HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHS 17-03 Statewide Medicaid Managed Care Program
SPONSOR(S): Health & Human Services Committee, Cummings
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	15 Y, 2 N	Poche	Calamas

SUMMARY ANALYSIS

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Department of Health, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The Statewide Medicaid Managed Care (SMMC) program requires AHCA to competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive health care coverage for most of the state's enrollees in the Medicaid program. The SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTC). The MMA waiver expires on June 30, 2017, and the LTC waiver was recently extended through December 27, 2021.

PCB HHS 17-03 enhances the SMMC program by incorporating changes informed by experiences from the first five years of the program. Specifically, the bill:

- Consolidates the eleven SMMC program regions into eight regions, which reflect enrollee utilization patterns and provider referral patterns over the first five years of the program;
- Increases, in each region, the minimum or maximum number of plans with which AHCA will contract to provide services to MMA and LTC enrollees;
- Directs AHCA to request federal approval to require enrollees to engage in work activities to maintain eligibility for MMA benefits;
- Directs AHCA to request federal approval to require monthly enrollee premiums, based on income, as a requirement for eligibility and enrollment in the SMMC program;
- Allows AHCA to waive the monthly premium due to hardship or for completing one or more healthy behavior programs established by a MMA plan;
- Requires AHCA to fine managed care plans for failing to promptly pay provider claims;
- Deletes the requirement that AHCA establish payment rates for nursing homes participating in the LTC program and requires LTC plans and providers to negotiate mutually acceptable payment rates, methods, and terms of payment; and
- Deletes obsolete provisions and makes conforming changes to reflect the provisions of the bill.

The bill is likely to have an indeterminate, positive fiscal impact on AHCA and DCF and no fiscal impact on local government.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), the Department of Health, the Agency for Persons with Disabilities, and the Department of Elderly Affairs (DOEA).

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

Florida Medicaid does not cover all low-income Floridians. The maximum income limits for programs are illustrated below as a percentage of the federal poverty level (FPL).

Current Medicaid and CHIP Eligibility Levels in Florida[4]
(With Income Disregards and Modified Adjusted Gross Income)

Children's Medicaid			**CHIP (KidCare)** Age 0-18	**Pregnant Women**	**Parents Caretaker Relatives**	**Childless Adults** (non-disabled)
Age 0-1	Age 1-5	Age 6-18				
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	31% FPL	0% FPL

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[5] Applicants must also agree to cooperate with Child Support Enforcement during the application process.[6]

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] U.S. Centers for Medicare and Medicaid Services, Medicaid.gov, *Florida,* http://www.medicaid.gov/medicaid-chip-program-information/by-state/florida.html (last visited April 2, 2017).
[5] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet,* p. 3 (April 2016), http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited April 2, 2017).
[6] Id.

The Florida Medicaid program covers approximately 4 million low-income individuals, including approximately 2.3 million, or 58.6%, of the children in Florida.[7] Medicaid is the second largest single program in the state, behind public education, representing 31 percent of the total FY 2016-2017 budget. Medicaid expenditures represent over 19 percent of the total state funds appropriated in FY 2016-2017. Florida's program is the 4th largest in the nation by enrollment, and the 6th largest in terms of expenditures.[8]

Medicaid Waivers

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, Section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

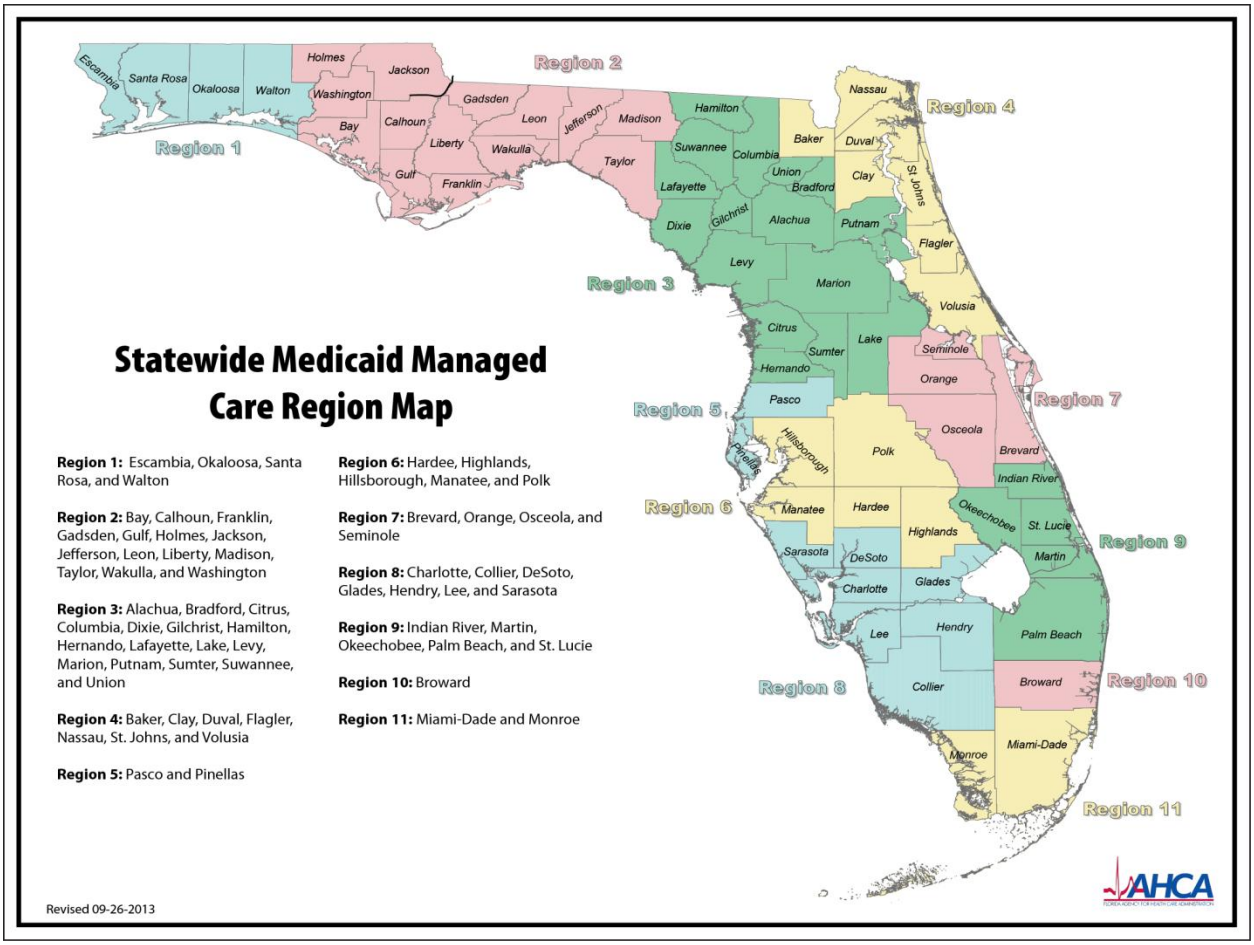
States may also ask the federal government to waive federal requirements to expand populations or services, or to try new ways of service delivery. For example, Florida has a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[9] In addition to the Section 1115 waiver for the MMA program, Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-term Care (LTC) program.[10]

Approximately 82% of the Medicaid population in Florida is enrolled in the MMA and LTC programs.[11]

Statewide Medicaid Managed Care (SMMC)

The SMMC program requires AHCA to competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most Medicaid program enrollees. The following map illustrates the SMMC regions.[12]

[7] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, February 2017, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last accessed April 2, 2017).
[8] The Henry J. Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending FY 2015 and Total Monthly Medicaid and CHIP Enrollment Nov. 2016*, available at http://kff.org/statedata/ (last viewed April 2, 2017).
[9] S. 409.964, F.S.
[10] Id.
[11] Supra, FN 7.
[12] Agency for Health Care Administration, *Update on the Statewide Medicaid Managed Care Program*, Presentation before the Health and Human Services Committee, January 23, 2015, slide 13 (on file with the Health and Human Services Committee).



The SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTC). The MMA waiver expires on June 30, 2017, and the LTC waiver was recently extended through December 27, 2021.[13]

The LTC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling recipients in May 2014 and finished its roll-out in August 2014. These contracts will be re-procured in 2017 with contract execution and implementation expected in 2018. The chart below shows the enrollment in MMA and LTC.

Statewide Medicaid Managed Care Enrollment (as of March 2017)			
Component	**Start Date**	**Budget[14]**	**Enrollment[15]**
Long-Term Care Plan	August 2013	$3.97 billion	94,803
Managed Medical Assistance	May 2014	$14.4 billion	3,233,235

[13] The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for July 31, 2014 through June 30, 2017. The Long-Term Care Managed Care waiver is approved as a section 1915(b) and section 1915(c) combination waiver and was most recently approved through December 27, 2021 by the federal Centers for Medicare and Medicaid Services.
[14] Agency for Health Care Administration, *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2, available at http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited April 2, 2017).
[15] Agency for Health Care Administration, *SMMC MMA Enrollment by County by Plan* (as of March 1, 2017), available at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited April 2, 2017).

MMA Program

The MMA program provides acute health care services through non-specialty managed care plans contracted with AHCA in the 11 regions across the state. Specialty plans are also available to serve distinct populations, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans. The following charts show the managed care plans participating in the MMA program, including the plans that offer a comprehensive plan, and the plans that offer specialty plans.[16]

MMA Standard and Comprehensive Plans, by Region

	1	2	3	4	5	6	7	8	9	10	11
Amerigroup					X	X	X				C
Better Health						X				X	
Coventry											C
Humana	X					X			X		C
Integral	x					X		X			
Molina				X			X		X		C
Preferred											X
Prestige		X	X		X	X	X	X	X		X
SFCCN										X	
Simply											X
Sunshine			C	C	C	C	C	C	C	C	C
United			C	C							C
Staywell		X	X	X	X	X	X	X			X

MMA Specialty Plans, by Region

	1	2	3	4	5	6	7	8	9	10	11
CMS Network Children with Special Health Care Needs	X	X	X	X	X	X	X	X	X	X	X
Clear Health HIV/AIDS	X	X	X		X	X	X	X	X	X	X
Freedom Chronically Ill Dual Eligibles			X		X	X	X	X	X	X	X
Magellan Serious Mental Illness		X		X	X	X	X		X	X	X
Positive HIV/AIDS										X	X
Sunshine Child Welfare	X	X	X	X	X	X	X	X	X	X	X

Most plans supplemented the required benefits and offered enhanced options, such as adult dental, hearing and vision coverage, outpatient hospital coverage and physician services. Under s. 409.967, F.S., accountability provisions for the managed care plans specify several conditions or requirements, including emergency care and physician reimbursement standards, access and credentialing requirements, encounter data submission guidelines, grievance and resolutions, and medical loss ratio calculations.

[16] Supra, FN 12, slides 14-15.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:

- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[17]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:

- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

LTC Program

The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) provided in a recipient's home, an assisted living facility, or an adult family care home. The following chart shows the managed care plans that participate in the LTC program.[18]

LTC Plans, by Region

	1	2	3	4	5	6	7	8	9	10	11
American Eldercare	X	X	X	X	X	X	X	X	X	X	X
Amerigroup										X	X
Coventry						X	X			X	X
Humana				X						X	X
Molina					X	X					X
Sunshine	X		X	X	X	X	X	X	X	X	X
United		X	X	X	X	X	X	X	X		X

Enrollment in the HCBS portion of LTC is based on a priority system and includes a wait list. For the 2016-2017 waiver year, the state is approved for 62,500 recipients in the HCBS portion of LTC.[19] In order to be eligible for the program, a recipient must be both clinically eligible under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

Eligibility and Enrollment in LTC

AHCA is the single state agency for Medicaid; however through an interagency agreement, the DOEA conducts Florida's federally mandated pre-admission screening program for nursing home applicants

[17] S. 409.972, F.S.
[18] Supra, FN 12, slide 16.
[19] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Beth Kidder, Interim Deputy Secretary for Medicaid, Agency for Health Care Administration, Dec. 19, 2016, available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited April 2, 2017).

through its Long-Term Care Services (CARES) program, including for the LTC component.[20] This frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on that score.

Individuals are released from the wait list periodically, based on the availability of funding and their priority scores. The Legislature has specifically directed funding in the past several years through the GAA to serve elders off the waitlist who have a priority score of 4 or higher.[21] Individuals who are more frail or have a more immediate need for services receive a higher rank on the waitlist. Those who have resided in a nursing facility for more than 60 days receive prior enrollment into the HCBS portion of the program. Exemptions from the wait list also exist under s. 409.979(3)(f), F.S.

Individuals who are enrolled in the following programs may, but are not required to, enroll in the LTC program:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Injury waiver;
- Project AIDS Care waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver; or
- Model waiver.[22]

Individuals, both those who are enrolled in LTC and those on the wait list, must be re-screened at least annually or whenever there is a significant change in circumstances, such as change in caregivers or medical condition.[23]

SMMC Delivery System and Benefits

The payment design of the SMMC was intended to facilitate a smooth transition from a mix of fee-for-service, primary care case management, and managed care delivery to a statewide system of Medicaid managed care. Services in SMMC are delivered by two types of managed care plans: traditional managed care organizations and provider service networks. Traditional managed care organizations, such as HMOs, are reimbursed as prepaid plans – they are risk-bearing entities that are paid capitated rates (prospective, per-member, per-month payments) by AHCA. Provider service networks (PSNs) are managed care plans controlled by health care providers, such as physician groups or hospitals. Because health care practitioners and facilities are unused to operating managed care plans or capitated payment arrangements, SMMC allowed an alternative risk-bearing arrangement for PSNs.

Current law allowed PSNs to be reimbursed on a fee-for-service basis, but only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever was later. Under that option, PSNs bear risk through a shared savings model. AHCA conducted cost reconciliations for the fee-for-service PSNs to determine any savings or amounts owed by the PSN. Current law requires PSNs to shift to a capitated payment model after the first two years of operation of a new PSN.

[20] Florida Department of Elderly Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES),* http://elderaffairs.state.fl.us/doea/cares.php (last visited April 2, 2017).
[21] See Ch. Law 2016-66, line item 232; Ch. Law 2015-232, line item 226; and Ch. Law 2014-51, line item 242. In state fiscal year 2013-14, the GAA provided funding during first year of the LTC program for those on the wait list with priority scores of 5 or higher. (Ch. Law 2013-40, line item 414).
[22] Id.
[23] Application for §1915(c) Home and Community-Based Services Waiver (Effective July 1, 2013), pp. 45-46, http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/LTC_1915c_Application.pdf (last visited April 2, 2017).

Current law also encourages the development of PSNs by requiring AHCA to award at least one contract in each region to a PSN, if any PSN submits a responsive bid. If no PSN submits a responsive bid in a region, AHCA must hold a plan slot open and issue an additional invitation to negotiate a year later to procure a PSN in that region.

