

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 PCB, will experience a reduction in enrollment opportunities.

D. FISCAL COMMENTS:

The Agency for Health Care Administration will require $3,302,186 in FY 2010-2011 to implement the provisions of this PCB. This includes funding and associated expenses for eight full time equivalent positions and two Other Personal Services positions. The positions are required to assist with procurement and waiver activities, project transition and outreach, and fiscal analysis. Contractual Services funding is also required for procurement development activities, actuary services, project management, research and consultant services.

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.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority to implement the provisions of this PCB.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES