# SUMMARY OF HB 7223
# ESTABLISHMENT OF STATEWIDE MANAGED CARE PROGRAM

**Section 1. Directory.**

**Section 2. S. 409.961.**

- Technical provisions regarding statutory construction; applicability; rules.

**Section 3. S. 409.962.**

- Definitions.

**Section 4. S. 409.963.**

- Establishes AHCA as single state agency pursuant to federal law.

**Section 5. S. 409.964.** Managed care program; state plan; waivers.

- Establishes Florida Medicaid as a managed care program; all covered services and LTC.

**Section 6. S. 409.965.** Mandatory enrollment.

- Provides for mandatory enrollment unless specifically exempt
- Exempt persons include:
  - Women only eligible for family planning
  - Women only eligible for breast and cervical cancer services
  - Persons eligible for emergency services for aliens

**Section 7. S. 409.966.** Qualified plans; selection.

(1) Qualified plans. May be designated as medical homes; PSN must be capable of providing all services to enrollees

(2) Plan selection: a limited number are selected in each specifically named regions listed below. (agency produces databook for procurement process)

- Region 1 = Panhandle: Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington
- Region II = No. Central and No. East Florida: 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 Florida: Charlotte, DeSoto, Glades, Hardee, Hernando, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota.
- Region IV = Central Florida: Brevard, Lake, Indian River, Orange, Osceola, Seminole, Sumter.
- Region V = Southeast Florida: Broward, Hendry, , Martin, Glades Okeechobee, Palm Beach, St. Lucie.
- Region VI = South Florida: Collier, Miami-Dade, Monroe.

(3) Quality selection criteria are established including accreditation, experience, adequacy of physician network, community partnerships, quality improvement programs, offers of additional benefits, withdrawal history, and specific preferences for medical homes or minority recruitment.

(4) Provides that challenges to selection may delay implementation.

**Section 8. S. 409.967** Managed care accountability.

Establishes specific requirements to assure accountability of managed care plans

(1) 5-year contract
(2) Specific contract requirements.
    (a) Plans must pay for emergency services
    (b) Plans must meet access standards and maintain online database for the agency and the public.
    (c) Plans must submit encounter data in accordance with agency standards.
    (d) Plans must establish specific performance standards that are raised over the term of the contract.
    (e) Plans must meet specific requirements to maintain program integrity and prevent fraud and abuse.
    (f) Plans must maintain internal grievance resolution process
    (g) Penalties are established for reducing enrollment or withdrawing prior to the end of a contract; penalties up to 5% of capitation.

**Section 9. S. 409.968.** Managed care plan Payment

(1) Prepaid plans - PMPM risk-adjusted rates
(2) Rate-setting methodology transition
(3) PSNs – PMPM risk-adjusted rates or FFS with shared savings

**Section 10. S. 409.969.** Enrollment; choice counseling; automatic assignment; disenrollment.

(1) All recipients shall be enrolled in managed care unless specifically exempt.
(2) Choice counseling shall be available to all recipients and include the following information:
    (a) Explanation of choice
    (b) Explanation of benefits
    (c) Explanation of benefit limits
    (d) List of participating providers
    (e) Plan performance information
(3) Specific procedures for disenrollment and grievances must be followed.
    (a) Plan grievance process within certain deadlines
    (b) Final agency determination on grievances within certain deadlines
    (c) Recipients are enrolled for 12-months

**Section 11. S. 409.970.** Encounter data.

The agency must maintain and operate a Medicaid encounter data system to collect, process, store, and report on covered services provided to all Medicaid recipients in prepaid plans.

**Specific Provisions – Managed Medical Assistance Program**

**Section 12. S. 409.971.** Managed Medical Assistance Program

The agency is responsible and shall begin implementation by January 1, 2012 with full implementation by October 1, 2013.

**Section 13. S. 409.972.** Mandatory and voluntary enrollment.

(1) Medically Needy must be enrolled in managed care.
(2) The following recipients may enroll voluntarily
  (a) Persons with other creditable health care coverage
  (b) Recipients in certain residential commitment programs
  (c) Persons eligible for refugee assistance
  (d) Recipients who are residents of Sunland or Tacachale.
(3) All recipients who are exempt and do not voluntarily enroll will be covered by fee-for-service program

**Section 14. S. 409.973.** Benefits.

(1) Benefit list: a specific list of benefits is provided and must be covered at a minimum.
(2) Plans may customize benefits subject to review by the agency.
(3) Plans must provide enhanced benefits
  (a) Enable recipients to earn and use credits in a flexible account for uncovered services.
  (b) Plans must provide more credits for modifications or management of high cost behaviors
  (c) Plans must maintain earned credits for up to 3 years and fund them through a reserved account.
  (d)

**Section 15. S. 409.974.** Qualified plans.

(1) The agency shall select a limited number of qualified plans
(2) Plans will be selected in specific regions (same as above)
(3) Quality selection criteria include written agreements or signed contracts or substantial progress in establishing relationships with providers; special weight given to signed contracts with providers of critical services; specialty plans shall be considered, and comprehensive plans—covering both medical assistance and long term care—are preferred.
(4) Children's Medical Services Network is a qualified plan and may participate statewide but is exempt from competitive procurement and must meet other plan requirements.

**Section 16. S. 409.975.** Medical loss ratio. Managed care plan accountability

(1) The agency will establish uniform cost reporting and analyze spending patterns
  (a) Less than 75% results in no auto enrollment and payback requirement up to 85%
  (b) Less than 85% results in payback requirement up to 85%.
  (c) Medical loss ratio tier four: above 92% results in further evaluation.
(2) Plans must include the following providers
  (a) FQHCs
  (b) Medical home certified primary care providers
  (c) Teaching hospitals, trauma hospitals, regional perinatal intensive care centers (RPICC)

After 12 months, any of these providers may be excluded for quality failures

(3) The following providers must participate
  (a) Teaching hospitals and their medical staff (employed or under contract)
  (b) Trauma hospitals and their medical staff (employed or under contract)
  (c) RPICCs and their medical staff (employed or under contract)
  (d) Specialty children's hospitals and their medical staff (employed or under contract)

(e) CON-permitted providers (hospitals and hospices) with a Medicaid provider agreement
(4) Plans must measure performance of providers based on transparent metrics.
(5) Plans must have special provisions for improving pregnancy outcomes and infant health
(6) EPSDT screening rates must equal or exceed 60%
(7) Provider payments may be negotiated, but hospital rates must be at least the Medicaid rate and no more than 150% of the Medicaid rate; the Medicaid rate is the rate the agency would have paid on the first day of the contract between the plan and the provider.
(8) The agency may provide a conflict resolution process for hospitals and their medical staffs in limited circumstances.
(9) Medically needy enrollees must enroll in managed care; must pay their share of cost as part of the premium; must be given 12 months continuous eligibility; and must be given a 60 day grace period before disenrollment for failure to pay.

**Section 17. S. 409.976.** Managed care plan payment

(1) Prepaid plans are paid rates negotiated as part of the selection process;
(2) Payments will be adjusted to return intergovernmental transfers, contingent on federal approval; the agency is authorized to set an enhanced rate and require plans to pay the rate to providers.

**Section 18. S. 409.977.** Choice counseling and enrollment

(1) Choice counseling must be provided and include specific information.
    (a) Enhanced benefits information
    (b) Cost sharing information
(2) Automatic enrollment may be based on quality standards; other considerations include:
    (a) Network capacity
    (b) Prior history with a primary care provider
    (c) Geographic accessibility
    (d) Medical condition if a specialty plan is available.
(3) Opt-out: recipients may use Medicaid premiums for purchase of other insurance.

**Specific Provisions – Long-Term Care Managed Care Program**

**Section 19. S. 409.978.** Authority.

(1) AHCA is responsible but may delegate certain responsibilities to DOEA; implementation shall begin July 1, 2011 with full implementation by October 1, 2012.
(2) Long term care shall be provided through a managed care model
(3) DOEA duties include: assist with ITN, determine clinical eligibility, assist in monitoring plans, assist families, facilitate interactions between plans and providers, and others.

**Section 20. S. 409.979.** Eligibility.

(1) Eligible recipients include:
    (a) Age 65+ or disability per federal standards;
    (b) Clinically eligible based on need for nursing care
(2) Waiver recipients are also eligible on the date plans become available in their regions.
    (a) Assisted Living waiver

(b) Aging & Disabled Adult waiver
(c) Adult Day Health Care waiver
(d) Consumer Directed Care waiver
(e) PACE
(f) Diversion
(g) Channeling

**Section 21. S. 409.980.** Benefits: a specific list is established as a minimum including services previously provided through waivers in addition to residential care.

**Section 22. S. 409.981.** Qualified Plans.

(1) All plans qualified pursuant to the general provisions may participate plus Medicare plans and long term care PSNs.
  (a) LTC plans provide home and community based care plus residential care and comprehensive LTC plans include these services in addition to medical assistance.
  (b) Specific criteria are established for plans including experienced staff, specific LTC providers included in the networks, and that the plan have signed contracts or have made substantial progress in establishing relationships with essential providers (nursing homes, hospices, and aging network providers).
(2) A limited number of plans are selected in each regions; preference is given to comprehensive plans.
(3) Preference is given to medical home networks and plans with consumer directed care options
(4) PACE is a qualified plan up to the limits established in the GAA.

**Section 23. S. 409.982.** Managed Care Plan Accountability

(1) Cost reporting and spending pattern analysis
  (a) Medical loss ratio tier one: less than 75% results in no auto enrollment and payback requirement up to 85%
  (b) Medical loss ratio tier two: less than 85% results in payback requirement up to 85%.
  (c) Medical loss ratio tier three: above 92% results in further evaluation.
(2) Plans must offer contracts to the following providers
  (d) Nursing homes
  (e) Hospices
  (f) Aging network providers
(3) Nursing homes and hospices must participate in all plans
(4) Plans must measure providers' performance and metrics must be transparent.
(5) The agency must establish specific network standards for the following providers:
  (a) Adult day care
  (b) Adult family care homes
  (c) ALFs
  (d) Health care services pools
  (e) HHAs
  (f) Homemaker/Companion organizations
  (g) Hospcies
  (h) Lead agencies
  (i) Nurse registries

(j) Nursing homes

(6) Plans must negotiate acceptable rates with providers. However, nursing homes and hospices will be paid state rates

**Section 24. S. 409.983.** Managed Care Plan Payment

(1) Rates are negotiated as part of the selection process.