Initial Procurement of the SMMC Contracts

In 2012, when first implementing SMMC, AHCA conducted a competitive procurement to select LTC and MMA plans in each of the 11 regions. For the MMA program, AHCA selected 10 different companies to serve as the health care delivery system. Of the plans selected, 11 of the awarded contracts went to general, non-specialty plans, of which five were PSNs.[24] Five different specialty plans and the Children's Medical Services plan were also awarded contracts.[25,26] Currently, MMA recipients receive services through 11 different managed care plans, of which two are PSNs.

In 2012, AHCA awarded seven LTC contracts, including one statewide contract.[27] One of the original LTC contracts operated as a PSN; however, that plan is no longer participating in SMMC. The LTC services are now delivered through six managed care plans, which vary based on the recipient's region. Each region has at least two plans to allow for recipient choice. For nursing facilities and hospices, the plans are required to pay those designated providers a rate set by AHCA. All six of the LTC plans also participate in the MMA program.

In addition to these plans, there are six specialty plans that serve unique populations: Children's Medical Services for children with chronic conditions; two plans for individuals with HIV/AIDS; a plan for child welfare enrollees; a plan for recipients eligible for both Medicaid and Medicare with chronic conditions, such as diabetes or congestive heart failure; and a plan for individuals with serious mental illness. Recipients in both components of the program receive choice counseling services to assist them in selecting the plan that will best meet their needs.

The total enrollment in the specialty plans as of March 1, 2017 is shown in the chart below:[28]

Specialty Plan Enrollment - March 2017	
Component	**Enrollment (as of March 1, 2017)**
Child Welfare Plan	31,810
Specialty Plans (Capitated)	78,842
Children's Medical Services Network	50,924
Total	**161,576**

Managed care plans under both components are required to cover mandatory benefits prescribed by s. 409.973, F.S., for the MMA plans and s. 409.98, F.S., for the LTC plans. However, plans may also offer an expanded menu of optional benefits.

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	**Long-Term Care**
Advanced registered nurse practitioner services	Nursing facility care
Ambulatory surgical treatment center services	Services provided in an ALF
Birthing center services	Hospice
Chiropractic services	Adult day care

[24] Agency for Health Care Administration, *Florida Managed Medical Assistance Program - 1115 Research and Demonstration Waiver (3rd Quarter Progress Report: January 1, 2014 - March 31, 2014),* p. 15 (on file with the Health and Human Services Committee).
[25] Id.
[26] Agency for Health Care Administration, *Medicaid and Managed Care* (Sept. 3, 2014), http://ahca.myflorida.com/Medicaid/recent_presentations/Child_Protection_Summit_2014-09-03.pdf (last visited April 2, 2017).
[27] Agency for Health Care Administration, *Statewide Medicaid Managed Care Update,* Oct. 8, 2013 (on file with the Health and Human Services Committee).
[28] Agency for Health Care Administration, *SMMC MMA Specialty Capitated Enrollment Report* (as of Mar. 1, 2017).

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	**Long-Term Care**
Dental services	Personal care
Early periodic screening diagnosis & treatment (age<21)	Home accessibility adaption
Emergency services	Behavior management
Family planning services and supplies	Home-delivered meals
Healthy Start services (with exceptions)	Case management
Hearing services	Therapies
Home health agency services	Occupational therapy
Hospice services	Speech therapy
Hospital inpatient services	Respiratory therapy
Hospital outpatient services	Physical therapy
Laboratory and imaging services	Intermittent and skilled nursing
Medical supplies, equipment, prostheses, and orthoses	Medication administration
Mental health services	Medication management
Nursing care	Nutritional assessment and risk reduction
Optical services and supplies	Caregiver training
Optometrist services	Respite care
Physical, occupational, respiratory, speech therapies	Personal emergency response system
Physician services, including PA	Transportation
Podiatric services	Medical equipment and supplies
Prescription drugs	
Renal dialysis services	
Respiratory equipment and supplies	
Rural health clinic services	
Substance abuse treatment services	
Transportation	

The LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may elect the same managed care plan for both components. These plans are referred to as comprehensive plans.

Re-Procurement of the SMMC Contracts

The initial SMMC contracts were procured in 2012 and became effective in 2013 as 5-year contracts. AHCA has started the process for the re-procurement of the managed care contracts for the SMMC program. An Invitation to Negotiate (ITN) will be released in the summer of 2017.[29] AHCA posted a request to receive non-binding Letters of Intent to Bid on its website with a deadline of February 13, 2017. AHCA received 41 total responses from interested providers and plans for the ITN.[30]

Current law requires AHCA to publish a databook of a comprehensive set of utilization and spending data for the most recent three contract years, including historic fee-for-service claims and validated encounter data. AHCA must publish this databook 90 days before issuing the procurement. Plans submitting bids will use the databook to calculate proposed capitation rates for their bids. For the next SMMC procurement, AHC posted the databook online on March 30, 2017[31], and a public meeting to review the databook with AHCA's contracted actuary is scheduled for April 12, 2017.

