The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Committee on Health and Human Services

BILL:	CS/SB 1084
INTRODUCER:	Appropriations Committee on Health and Human Services and Senator Trumbull
SUBJECT:	Long-term Managed Care Program
DATE:	April 20, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Favorable**
2.	Gerbrandt	Money	AHS	**Fav/CS**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1084 creates s. 409.9855, F.S., to establish a Medicaid long-term care managed care pilot program in certain counties to integrate health care services, long-term care services, and home and community-based services for persons with developmental disabilities. The pilot program will be available, on a volunteer basis, to Medicaid eligible individuals on the iBudget waitlist.

The bill is likely to have a significant negative fiscal impact. Neither the Agency for Health Care Administration (AHCA), which operates the state's Medicaid program, nor the Agency for Persons with Disabilities, which administers the iBudget Wavier, have submitted an estimate of the bill's potential fiscal impact. See Section V. of this analysis.

The bill takes effect upon becoming a law.

II. Present Situation:

The Florida Medicaid Program

Florida Medicaid is the health care safety net for low-income Floridians. The national Medicaid program is a partnership of federal and state governments established to provide coverage for health services for eligible persons. Florida's program is financed through state and federal funds.[1]

[1] Section 20.42, F.S.

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA).[2] This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare & Medicaid Services (CMS) and maintaining any Medicaid waivers needed to operate the Florida Medicaid program as directed by Florida Statute,[3] the General Appropriations Act (GAA), and other legislation accompanying the GAA.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request from CMS a formal waiver of the requirements codified in the SSA, which provides states flexibility in providing services not afforded through their Medicaid state plan.

Statewide Medicaid Managed Care

In Florida, a large majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[4] Other recipients who are not eligible for managed care, are not subject to mandatory managed care enrollment, or are not yet enrolled in a plan, are provided services directly from health care practitioners or facilities, and in those cases, providers are paid on a fee-for-service basis.

SMMC has three components:

- Managed Medical Assistance (MMA), under which the AHCA makes payments for primary and acute medical treatments and related services using a managed care model;
- Long-term Care Managed Care (LTCMC), under which the AHCA makes payments for long-term care, including home and community-based services, using a managed care model; and
- The Medicaid Prepaid Dental Health Program (Prepaid Dental), under which the AHCA makes payments for dental services for children and adults using a managed care model.

SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S. SMMC benefits cover primary, acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Section 409.973, F.S., specifies the minimum services that must be provided by managed care plans:

[2] Section 409.963, F.S.
[3] *See* parts III and IV of ch. 409, F.S.
[4] As of January 31, 2023, Florida Medicaid's total enrollment comprised 5,696,638 persons. Eighty-seven percent were enrolled in a Medicaid managed care plan. *See:* https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_202301.xls (last visited March 9, 2023).

Managed Care Plan Benefits[5]	
Advanced practice registered nurse services	Medical supplies, equipment, prostheses, and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Donor human milk bank services	Optometrist services
Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy services
Emergency services	Physician services, including physician assistant services
Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate	Podiatric services
Healthy start services, except as provided in s. 409.975(4)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

Florida Medicaid does not cover all low-income Floridians. Current eligibility prioritizes low-income children, disabled persons, and elders, and sets income eligibility by reference to the annual federal poverty level. For some groups, clinical eligibility provisions apply, as well.

The Florida Medicaid program covers:[6]

- More than 5.5 million low-income individuals, including approximately 2.5 million children, or 54 percent of the children in Florida;
- More than 54 percent of the births occurring in Florida in calendar year 2020; and
- More than 60 percent of the nursing home days in Florida.

Types of Comprehensive Medicaid Managed Care Plans

Comprehensive services in SMMC are managed by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations are usually health insurers or health maintenance organizations (HMOs). PSNs are managed care plans that are owned or are majority-controlled by health care providers, such as physician groups or hospitals.

[5] Section 409.973, F.S.
[6] Agency for Health Care Administration, Presentation to the Senate Health Policy Committee, Jan. 23, 2023.