(2) Comprehensive LTC plans receive rates that combine the LTC rate and the medical assistance rate.

(3) Calculation of rates must be based on historic use and spending adjusted for level of care.

(4) Cares assessments determine the initial levels of care, the agency must make rate adjustments periodically to reflect the composition of the plan's enrollees.

  (a) Level 1: residing in a nursing home or in need of immediate placement.

  (b) Level 2: requiring constant availability of routine care with extensive needs for related services.

  (c) Level 3: requiring constant availability of routine care and a limited need for related services with a priority 5 or above.

(5) Rates will be adjusted to create incentive for plans to increase use of home and community based services.

(6) Nursing home rates are set by the state and passed through the payment to the plans.

(7) Hospice rates are set by the state and passed through the payment to the plans.

**Section 25. S. 409.984.** Choice Counseling and enrollment.

(1) Choice counseling must be offered and enrollment must meet specific requirements.

(2) The agency is authorized to make automatic enrollment based on quality; other criteria include:

  (a) Network capacity

  (b) Prior relationships with home and community based providers

  (c) Geographic accessibility

(3) Individuals referred for hospice services have 30 days in which they may select another plan to access the hospice provider of their choice

**Section 26. S. 409.985.** CARES

(1) The agency will operate CARES

(2) AHCA may establish an interagency agreement with DOEA

(3) CARES will determine clinical eligibility and level of care

**Specific Provisions – Long-Term Care Managed Care Program for Persons with Developmental Disabilities**

**Section 27. S. 409.986.** Managed Long-Term Care for Persons with Developmental Disabilities

(1) The agency is responsible but may delegate to APD; implementation shall begin by January 1, 2014 with full implementation by October 1, 2015.

(2) The program is established as a managed care model.

(3) APD duties include assisting with ITN, determining clinical eligibility, assisting to monitor performance, assisting clients and families interact with plans, facilitating relations between providers and plans, and other.

**Section 28. S. 409.987.** Eligibility.

(1) To be eligible recipients must meet the following:
  (a) Financially eligible based on Medicaid income and asset tests;
  (b) Developmental disability
  (c) Meet level of care standards (four levels)
  (d) Be in an ICF/DD
  (e) Be enrolled in the HCBS waiver for persons with DD
  (2) Residents of DDCs (Sunland and Tacachale are exempt from enrollment but may voluntarily enroll.

**Section 29. S. 409.988.** Benefits. (List, (1)-(20).)

**Section 30. S. 409.989.** Qualified Plans.

(1) Plans can provide only residential and home and community based services or can be comprehensive plans that also cover medical assistance.
(2) Plan must meet specific criteria including:
  (a) Specialized staffing
  (b) Network composition that meets specific qualifications for access and availability
  (c) Specialty networks must include certain DD providers.
(3) A limited number of plans will be selected (Regions)
(4) Specific selection criteria are defined including:
  (a) A preference for DD comprehensive LTC plans with current contract for Medicaid medical assistance.
  (b) A preference for plans that include a consumer directed care option in their benefit package.
  (c) A preference for plans with signed contracts or substantial progress in establishing providers
(5) CMS is a qualified plan and not subject to competitive procurement

**Section 31. S. 409.990.** Managed Care Plan Accountability

(1) Requirements for cost reporting and agency analysis are established consistent with previous provisions
  (a) Less than 75% results in no auto enrollment and payback requirement up to 85%
  (b) Less than 85% results in payback requirement up to 85%.
  (c) Above 92% results in further evaluation.
(2) Plans must include certain providers in their networks:
  (g) ICF/DDs
  (h) Alternate residential facilities
(3) Certain providers (ICF/DDs)must participate in networks;
(4) Plans must measure provider performance using transparent metrics.
(5) Payments to ICF/DDs must be made at the state rate.
  (6) Plans must provide for consumer and family involvement

**Section 32. 409.991.** Managed Care Plan Payment

(1) Rates are negotiated as part of the selection process.
(2) DD LTC comprehensive plans receive payments that combine the rate for the residential and home and community based care with the medical assistance rate.
(3) Rates are based on historic use and spending adjusted to reflect level of care
(4) APD assessments are used to initially determine the level of care.
(5) Five levels of care are specifically defined and the agency periodically adjusts rates to reflect the plans' enrollee population

**Section 33. S. 409.992.** Auto Enrollment

(1) The agency may make auto-enrollments based on quality; other criteria include:
    (a) Network capacity
    (b) Previous service by a home and community based provider
    (c) Geographic accessibility

**Section 34.** Effective date.