[29] Agency for Health Care Administration, *AHCA Announces Start of Re-Procurement Process for Statewide Medicaid Managed Care Program*, Feb. 3, 2017, available at: http://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/ReprocurementPressRelease.pdf (last visited April 2, 2017).
[30] Agency for Health Care Administration, *Statewide Medicaid Managed Care Program Non-Binding Letters of Intent Received by 2/13/2017, in response to Intent to Bid Posted 2/3/2017,* available at: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Intent_to_Bid_Responses.pdf (last visited April 2, 2017).
[31] The Statewide Medicaid Managed Care Databook is available at http://ahca.myfloridca.com/medicaid/statewide_mc/Data_Book/03-30-2017_Report11_Florida_SMMC_Data_Book.zip (last viewed on April 2, 2017).

Prompt Payment of Claims

Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs under with ss. 627.6131 and 641.3155, F.S., respectively.[32] These provisions delineate the rights and responsibilities of insurers, HMOs, and providers for the payment of claims. An insurer or HMO has 12 months after payment is made to a provider to make a claim for overpayment against the provider, if the provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch. 461, F.S., (podiatrists), or ch. 466, F.S., (dentists). For all other types of providers, an insurer or HMO has up to 30 months after such payment to make a claim for overpayment.[33] The law provides a process and timeline for providers to pay, deny, or contest the claim. Further, the law prohibits an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid.

Section 409.967(2)(j), F.S., makes those provisions applicable to Medicaid managed care plans, which AHCA enforces the prompt payment requirements at its discretion pursuant to the terms of its contracts with the managed care plans. Current law does not make enforcement mandatory.

TANF Cash Assistance Work Requirements

Under the federal welfare reform legislation of 1996, the Temporary Aid for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides federal funds to states, territories, and tribes each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized by the Deficit Reduction Act of 2005. States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.

Florida's temporary cash assistance (TCA) program is one of several programs funded with TANF block grant funds. The purpose of the TCA program is to help families with children become self-supporting while allowing children to remain in their own homes. It provides cash assistance to families that meet the technical, income, and asset requirements.[34]

Various state agencies and entities work together through a series of contracts or memoranda of understanding to administer the TCA program. DCF receives the federal TANF block grant and administers the TCA program, monitoring eligibility and dispersing benefits. The Department of Economic Opportunity (DEO) is responsible for financial and performance reporting to ensure compliance with federal and state measures, and for providing training and technical assistance to Regional Workforce Boards (RWBs). RWBs provide information about available jobs, on-the-job training, and education and training services within their respective areas and contract with one-stop career centers.[35] CareerSource Florida has planning and oversight responsibilities for all workforce-related programs.

[32] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization , and individual and group contracts that only provide direct payments to dentists.
[33] Section 627.6131, F.S., and 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.
[34] Children must be under the age of 18, or under age 19 if they are full time secondary school students. Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[35] Workforce Investment Act – Workforce Innovation and Opportunity Act Annual Report for 2015-2016 Program Year, CareerSource Florida, Inc., *available at* https://careersourceflorida.com/wp-content/uploads/2016/10/161003_AnnualReport.pdf (last visited April 6, 2017).

TCA Work Requirement

To be eligible for full-family TCA, applicants must participate in work activities in accordance with s. 445.024, F.S., unless they qualify for an exemption.[36] Section 445.024(3), F.S., permits exemptions from the work requirements for:

- An individual who receives benefits under the Supplemental Security Income (SSI) program or the Social Security Disability Insurance (SSDI) program.
- An adult who is not defined as a work-eligible individual[37] under federal law.
- A single parent of a child under 3 months of age, except that the parent may be required to attend parenting classes or other activities to better prepare for raising a child.
- An individual who is exempt from the time limitations of TCA because of a hardship exemption.[38]

Individuals receiving TCA who are not otherwise exempt from work activity requirements must participate in work activities for the maximum number of hours allowable under federal law.[39] The number of required work or activity hours is determined by calculating the value of the cash benefits and then dividing that number by the hourly minimum wage amount. Federal law requires individuals to participate in work activities for at least:

- 20 hours per week (or attend a secondary school or the equivalent or participate in education directly related to employment) for those under the age of 20 and married or single head-of-household;
- 20 hours per week for single parents with a child under the age of six;
- 30 hours per week for all other single parents;
- 35 hours per week, combined, for two-parent families not receiving subsidized child care; or
- 55 hours per week, combined, for two-parent families receiving subsidized child care.

Pursuant to federal rule[40] and state law,[41] job search, on-the-job training, education, and subsidized and unsubsidized employment, among other things, may be used individually or in combination to satisfy the work requirements for a participant in the TCA program.

TCA Workforce Services

If no exemptions from work requirements apply, DCF refers the TCA applicant to DEO.[42] Upon referral, the participant must complete an intake application and undergo assessment by RWB staff which includes:

- Identifying barriers to employment;
- Identifying the participant's skills that will translate into employment and training opportunities;
- Reviewing the participant's work history; and

[36] S. 414.095(1), F.S.
[37] 45 C.F.R. 261.2(n) excludes from the definition of "work-eligible individuals" minor parents who are not the head of household, ineligible non-citizens, recipients of SSI, parents caring for a disabled family member, parents who receive SSDI, and certain individuals participating in a Tribal TANF program.
[38] S. 414.105, F.S., provides hardship exemptions for individuals who have diligently participated in activities but have an inability to obtain employment or extraordinary barriers to employment, victims of domestic violence, individuals subject to a time limitation under the Family Transition Act of 1993, individuals who receive SSI or SSDI, and individuals who are totally responsible for the care of a disabled family member.
[39] S. 445.024(2), F.S.
[40] 45 C.F.R. § 261.30.
[41] This information is not required as part of CareerSource Florida's annual report to the Legislature and Governor. *See*, s. 445.024, F.S.
[42] This is an electronic referral through a system interface between DCF's computer system and DEO's computer system. Once the referral has been entered into the DEO system the information may be accessed by any of the RWBs or One-Stop Career Centers.

- Identifying whether a participant needs alternative requirements due to domestic violence, substance abuse, medical problems, mental health issues, hidden disabilities, learning disabilities or other problems which prevent the participant from engaging in full-time employment or activities.

Once the assessment is complete, the staff member and participant create an Individual Responsibility Plan (IRP). The IRP includes:

- The participant's employment goal;
- The participant's assigned activities;
- Services provided through program partners, community agencies and the workforce system;
- The weekly number of hours the participant is expected to complete; and
- Completion dates and deadlines for particular activities.

RWBs currently have discretion to assign an applicant to a work activity, including job search, before receiving TCA.[43] Currently, Florida's TANF Work Verification Plan[44] requires participants to record each on-site job contact and a representative of the employer or RWB provider staff to certify the validity of the log by signing each entry. If the applicant conducts a job search by phone or internet, the activity must be recorded on a job search report form and include detailed, specific information to allow follow-up and verification by the RWB provider staff.[45]

Current Medicaid law does not require participation in work or work-related activities as a condition of program eligibility or enrollment in a managed care plan.

Effect of Proposed Changes

PCB HHS 17-03 proposes enhancements to the SMMC program by incorporating changes informed by experiences and lessons learned during the first five years of the program.

Consolidation of Regions and Plans

The bill proposes consolidating the eleven SMMC program regions into eight regions. According to AHCA, which proposed the region redesign, this configuration is based on enrollee utilization patterns and provider referral patterns over the first five years of the program.[46] The chart below shows the current regions and the proposed consolidated regions.

SMMC Proposed Regions		
Current Region 1	Escambia, Okaloosa, Santa Rosa, Walton	**REGION A**
Current Region 2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	
Current Region 3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Levy, Marion, Putnam, Sumter, Suwannee, Union	**REGION B**
Current Region 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	
Current Region 5	Pasco, Pinellas	**REGION C**
Current Region 6	Hardee, Highlands, Hillsborough, Manatee, Polk	
Current Region 7	Brevard, Orange, Osceola, Seminole	**REGION D**

[43] Department of Children and Families, *Agency Analysis of 2016 House Bill 563* (Nov. 20, 2015) (on file with Children, Families, and Seniors Subcommittee staff).
[44] Department of Children and Families Economic Self-Sufficiency Program Office, *Temporary Assistance for Needy Families State Plan Renewal October 1, 2014 – September 30, 2017,* Nov. 14, 2014, available at www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf (last visited April 6, 2017).
[45] *Supra*, note 43 at 2.
[46] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis, SB 916*, p. 4, March 31, 2017.

Current Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	**REGION E**
Current Region 9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	**REGION F**
Current Region 10	Broward	**REGION G**
Current Region 11	Miami-Dade, Monroe	**REGION H**

Combining Regions 1 and 2 will create a larger enrollee base to support additional plans in the new region, creating more competition that should drive capitation rates down and increase additional benefits provided by plans seeking enrollees. Regions 1 and 2 have had similar program costs.

Regions 3 and 4 also have similar program costs. In addition, utilization patterns show enrollees use hospitals across both regions at a greater than normal rate. For example, at Shands Teaching Hospital, located in Region 3, 76 percent of claims are for enrollees located in Region 3 while 9 percent of claims are for enrollees in Region 4; at Flagler Hospital, located in Region 4, 83 percent of claims are for enrollees in Region 4, while 16 percent of claims are for enrollees in Region 3.[47] Regions 5 and 6 also see common hospital usage across regions by enrollees at a greater rate than hospital usage across Regions 3 and 4, which supports the consolidation of those two regions.[48]

The bill proposes, in most regions, to increase the minimum or maximum number of plans with which AHCA will contract to provide services to MMA and LTC enrollees. The chart below shows the current number of plans and the proposed number of plans in each region.