All managed care plans in SMMC, including PSNs, are reimbursed as prepaid plans. That is, they are paid capitated rates (prospective, per-member, per-month payments) by the AHCA in advance for any particular month and are expected to provide medically necessary services to their respective members during that month, using the dollars within that month's capitation. Medically necessary services are required to be provided regardless of whether the capitation includes all the dollars necessary to provide those services.[7]

The AHCA contracts with managed care plans on a statewide and regional basis, in sufficient numbers to ensure choice. The cyclical Medicaid procurement process ensures plans offer competitive benefit designs and prices. In addition, plans compete for consumer choice. That is, while Medicaid requires a basic benefit package, and regulates the adequacy of plans' provider networks, plans can add to their benefit packages and offer provider networks attractive to Medicaid recipients when choosing a plan.

The AHCA began the next procurement process in 2022 for implementation in the 2025 plan year and released the re-procurement solicitation documents on April 11, 2023.[8]

Medicaid Long-Term Care

Federal Medicaid law establishes coverage for institutional care, such as nursing home care and residential institutions for people with developmental disabilities, but does not allow federal dollars to be spent on alternatives to such care. Those alternatives include home and community-based services designed to keep people in their homes and communities instead of going into an institution when they need higher levels of care. This federal spending limitation creates a bias toward institutional care, and toward acute care, rather than allowing the non-acute supports that prevent institutionalization.

Florida obtained federal waivers to allow the state Medicaid program to cover other kinds of long-term care services for elders and people with disabilities, to prevent admission into a nursing home. The Medicaid Long-term Care Waiver provides services to eligible individuals age 18 or older who need long-term services and supports, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. The Long-term Care Waiver is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community. Individuals in the program may also be served in a nursing facility setting. The Long-Term Care Waiver is a capitated, managed care program.

Section 409.98, F.S., specifies the non-institutional, often non-acute, long-term care benefits that must be provided by the long-term care managed care program:

[7] *See* s. 409.968(1) and (2), F.S.
[8] Agency for Health Care Administration, Presentation to the Senate Health Policy Committee, Jan. 23, 2023.

SMMC Long-Term Care Mandatory Benefits	
Services provided in an ALF	Physical therapy
Hospice services	Intermittent and skilled nursing
Adult day care	Medication administration
Personal care	Medication management
Home accessibility adaption	Nutritional assessment and risk reduction
Behavior management	Caregiver training
Home-delivered meals	Respite care
Case management	Personal emergency response system
Occupational therapy	Transportation
Speech therapy	Medical equipment and supplies
Respiratory therapy	Nursing Facility Care Services

Medicaid Home and Community-Based Waiver for Persons with Developmental Disabilities

Under federal law, fee-for-service Medicaid provides coverage for health care services to cure or ameliorate diseases. Generally, Medicaid does not cover services that will not cure or mitigate a medical diagnosis. However, people with developmental disabilities, while certainly requiring traditional medical services, need other kinds of services to maintain their independence and avoid institutionalization. Home and community-based services (HCBS) can be provided to assist people with developmental disabilities with activities of daily living which enables them to live in their homes or communities, rather than moving to a facility for care.

To obtain federal Medicaid funding for HCBS, Florida obtained a Medicaid waiver.[9] This allows coverage of non-medical services to avoid institutionalization and allows the state to limit the scope of the program to the number of enrollees deemed affordable by the state. In this way, the HCBS waiver is not an entitlement; it is a first-come, first-served, slot-limited program.

The HCBS waiver, known as iBudget Florida, serves eligible[10] persons with developmental disabilities. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[11]

The Agency for Persons with Disabilities (APD) administers the iBudget program with the stated purpose of:

[9] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[10] The HCBS waiver retains the Medicaid requirement that enrollees be low-income, but measures only the developmentally disabled person's income; not the income generated by the whole household.
[11] Section 393.063(12), F.S.

- Promoting and maintaining the health and welfare of eligible individuals with developmental disabilities.
- Providing medically necessary supports and services to delay or prevent institutionalization.
- Fostering the principles of self-determination as a foundation for services and supports.[12]

Section 393.066 (3), F.S., specifies that community-based services offered through the iBudget must include the following medically necessary services to prevent institutionalization:

Home and Community-Based Services[13]	
Adult Day Training	Respite Services
Family Care Services	Social Services
Guardian Advocate Referral Services	Physical, Occupational, Respiratory, and Speech Therapy
Medical/Dental Services	Supported Employment
Parent Training	Supported Living
Personal Care Services	Behavioral Services
Recreation	Transportations
Residential Facility Services	Residential Habilitation

Under the broad service categories specified in s. 393.066(3), F.S., the APD offers 26 supports and services delivered by contracted service providers to assist individuals to live in their own homes or the community.[14] These 26 services include:

- Adult day training.
- Behavioral analysis services.
- Behavior assistant services.
- Companion services.
- Consumable medical supplies.
- Dietician services.
- Durable medical equipment and supplies.
- Environmental accessibility and adaptations.
- Occupational therapy.
- Personal emergency response systems.
- Personal supports.
- Physical therapy.
- Prevocational service.
- Private duty nursing.
- Residential habilitation, including the following levels:
  - Standard level.
  - Behavior-focused level.
  - Intensive-behavior level.
  - Enhanced-intensive-behavior level.

[12] Agency for Health Care Administration, *Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook,* September 2021.
[13] Section 393.006(3), F.S.
[14] *Supra,* note 11.

- Residential nursing services.
- Respiratory therapy.
- Respite Care.
- Skilled Nursing.
- Specialized medical home care.
- Specialized mental health counseling.
- Speech therapy.
- Support coordination.
- Supported employment.
- Supported living coaching.
- Transportation.[15]

Currently, HCBS services are not integrated with Medicaid acute medical services, as those services are administered for iBudget enrollees by the AHCA, usually through the fee-for service model, not through SMMC. However, every iBudget enrollee receives case management services from a waiver support coordinator. Waiver support coordinators are responsible for identifying, coordinating, and accessing supports and services from all available funding sources for iBudget enrollees, including Medicaid state plan services.

Florida law requires that Medicaid be the payer of last resort for medically necessary supports and services,[16] and that iBudget enrollees use all available services authorized under the Medicaid state plan, school-based services, private insurance and other benefits, prior to using iBudget Waiver funds.[17] Therefore waiver support coordinators must first obtain supports and services from third party payers, other government or community programs, school-based programs, and natural supports.

Historically, despite the utilization management tools authorized by law and the entitlement flexibilities provided by the federal waiver, APD has frequently been unable to manage the iBudget program within the budget appropriated by the legislature, resulting in significant deficits[18] and surpluses.[19]

In 2019, the Legislature directed the APD to implement better monitoring and accounting procedures and to take corrective action when deficits are projected to develop. Additionally, APD was required to develop a plan to redesign the iBudget program if a deficit were to reoccur

[15] All providers must be in compliance with the provider qualifications as stated in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, September 2021, incorporated by reference in rule 59G-13.070, F.A.C. The handbook is available on the Agency for Health Care Administration's Web site at: http://ahca.myflorida.com/Medicaid/review/index.shtml, and at http://www.flrules.org/Gateway/reference.asp?No=Ref-13442 (last visited April 17, 2023).
[16] Section 409.910, F.S.
[17] 393.0662(3), F.S.
[18] For example, the legislature made retroactive general revenue appropriations to address APD deficits that occurred in Fiscal Year's 2017-2018 ($22.0 million), 2018-2019 ($41.2 million), and 2019-2020 ($50.8 million). *See*, the Fiscal Year 2019-2020 General Appropriations Act, section 30 and the Fiscal Year 2020-2021 General Appropriations Act, sections 29 and 30, respectively.
[19] The APD's historical deficits have been offset by more recent general revenue surpluses of $11.3 million, $1.0 million and $39.6 million in Fiscal Year's 2019-2020, 2020-2021, and 2021-2022, respectively. Data was retrieved from the Legislative Budgeting System.

in the 2018-2019 fiscal year.[20] The APD did generate a deficit that year and submitted a plan to address the budget shortfall that included the following recommendations:

- Include the iBudget Waiver in the Social Services Estimating Conference;
- Implement a behavioral health Intermediate Care Facility service rate;
- Implement individual caps for iBudget clients;
- Implement budget transfers from the Medicaid state plan to the iBudget waiver for clients turning 21;
- Expand the Medicaid Assistive Care Services program to include APD group homes;
- Centralize the significant additional needs process;
- Implement service limitations on Life Skills Development services; and
- Restructure support coordination services.[21]

In 2020, Senate Bill 82 was passed and addressed some of the recommendations from the APD's iBudget waiver redesign plan, specifically the bill:

- Centralized the significant additional needs process at APD headquarters; and
- Restructured support coordination services.[22]

For FY 2022-2023, the Legislature appropriated $1,871,531,214 to APD for the iBudget waiver program, of which $742,997,892 are state funds. [23] Currently, the program serves over 35,300 enrolled people.[24]

iBudget Waiver Waitlist

The APD maintains a waitlist of people who would like to enroll in the iBudget. Currently, the waitlist includes 22,535 people. About 660 of those receive other, limited, services from APD, and over 9,000 people on the waitlist are otherwise eligible for, and receive, Medicaid coverage for medical care. About 13,500 people on the waiver waitlist receive no APD or Medicaid services.[25]

As new funding becomes available, APD enrolls people from the waitlist in a statutory order of priority in seven categories:[26]

- Category 1 – Clients deemed to be in crisis.
- Category 2 – Specified children from the child welfare system.[27]

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[20] Chapter 2019-116, s. 26, Laws of Fla.
[21] Agency for Persons with Disabilities and Agency for Health Care Administration, 2019 iBudget Waiver Redesign, Sept. 30, 2019.
[22] Chapter 2020-71, Laws of Florida
[23] Chapter 2022-156, Laws of Fla., Specific Appropriation 245.
[24] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).
[25] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).
[26] Section 393.065(5), F.S.
[27] *See* s. 393.065(5)(b), F.S., for specific criteria.

- Category 3 – Includes, but is not limited to, clients:
  - Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;
  - Who are at substantial risk of incarceration or court commitment without supports;
  - Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or
  - Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.
- Category 4 – Includes, but is not limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available;
- Category 5 – Includes, but is not limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.
- Category 6 – Clients 21 years of age or older who do not meet the criteria for categories 1-5.
- Category 7 – Clients younger than 21 years of age who do not meet the criteria for categories 1-4.[28]

APD rarely moves beyond Category 1 (individuals experiencing a crisis) in enrolling people off the wait list. In Fiscal Years 2020-2021 and 2021-2022, for example, APD enrolled a total of 2,646 new enrollees in the waiver program. Of those, 1,841 (70%) were Category 1 enrollees.[29]

Medicaid Coverage for iBudget Enrollees

iBudget waiver benefits include Medicaid coverage for medical services, administered by the AHCA. The vast majority of full-coverage Medicaid recipients receive services through the SMMC managed care model, in which the recipient can choose from different health plans to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees – not a requirement. iBudget participants may opt to use the traditional fee-for-service model of service delivery.[30]

Medical services and HCBS are currently not integrated because they are provided by two different programs in two different state agencies.

[28] Section 393.065(5), F.S.
[29] Of the 2,646 new enrollees, 182 were in Category 2 (children aging out of the child welfare system); the remainder were in special categories authorized by the legislature to jump the queue (military dependents, people with Phelan-McDermid Syndrome, and people in ICFs or nursing facilities), *see* s. 393.064(6), (7), F.S. *See*, Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).
[30] Section 409.972(1)(e), F.S.

