

Summary of HB 7223 and HB 7225, Engrossed

- i. The House Medicaid proposal consists of two bills:
 - a. **HB 7223** creates a new part and numerous new sections of law in Chapter 409 that will be phased in over a 5-year period.
 - b. **HB 7225** makes date-specific, conforming changes to current law (e.g., set expiration dates for certain sections of existing law). The bill also authorizes some immediate changes in the Medicaid program.
- ii. The Florida Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care. AHCA is authorized to apply for and implement waivers necessary for this program.
- iii. General provisions that apply across the Medicaid program:
 - a. **All Medicaid recipients are enrolled in managed care** unless explicitly exempt. Exempt populations include those who receive limited benefits (e.g. women only eligible for family planning or breast and cervical cancer services; aliens eligible for emergency services).
 - b. **Plans qualified** to participate include
 - i. provider service networks (**PSN**),
 - ii. exclusive provider organizations,
 - iii. health maintenance organizations (**HMO**),

- iv. health insurers
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- c. Plans may target special populations based on age, medical condition or diagnosis, but **all plans must cover or arrange for all services** for enrollees. The bill eliminates the existence of “carve-out” plans.

 - d. In order to ensure plans have a sufficient number of enrollees to be viable, a limited number of plans will be selected through a **competitive selection process**.
 - i. Each region will have a **minimum** number of plans (3-5).

 - ii. Each region will have a **maximum** number of plans (7-10).

 - iii. Each region will have a **guaranteed participation for one or two PSNs**, provided there are responsive bidders, to ensure consumer choice and competition between different models of managed care (PSN v HMO).

 - iv. Each region will have a guaranteed number of plans for the developmentally disabled population (2-6).

 - e. Medicaid payment rates will be negotiated as part of the selection process but will be based on historic utilization and spending, adjusted for clinical risk (“**risk adjusted rates**”).

 - f. **In addition to price**, the competitive selection process will also evaluate a managed care organization’s
 - i. Accreditation;

- ii. Experience with similar populations;
 - iii. Availability and accessibility of primary care providers;
 - iv. Community partnerships that create re-investment opportunities;
 - v. Commitment to quality improvement;
 - vi. Additional benefits, particularly dental care, disease management and other enhanced services;
 - vii. History of voluntary or involuntary withdrawals.
 - viii. Pre-bid agreements with physicians to meet network requirements or provide sufficient compensation to meet network requirements over the 5-year contract term.
 - ix. Pre-bid agreements with select providers of critical services required to participate in the chosen plans in each program (e.g., teaching hospitals, nursing homes and ICF/DDs).
- g. **Preference** will be given in the competitive selection process to
- i. Organizations that are **medical homes**. Plans must assist and incentivize primary care providers to become medical homes.
 - ii. Organizations that **recruit minority providers**.
 - iii. Organizations that cover both acute and long term care services.

h. Plans will be selected on a **regional basis**

i. **The Panhandle Region:** Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington

1. The smallest region with a little more than 200,000 current Medicaid enrollees. Region 1 would be capped at a maximum of 3 managed care plans.

ii. **The North Central/ Northeast Florida Region:** Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, Union, Volusia.

iii. **The West Central Florida Region:** Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota.

1. The largest region, with nearly 700,000 current Medicaid enrollees.

iv. **The Central Florida Region:** Brevard, Lake, Orange, Osceola, Seminole, Sumter.

v. **The Southeast Florida Region:** Broward, Hendry, Indian River, Martin, Okeechobee, Palm Beach, St. Lucie.

vi. **The South Florida Region:** Collier, Miami-Dade, Monroe

Medical/Long Term	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	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	9	44
DD plans Min - Max (1 PSN each)	2	2 - 5	3 - 6	3 - 6	3 - 6	3 - 6	16 - 31

- i. Managed care plans will be held **accountable**.
 - i. AHCA will establish 5-year contracts with **no renewals**.
 - ii. Plans will be required to **pay for emergency services**.
 - iii. Plans will be required to meet **network adequacy standards** and maintain an accurate database of providers online and accessible to AHCA and the public. The public will have the opportunity to post feedback about providers.
 - iv. **Performance standards** will be established and raised over the term of the contract.
 - v. Plans will be required to maintain program integrity functions including specific activities that **reduce fraud and abuse**:
 - 1. Provider credentialing and monitoring
 - 2. Prepayment and post payment reviews;

3. Reporting procedures;
 4. Mandatory compliance plans;
 5. Designation of a program integrity compliance officer.
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- vi. **Grievance resolution process** will be required and AHCA will maintain a process for those recipient complaints that are not resolved by the plans.
 - vii. **Penalties for reducing enrollment or early withdrawal**, including reimbursement of transition costs and a fine of up to 5% of the capitation payment.
 - viii. **Specific requirements for enrollment, choice counseling, automatic assignment and disenrollment are established.** When a recipient with a specific condition or diagnosis does not choose a plan, the recipient will be automatically enrolled into a specialty plan if one is available.
 - ix. Plans must provide **30-days written notice to recipients** prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.
 - x. **Ongoing Medicaid encounter data analysis** by AHCA to determine whether there has been systemic under-utilization, inappropriate utilization, or systemic claim denials.
 - xi. **Repayment of intergovernmental transfers** is guaranteed by ensuring that providers are paid the exact amount the agency determines and are paid within 15 days.
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- iv. Specific provisions that apply to managed medical assistance – primary and acute care

- a. **Implementation** shall begin January 1, 2012, with full implementation by **October 1, 2013**.

- b. **Enrollment**
 - i. All non-exempt Medicaid recipients will be required to enroll in a managed care organization (PSN, HMO).

 - ii. Exempt persons who may **voluntarily enroll** include:
 1. Recipients with other creditable coverage.
 2. Recipients in residential placements.
 3. Refugee assistance recipients.
 4. Residents of a developmental disability center

 - iii. Fee-for-service Medicaid is maintained only for exempt persons and those who may, but do not, voluntarily enroll.

- c. **Benefits**
 - i. All current mandatory and optional services.

 - ii. Plans may customize benefits, subject to review by AHCA.

 - iii. Plans are required to maintain an enhanced benefits program.

- d. **Children's Medical Services** is a qualified plan statewide and exempt from competitive procurement, but must meet other plan requirements.

- e. **Accountability measures** specific to managed medical assistance
 - i. **Medical loss ratio** thresholds
 - 1. Less than 75% = payback up to 85% and no auto-enrollment
 - 2. 75%-85% = payback up to 85%
 - 3. Greater than 92% = evaluation to determine effectiveness of care management
 - 4. 95% or more and determined to be failing to adequately manage care = no auto-enrollment
 - ii. Plans are required to have specific **programs for pregnant women and infants**.
 - iii. Plans must achieve an **EPSDT screening** rate of at least 80%.
- f. **Rules** for plans and providers:
 - i. **Plans may** limit providers
 - 1. Must offer a contract in first period to:
 - a. FQHCs
 - b. Medical home primary care providers
 - c. Select providers of critical services

2. After 12 months, these providers may be excluded for failure to meet quality standards
- ii. **Providers may** limit plans, but providers with special state-granted designations must agree to contract with qualified plans:
1. Statutory teaching hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)
 2. Trauma hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)
 3. RIPCCs (must ensure that center has adequate medical staff to fulfill contractual obligations)
 4. Specialty licensed children's hospitals (must ensure that hospital has adequate medical staff to fulfill contractual obligations)
 5. Providers with an active Medicaid agreement and CON (hospitals and hospices)
- iii. **Hospital payments** must be a minimum of the Medicaid rate up to 150% of Medicaid unless approved by AHCA.
- iv. Requires **performance measurement** of providers with transparent metrics.
- v. The **Medicaid Resolution Board** will resolve disputes between plans and hospitals, and plans and hospital medical staff.
- g. **Medically needy** recipients shall be enrolled in managed care.

- i. Plans **must accept and provide 12 months continuous eligibility** to Medically Needy enrollees;
 - ii. Enrollees must **pay the premium up to their share of cost**; contingent on federal approval
 - iii. Plans must provide at least a **120-day grace period** before disenrolling for failure to pay premiums.
- v. Specific provisions that apply to long-term care
- a. **Implementation** will begin July 1, 2011, and be complete in all regions by October 1, 2012.
 - b. **Eligibility**
 - i. Medicaid recipients who are 65+ or disabled and meet level of care standards as determined by CARES
 - ii. All recipients in a nursing facility or enrolled in a waiver on the day managed care plans become available in their region
 - c. Two **types of plans**
 - i. Comprehensive plans that combine medical and home and community based services

- ii. Long-term care plans that only provide home and community based services

d. Long-term care managed care **plan requirements**

- i. Must provide both residential care (nursing facility or other) and a comprehensive range of home and community based services.
- ii. Medicare plans are qualified plans for long-term care managed care.
- iii. PACE plans are qualified but exempt from procurement.
- iv. Qualified plans must have specialized staffing with experience in serving elders and the disabled.
- v. A limited number of plans are selected in specific regions.
- vi. Follow specific standards for availability and accessibility of home and community based services.

e. **Home and community based care:**

- i. **Payment rates** reflect an adjustment to create incentives for keeping individuals out of nursing homes as long as possible; at least 3% up to 5% re-balancing of nursing home and home and community based care is expected each year.
- ii. **CARES staff** will continue to evaluate whether an individual needs a nursing facility level of care and will initially assign the individual to a level of care.

f. **Medical loss ratio** thresholds

- i. Less than 75% = payback up to 85% and no auto-enrollment
 - ii. 75% - 85% = payback up to 85%
 - iii. Greater than 92% = evaluation to determine effectiveness of care management
 - iv. 95% or more and determined to be failing to adequately manage care = no auto-enrollment
- g. Auto-assignments can be quality based.
- h. Preservation of roles for traditional aging service providers**
- i. Aging Resources Centers will be a community access point for seniors seeking services and will either offer choice counseling to enrollees through a contract with AHCA, or will work cooperatively with choice counseling vendors.
 - ii. Plans must include all nursing homes and hospices and these providers are must agree to participate in a plan's network if offered a contract.
 - iii. Nursing homes and hospices will receive a "pass through" payment for services from the plan.
 - iv. A plan's network must include:
 - 1. Adult Day Center Centers
 - 2. Adult Family Care Homes

3. Assisted Living Facilities
4. Health Care Services Pools
5. Home Health Agencies
6. Homemaker and Companion Services
7. Hospices
8. Lead Agencies
9. Nurse Registries
10. Nursing Homes

i. **Hospice Services**

- i. Recipients referred for hospice services will have 30 days to select another plan to access a preferred hospice

vi. Specific provisions that apply to developmental disabilities

- a. **Implementation** will begin January 1, 2014, and be complete in all regions by October 1, 2015.
- b. Two **types of plans**
 - i. Comprehensive plans that combine medical and home and community based services
 - ii. Long-term care plans that only provide home and community based services

c. **Eligibility**

- i. Criteria are the same as the current Medicaid waiver program and the Intermediate Care for the Developmental Disabilities program.
 - ii. All recipients of these services on the date the plans become available in their region will be eligible to enroll in the Plans.
- d. The **benefits** that will be required of participating plans are substantially the same as those currently offered under the four-tier Medicaid waiver program and the Intermediate Care for Developmental Disabilities program.
- e. To be **qualified**, a managed care plan must
- i. Have staffing with experience serving persons with developmental disabilities
 - ii. Provider service networks must include certain licensed residential providers with 10 years of experience in developmental disabilities.
 - iii. Plans must involve consumers and families in design and oversight of plans.
 - iv. Plans must contract with all residential providers upon implementation of the new program to ensure no disruption in living situations.
 - v. AHCA will give preference to those plans that have pre-bid agreements with providers to meet network requirements.
 - vi. Plans must provide 90-days' written notice to recipients prior to the recipient's provider being excluded from the plan for failure to meet quality or performance criteria.

f. **Medical loss ratio** thresholds

- i. At least 92% of premiums must be spent on direct care cost and services

g. **Payment**

- i. AHCA will pay plans based on five specific levels of care for enrolled individuals.
 - ii. APD will perform the initial assessment and assignment of persons into levels of care.
 - iii. Rates paid to intermediate care for the developmental disabilities facilities and intensive behavior residential habilitation facilities will be determined by AHCA.
- h. Residents of Sunland Marianna, Tacachale and the mentally retarded defendant program are exempt from mandatory enrollment in the new program, but may voluntarily enroll if they so choose.

vii. Immediate changes to begin transition of current Medicaid system

- a. The agency is directed to seek an **extension and modification of the 1115 waiver**.
- b. The **reform pilot is expanded to Miami-Dade County**, beginning July 1, 2010, with full implementation expected by June 30, 2011.
- c. **Payment** of existing managed care plans will change in two ways

- i. All plans (whether in reform counties or elsewhere in the state) will begin a **3-year transition to risk-adjusted rates**.
 - ii. The agency will begin a 3-year process to modify the basis for setting capitation rates to include **consideration of encounter data**. AHCA is required to review available encounter data to establish actuarially sound rates prior to using the encounter data to adjust rates for prepaid plans.
 - iii. Rates will be **immediately risk-adjusted for public hospitals** in Miami-Dade County
- d. **Miami-Dade County IGTs are preserved** by directing the agency to develop a methodology, such as a supplemental capitation rate, to be paid to prepaid plans or providers under contract with trauma, children's or safety net hospitals.
 - e. All plans statewide (both in reform areas and elsewhere) are required to **develop enhanced benefit plans** and **report encounter data**.
 - f. All Medicaid recipients statewide will be permitted to use their Medicaid premium to **purchase private insurance**.
 - g. The agency will establish a **uniform method of accounting and reporting medical and non-medical expenses** and the plans will begin reporting.
 - h. Provisions for **designation of medical homes** are established.
 - i. **Prepaid PSNs are permitted to provide comprehensive behavioral health** and specific requirements are established for the reconciliation process that determines shared savings.
 - j. AHCA is required to contract with **prepaid dental plans** until the Medicaid Managed Medical Assistance program is fully implemented in all regions.
 - k. AHCA is **authorized to accept Medicare plans as Medicaid plans** and make appropriate payments for dually eligible enrollees. Medicare crossover providers can be enrolled as Medicaid providers for both payment and claims processing.

1. Area One of APD will participate in an **ibudget (individual budget) demonstration project** to test the effectiveness of the ibudget proposal serving people with developmental disabilities in the Medicaid program.