Proposed Region	Proposed Number of Plan Contracts	Current Number of Plan Contracts	Current MMA Enrollment	Current LTC Enrollment
REGION A	**3 - 4**	Region 1: 2 Region 2: 2	228,106	6,549
REGION B	**3 - 6**	Region 3: 3 - 5 Region 4: 3 - 5	597,561	16,039
REGION C	**5 - 10**	Region 5: 2 - 4 Region 6: 4 - 7	627,868	20,029
REGION D	**3 - 6**	Region 7: 3 - 6	422,239	9,028
REGION E	**3 - 4**	Region 8: 2 - 4	218,590	5,964
REGION F	**3 - 5**	Region 9: 2 - 4	292,120	8,754
REGION G	**3 - 5**[49]	Region 10: 2 - 4	284,294	7,188
REGION H	**5 - 10**	Region 11: 5 - 10	562,457	21,252

Each region will have a minimum of three plans to provide services in the SMMC program. According to AHCA, enforcing contract requirements in a region with only two plans is difficult. For example, and enrollment freeze sanction would eliminate recipients' ability to have a choice of at least two plans, which is a federal requirement. With at least three plans, AHCA will be able to impose the full range of penalties available against noncompliant plans, including imposing an enrollment freeze. Also, having at least three plans in any region protects against enrollees falling into the fee-for-service category should any one plan fail or withdraw from the SMMC program.

Current law allows plans to establish comprehensive long-term care plans, which are plans that provide both MMA benefits and LTC benefits. Comprehensive plans make it easier for enrollees who are eligible for both programs, by allowing them to work with only one plan instead of two. Such plans also improve care management across the acute and long-term care programs. Current law encourages comprehensive long-term care plans by requiring AHCA to prefer such plan proposals in the procurement. The bill moves the preference language to a more appropriate section of law.

[47] Milliman, *Regional Realignment Analysis for SMMC Reprocurement, Exhibit B*, August 30, 2016 (on file with Health and Human Services Committee).
[48] Id.
[49] For the long-term care program, the bill proposes 3 to 4 plans for Region G.

Current law requires each managed care plan to have an accurate and complete online database of the providers in their networks, including information about their credentials, licensure, hours of operation and location. The bill requires AHCA to conduct systematic, ongoing testing of each plan's network database to ensure that the provider listing is accurate, including only those providers with an active contract with the plan. Also, AHCA's network testing activities must confirm that the providers in each network are accepting new Medicaid patients and that such enrollees have access to care.

MMA Eligibility Requirements

Work Requirements

The bill requires AHCA to request approval from the federal government to impose work requirements as condition of eligibility for Medicaid and enrollment in a MMA plan.[50] The work requirements and the Medicaid recipients subject to them must be consistent with those in the TANF TCA program.

Under the bill, the work requirements would only apply to MMA enrollees; not LTC enrollees. Assuming the federal government approves work requirements for Medicaid recipients consistent with those applicable to TCA, the work requirements would not apply to children or:

- An individual who receives SSI or SSDI benefits;
- An adult who is not defined as a work-eligible individual under federal law[51];
- A single parent of a child under 3 months, except that the parent may be required to attend parenting classes or other activities to better prepare for the responsibilities of raising a child; or
- An individual who is exempt from the time period pursuant to s. 414.105[52].

Work requirements would apply to able-bodied adults with children, and able-bodied adults without children ages 19-20, who meet the current income eligibility requirements. Medicaid recipients who are also TCA beneficiaries are already subject to TANF work requirements.

If approved by the federal government, MMA enrollees must submit proof to DCF of work activities for no more than 40 hours per week, consistent with federal TCA requirements. Assuming the federal government approves work activities consistent with those applicable to TCA, work activities may be in the following categories:

- Unsubsidized employment;
- Subsidized private sector or public sector employment;
- On-the-job training;

[50] The U.S. House of Representatives is currently considering legislation to allow a mandatory work requirement for non-disabled, non-elderly, non-pregnant adults in the Medicaid program. American Health Care Act of 2107, H.R. 1628, 115th Cong., Sec. 117 (as reported by the H. Committee on Rules, April 9, 2017).

[51] 45 CFR 261.2(n):

(1) Work-eligible individual means an adult (or minor child head-of-household) receiving assistance under TANF or a separate State program or a non-recipient parent living with a child receiving such assistance unless the parent is:

(i) A minor parent and not the head-of-household;

(ii) A non-citizen who is ineligible to receive assistance due to his or her immigration status; or

(iii) At State option on a case-by-case basis, a recipient of Supplemental Security Income (SSI) benefits or Aid to the Aged, Blind or Disabled in the Territories.

(2) The term also excludes:

(i) A parent providing care for a disabled family member living in the home, provided that there is medical documentation to support the need for the parent to remain in the home to care for the disabled family member;

(ii) At State option on a case-by-case basis, a parent who is a recipient of Social Security Disability Insurance (SSDI) benefits; and

(iii) An individual in a family receiving MOE-funded assistance under an approved Tribal TANF program, unless the State includes the Tribal family in calculating work participation rates, as permitted under §261.25.

[52] S. 414.105, F.S., provides hardship exemptions for individuals who have diligently participated in activities but have an inability to obtain employment or extraordinary barriers to employment, victims of domestic violence, individuals subject to a time limitation under the Family Transition Act of 1993, individuals who receive SSI or SSDI, and individuals who are totally responsible for the care of a disabled family member.