Person-Centered Planning

Currently, all iBudget recipients are required to receive case management and person-centered planning.[31] A person-centered service plan reflects the services and supports that are important to the individual in meeting their long-term goals, and the preferences for the delivery of such services and supports.

HCBS and Managed Care Models

Some states use managed care models for HCBS for persons with developmental disabilities, in varying forms.

Iowa and Kansas use a long-term care managed care model to provide developmental disability services. These states use a single, risk-bearing, managed care plan to coordinate all services for this population, including primary care, acute care, behavioral health, and long-term care services. Tennessee takes a similar approach, but its managed care plans do not bear risk.[32]

New York obtained a federal waiver to transition the Medicaid developmental disability population into managed care based on a phased-in model, beginning with integrated care coordination under a single, comprehensive plan. In addition, New York operates a service delivery model that fully integrates with Medicare coverage, for persons eligible for both programs, offering primary, acute, long-term care, and habilitation services.[33]

Using managed care for the developmental disability population requires careful adaptation of acute care models to address factors that differentiate this population from a typical long-term care population. These factors include: the longer length of time individuals will require these services, often for a lifetime; the role of community services and supports and the need to integrate them into the model; and the unique developmental disability provider community, composed of smaller organizations exclusively dependent on government funding and inexperienced at navigating a managed care environment; among other differentiating factors.[34]

Florida does not use a risk-based managed care model for HCBS services, and the Medicaid managed care model is rarely used by iBudget enrollees. Medicaid acute care services and HCBS services are not integrated, or coordinated, by any single entity for individual enrollees.

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[31] 42 C.F.R. 441.301(c)(1)

[32] National Association of States United for Aging and Disabilities, MLTSS Institute, "MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success (2018), available at: http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success_0.pdf (last viewed Mar. 24, 2023).

[33] Center for Health Care Strategies, "Enrolling Individuals in Intellectual/Developmental Disabilities in Managed Care: A strategy for Strengthening Long-Term Services and Supports", March 2019, available at: https://www.chcs.org/media/Integration-Strategy-3-Strengthening-LTSS-Toolkit_032019.pdf (last viewed March 24, 2023).

[34] *Id.*

III. Effect of Proposed Changes:

Managed Care Pilot Program for Individuals with Developmental Disabilities

CS/SB 1084 creates s. 409.9855, F.S., to establish a Medicaid managed care pilot program to provide comprehensive, integrated medical, long-term, and home and community-based services to individuals with developmental disabilities. The pilot program will operate in Hardee, Highlands, Hillsborough, Manatee, Polk, Miami-Dade and Monroe counties (Medicaid regions D and I). The Agency for Health Care Administration (AHCA) is required to seek federal approval to implement the pilot program by September 1, 2023.

Under the pilot program the AHCA is responsible for the following:
- Seeking federal authority to amend the Medicaid state plan to implement the pilot program;
- Adopting rules necessary to comply with any federal requirements related to the pilot program and implementation of the pilot program;[35]
- Negotiating with and selecting qualified plans to participate in the pilot program;
- Ensuring that the rate setting methodology is inclusive of the intent to provide individualized, quality care in the least restrictive setting;
- Making payments for services under the pilot program;
- Ensuring minimum contract standards are met, including, but not limited to, data collection, access, quality care, complaint resolution, claims payment, and transparency;[36]
- Evaluating the feasibility of statewide implementation of the capitated managed care model used by the pilot program to serve individuals with developmental disabilities; and
- Delegating specific duties to the Agency for Persons with Disabilities (APD).

Under the pilot program the APD is responsible for the following:
- Being a part of the negotiating team that selects plans to participate in the pilot program;
- Conducting an initial needs assessment to determine the level of functional, behavioral, and physical needs of the prospective participant;
- Making enrollment offers;
- Ensuring services are provided in accordance with an individualized care plan;
- Ensuring the capitation rate setting methodology is inclusive of the intent to provide individualized, quality care in the least restrictive setting;
- Auditing selected plans implementation of person-centered planning;
- Providing progress reports on implementation of the pilot program, and annual reports on operation of the pilot program; and
- Evaluating specific measures of access, quality, and costs of the pilot program.

Participant Eligibility

Participation in the pilot program is limited to the maximum number of enrollees specified in the General Appropriations Act, if any. The APD is required to make enrollment offers and to ensure

[35] The bill specifies, that unless otherwise stated ss. 409.961-409.969, F.S., apply to the pilot program. As such, s. 409.961, F.S., authorizes the ACHA to adopt rules as necessary to comply with federal requirements and administer the Medicaid Managed Care Program.
[36] The bill specifies, that unless otherwise stated ss. 409.961-409.969, F.S., apply to the pilot program. As such, s. 409.967(2), F.S., requires the AHCA to establish minimum contract requirements.

that enrollment is sufficiently diverse to conduct a statistically valid evaluation of the pilot program within three years. The pilot program will be available, on a volunteer basis, to Medicaid eligible individuals who:

- Are 21 years of age or older;
- Have been assigned to category 3, 4, 5 or 6 on the iBudget waitlist; and
- Reside in a pilot program region.

Pilot Program Benefits

The plans participating in the pilot program must, at a minimum, provide the following services through a single, integrated model of care:

- Medical care benefits described in s. 409.973, F.S., including access to prepaid dental plans;
- Long-term care benefits described in s. 409.98, F.S.;
- Home and community-based services described in 393.066, F.S.; and
- Services currently listed in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, and prevocational services.

Services must be provided in accordance with an individualized care plan that is evaluated and updated as warranted by changes in a participant's circumstances. Natural and community services and supports must be utilized prior utilization of state resources.

All service providers of home and community-based services under the pilot program must meet the same provider qualifications as service providers under the iBudget waiver. The iBudget waiver service provider qualifications are outlined in the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.[37]

Plan Eligibility and Selection

For a plan to be selected to participate in the pilot program, the plan must have been awarded a contract as a result of the invitation to negotiate, ITN-04836, for Statewide Medicaid Managed Care Program which was issued on April 11, 2023. The AHCA must select one plan for each region of the pilot program.

The AHCA must select the plans, with which they will negotiate, based on specific criteria that must include, but is not limited to, the following:

- Experience serving similar populations and achieving specific quality standards.
- Establishment of provider partnerships that create opportunities for re-investment in community-based services;
- Provision of additional benefits including behavioral health services, coordinated dental care, and mental health therapy and analysis;
- Evidence of established relationships with providers;
- Experience in the provision of person-centered planning; and
- Experience in provider development program that result in increased availability of providers to serve individuals with developmental disabilities.

[37] *See*, Rule 59G-13.070, F.A.C.

The APD is required to be a part of the negotiating team. After negotiations are complete preference will be given to plans that:

- Have signed contracts in sufficient numbers to meet the access standards specified in s. 409.967, F.S., including contracts for personal supports, skilled nursing, residential habilitation, adult day training, mental health services, respite car, companion services, and supported employment;
- Have well-defined programs for recognizing patient-centered medical homes, and providing increased compensation to recognized medical homes;
- Have well-defined programs related to person-centered planning; and
- Have robust and innovative provider development programs.

Plan Accountability

Managed care plans participating in the pilot program must meet the accountability measures required by ss. 409.967, 409.975, and 409.982, F.S. The bill requires the AHCA to include the same accountability measures required of managed care plans, in its contract with participating plans that are selected to participate in the pilot program. These measures include, but are not limited to, the following:

- Participation in the achieved savings rebate program;[38]
- Performance measures related to access, quality care, grievance resolution, prompt payment, and transparency, among others;[39]
- Compliance with the AHCA's reporting requirements;[40]
- Development and maintenance of adequate provider networks;[41]
- Establishment of provider quality and performance monitoring;[42]
- Development of negotiated, mutually acceptable provider rates and terms of payment;[43] and
- Specific standards for the number, type, and distribution of providers in the plan's network, as developed by the AHCA.[44]

In addition, the bill requires the plans must have provider capacity within a maximum travel distance of 15 miles for urban areas and 30 miles for rural areas, for the provision of specialized therapies, adult day training, and prevocational training.

Plans must consult with the APD prior to placing a pilot program participant in a facility licensed by the APD.

Plan Payment

The plans will receive an actuarially sound capitated per-member, per-month payment. The bill requires the rate-setting methodology used to develop the capitated rate to reflect the intent to provide individualized, quality care in the least-restrictive setting.

[38] The achieved savings rebate program requires plans to share savings with the state, and authorizes plans to retain statutorily-defined portions of savings, some increments of which are tied to achieving AHCA-defined quality measures. Section 409.967(3)(f), F.S.
[39] Section 409.967, F.S.
[40] Section 409.973(2)(e), F.S.
[41] Section 409.975 (1), F.S.

The AHCA must include in the dental capitation-rate-setting methodology for the prepaid dental health program the inclusion of serving individuals with developmental disabilities.

Pilot Program Reporting and Evaluation

The bill requires the AHCA to evaluate the feasibility of statewide implementation of the capitated managed care model used by the pilot program.

Upon implementation of the pilot program, the bill authorizes the APD to conduct audits of the plan's implementation of person-centered planning and quality assurance monitoring. Quality assurance monitoring must include client satisfaction with services, health and safety outcomes, well-being outcomes, and service delivery in accordance with the client's care plan.

Additionally, the APD, in consultation with the AHCA, must submit the following reports:

- By December 31, 2023, a report on the progress made toward federal approval of the pilot program.
- By December 1, 2024, a report on the progress made toward full implementation of the pilot program.
- By December 1, 2025, and annually thereafter, a report on the operation of the pilot program, including, but not limited to, the following:
  - Program enrollment data;
  - Any complaints received; and
  - Access to approved services.
- By October 1, 2029, an evaluation of the pilot program, including, but not limited to, the following:
  - Specific measures of access, quality, and costs;
  - Assessments of cost savings;
  - Consumer education, choice, and access to services;
  - Plans for future capacity and the enrollment of new Medicaid providers;
  - Coordination of care;
  - Person-centered planning, and person-centered well-being outcomes;
  - Health and quality-of-life outcomes;
  - Quality of care; and
  - Any barriers to implementation and operation of the pilot program.

The evaluation required by the bill must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2029.

The pilot program is repealed on October 2, 2029, after the submission of the program evaluation, unless reviewed and saved from repeal by the Legislature.

The bill authorizes the APD to develop rules to establish a process to enroll pilot program participants onto the iBudget waiver upon the cessation of the pilot program.

[42] Section 409.975(3), F.S.
[43] Section 409.975(6), F.S.
[44] Section 409.982(4)

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons who enroll in the pilot will experience an increase in home and community-based services.

An organization awarded a contract under the pilot program will benefit financially from the bill's implementation, if that organization is able to successfully manage services rendered to program participants. The Agency for Health Care Administration (AHCA) has not provided an analysis of the bill; therefore, the number of managed care organizations, if any, who currently meet the bill's qualifications, or could potentially be created to meet those qualifications, is unknown.

C. Government Sector Impact:

The bill will have a significant negative fiscal impact on state expenditures. The pilot program limits participation to the maximum number of enrollees specified in the General Appropriations Act.

Currently, House Bill 5001, the House proposed General Appropriations Act for Fiscal Year 2023-2024, provides that AHCA may request budget authority associated with the enrollment of up to 600 individuals who are currently on the iBudget waiting list and who voluntarily choose to participate in the pilot program.

The Agency for Persons with Disabilities estimates the average annual cost for a non-crisis enrollee on the iBudget Waiver is $53,136. Therefore, the estimated cost to provide home and community-based services to 600 individuals who are on the waitlist, and who are not in crisis, is $31.8 million ($12.9 million GR; $18.9 million TF).[45]

The bill will likely have an indeterminate yet negative fiscal impact on both the AHCA and the APD due to the responsibilities required of both agencies under the bill. However, the fiscal impact is likely to be realized in Fiscal Year 2024-2025 when contracts are awarded and implementation of the pilot program begins.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.981 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Appropriations Committee on Health and Human Services on April 18, 2023:
The committee substitute:

- Requires the AHCA to submit a request for federal approval to provide a managed care service delivery system for providing medical, long-term, home and community-based services to individuals with developmental disabilities, by September 1, 2023.
- Requires that the AHCA to delegate specific duties and responsibilities to the Agency for Persons with Disabilities (APD).
- Expands the pilot program from only Miami-Dade County, to Medicaid regions D and I, which include Hardee, Highlands, Hillsborough, Manatee, Polk, Miami-Dade and Monroe counties.
- Expands the list of services that must be provided to include all of the 27 services currently provided by the APD through the iBudget waiver.

[45] This estimate excludes medical costs provided to people with developmental disabilities currently covered by Medicaid.

- Requires that home and community-based service providers under the pilot program to meet the same provider qualifications currently required of providers under the iBudget waiver.
- Requires the maximization of natural and community supports prior to the utilization of state resources.
- Requires the APD to conduct an initial needs assessment to determine an individual's level of need.
- Specifies participant eligibility, to include individuals who are 21 years of age or older, who are currently in certain categories on the waitlist, and who reside in the pilot areas.
- Requires the APD to make pilot program enrollment offers, under certain circumstances and to a specified population, to ensure a statistically valid test of the pilot program can be conducted within 3 years.
- Expands the types of entities that may be awarded a contract to implement the pilot program to include any plan that is awarded a contract to provide long-term care services under the AHCA's Statewide Medicaid Managed Care invitation to negotiate, which was released on April 11, 2023. The underlying bill limited the type of plan that could be awarded a contract to only a provider service network.
- Requires the selected plans to meet additional criteria, including:
  - Provider capacity within a certain distance for the provision of certain services;
  - Experience serving similar populations and achieving specific quality standards;
  - Establishment of provider partnerships that create opportunities for re-investment in community-based services;
  - Provision of additional benefits including behavioral health services, coordinated dental care, and mental health therapies;
  - Evidence of established relationships with providers;
  - Experience in the provision of person-centered planning; and
  - Experience in provider development program that result in increased availability of providers to serve individuals with developmental disabilities.
- Authorizes the AHCA to give preference in awarding contracts to plans that meet the following additional criteria:
  - Have a sufficient amount of signed contracts for the provision of certain home and community-based services;
  - Have well-defined programs for recognizing patient-centered medical homes, such as those that serve people with intensive behaviors, and providing increased compensation to recognized medical homes;
  - Have well-defined programs related to person-centered planning; and
  - Have robust provider development programs.
- Authorizes the AHCA to pay selected plans a capitated per-member, per-month payment based on a new actuarially sound rate-setting methodology specific to providing developmentally disabled individuals with individualized, quality care in the least restrictive setting. The underlying bill was less specific only requiring that the plan be paid a risk-adjusted capitation rate.
- Requires the AHCA to include the inclusion of serving individuals with developmental disabilities in the dental-capitation-rate-setting methodology.

- Authorizes the APD to conduct audits of the plan's implementation of person-centered planning and quality assurance monitoring of the pilot program.
- Requires the APD to submit a report on progress made toward federal approval and implementation of the pilot program, by certain dates.
- Requires the APD to submit a report by December 31, 2025 and annually thereafter, on the operation of the pilot program.
- Requires the APD and the AHCA, to conduct an evaluation of the pilot program and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2029.
- Repeals the pilot program after October 2, 2029, unless reviewed and saved from repeal by the Legislature.
- Authorizes the APD to develop rules to establish a process to enroll pilot program participants onto the iBudget waiver upon the cessation of the pilot program.

B. Amendments:

None.