- Community service programs;
- Work experience;
- Job search and job readiness assistance;
- Vocational educational training;
- Job skills training directly related to employment;
- Education directly related to employment;
- Satisfactory attendance at a secondary school or in a course of study leading to a high school equivalency diploma; or
- Providing child care services.[53]

Premiums

The bill also directs AHCA to seek federal approval to implement monthly premiums payable by enrollees in the MMA program. The amount of premium is based on an enrollee's income: for incomes between 50 percent and 100 percent of the federal poverty level, the premium is $10 per month; for incomes between 101 percent of the federal poverty level and greater, the premium is $15 per month. Premiums will be collected by DCF or by a contracted entity with experience in collecting premiums, and used to offset the cost of medical assistance provided to enrollees in the MMA program. Premium payment is a condition of eligibility and enrollment in the program. The bill establishes a 60-day grace period for any missed premium payment. If an enrollee does not pay the premium by the end of the grace period, the enrollee will be disenrolled from the MMA program and ineligible for reenrollment for 12 months.

Monthly premiums can be waived for hardship, as defined by AHCA rule, or upon successful completion of one or more healthy behavior programs established by a managed care plan pursuant to s. 409.873(3), F.S. Such programs include smoking cessation, a medically directed weight loss program, and medically approved alcohol or substance abuse recovery programs, among other options.

Provider Service Networks

The bill deletes the requirement that AHCA, in a region where a PSN does not submit a responsive bid to the ITN, contract with one fewer plan than is permitted in the region, to reserve a plan slot for a future PSN. The bill also deletes the requirement that AHCA attempt to procure a PSN within 12 months after the ITN, if no qualified PSN responds to the first ITN. This provision eliminates an administrative burden on AHCA to repeat its attempt to procure a PSN in a region where there was originally no interest in establishing such a plan during the procurement process. The bill retains the option for new PSNs to be paid under a fee-for-service/shared savings model, for the first two years of operation, after which they would be capitated.

Prompt Payment

The bill requires AHCA to impose fines on any plan that willfully fails to promptly pay a "clean" claim for payment from a provider, pursuant to s. 409.982(5), F.S. Current law gives AHCA the discretion to fine a managed care plan for failing to comply with the prompt payment provisions of ss. 641.315, 641.3155, and 641.513, F.S.

Nursing Home Rates

The bill repeals the requirement for AHCA to establish nursing facility-specific rates for each licensed nursing home participating in the LTC program. Instead, the bill directs managed care plans and providers to negotiate rates, methods, and terms of payment. The provision gives the plans and nursing homes the flexibility to agree to payment rates that are commensurate with enrollee population,

[53] S. 445.024(1), F.S.

geographic location, and network requirements. This aligns nursing home payment with payment for other providers in SMMC.

Claims and Encounter Data Databook

Under current law, at least 90 days before issuing an ITN to procure MMA and LTC plans under the SMMC program, AHCA compiles and publishes a databook that includes utilization and spending data for the program. The data comes from the 3 most recent contract years and include historic fee-for-service claims and validated Medicaid encounter data. Prospective plans use the databook to formulate proposals to respond to the ITN. The bill limits the data to the 2 most recent contract years and validated Medicaid encounter data only.

Lastly, the bill deletes obsolete provisions referencing expired deadlines related to implementation of the SMMC program. And, the bill makes conforming changes to reflect the proposed language in the bill.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.964, F.S., relating to managed care program; state plan; waivers.
Section 2: Amends s. 409.966, F.S., relating to eligible plans; selection.
Section 3: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 4: Amends s. 409.971, F.S., relating to managed medical assistance program.
Section 5: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 6: Amends s. 409.974, F.S., relating to eligible plans.
Section 7: Amends s. 409.978, F.S., relating to long-term care managed care program.
Section 8: Amends s. 409.981, F.S., relating to eligible long-term care plans.
Section 9: Amends s. 409.983, F.S., relating to long-term care managed care plan payment.
Section 10: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA may realize an indeterminate increase in revenue from fines imposed on managed care plans that do not comply with the prompt pay requirements for clean claims, authorized by the bill.

Conditioned on federal approval, DCF, or a contracted entity, will collect monthly premiums from enrollees in the SMMC program. The total amount of premiums will be impacted by waivers for hardship and waivers for successful completion of healthy behavior programs established by the plans. Collected premiums must be used by AHCA to offset the amount of medical assistance provided to SMMC program enrollees.

2. Expenditures:

The bill may have a significant, indeterminate, negative fiscal impact on DCF to administer the premium collections required by the bill. DCF may also have significant, indeterminate, negative fiscal impact related to the bill's imposition of work requirements on Medicaid recipients: DCF, as part of its eligibility functions, would refer Medicaid recipients to the DEO/RWB/CareerSource work programs, track work participation, and take action for recipient failure to comply. However,

implementation of these programs is conditioned on federal approval. Implementation will likely require additional budget authority for DCF for information technology improvements and eligibility workload, in a future legislative approval of the terms of any successful negotiation with the federal government.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Managed care plans that fail to comply with prompt pay requirements are subject to contract-based fines from AHCA.

Conditioned on federal approval, Medicaid enrollees will be required to maintain work activities and pay monthly premiums (unless exempt) to maintain eligibility for Medicaid. An indeterminate number of enrollees may be disenrolled and prohibited from reenrolling in the program for 12 months for failing to meet these requirements. Disenrollments may lead to an increase in charity care or uncompensated care provided by hospitals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA and DCF have sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES