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 Committee on Health Policy

BILL:	CS/SB 682
INTRODUCER:	Health Policy Committee and Senator Stargel
SUBJECT:	Medicaid Managed Care
DATE:	March 29, 2017
REVISED:	3/29/2017

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 682 exempts from the Long-Term Care component (LTC) of the Statewide Medicaid Managed Care (SMMC) program those Medicaid recipients who have resided in a nursing facility for 60 or more consecutive days, with certain exceptions. The bill also exempts those recipients in the LTC component who are receiving hospice care while residing in a nursing facility. These recipients would receive long-term care services through fee-for-service Medicaid providers and other medical services through the managed medical assistance component (MMA) of the SMMC program. This section of the bill is effective October 1, 2018.

The bill provides that a nursing home resident would not be exempt from the LTC component if the resident has been identified as a candidate for home and community-based services (HCBS) by specified individuals. The agency must confirm whether an individual has been identified as a candidate for HCBS before determining that a person is exempt from the LTC component. The bill provides notice provisions should the nursing resident later be identified as a candidate for HCBS services. The additional exceptions apply to a Medicaid recipient who is aged 18 or older and eligible for Medicaid by reason of a disability or a person who has priority enrollment for home and community-based services.

Effective July 1, 2017, the bill requires the Agency for Health Care Administration (AHCA) to impose fines and authorizes other sanctions for willful violations with the prompt pay provisions of ss. 641.315, 641.3155, 641.513, and 409.982(5), F.S.

Managed care plans must also contract with all nursing homes and hospices that meet credentialing and re-credentialing requirements as specified in the plan's contract with the AHCA for the first 12 months following a procurement in any regions where a plan is awarded a contract and that region was not previously served by that plan during the most recent procurement period. If a plan excludes a nursing home or hospice for the remainder of the contract period, the AHCA must require the plan to submit the performance and quality criteria that was used to exclude the provider and to demonstrate how the provider failed to meet the plan's criteria.

Obsolete language is removed from the bill relating to the submission of the original SMMC waiver.

The AHCA has not provided a revised fiscal analysis reflecting the changes in CS/SB 682.

Except as otherwise provided, the bill is effective upon becoming law.

II. Present Situation:

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid serves as the safety net to Florida's healthcare delivery system. Medicaid currently is the second largest expenditure in Florida's budget behind education with estimated expenditures for the 2016-2017 state fiscal year of $25.8 billion[1]and covers 20 percent of all Floridians. Over 4 million Floridians are currently enrolled in Medicaid, including:

- 47 percent of Florida's children;
- 63 percent of Florida's births; and
- 61 percent of Florida's nursing home days.[2]

However, 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).

[1] Office of Economic and Demographic Research, Social Services Estimating Conference, Medicaid Caseload and Expenditures (February 17, February 27, and March 9, 2017) Executive Summary, http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited Mar. 21, 2017).
[2] Agency for Health Care Admin., Senate Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), slide 2, http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last visited Mar. 17, 2017).

Florida's Current Medicaid and CHIP Eligibility Levels in Florida[3] (With Income Disregards and Modified Adjusted Gross Income)						
Children's Medicaid			**CHIP (Kidcare)**	**Pregnant Women**	**Parents**	**Childless Adults**
Age 0-1	Age 1-5	Age 6-18	Ages 0-18			
206% FPL	140% FPL	133% FPL	210% FPL	191% FPL	31% FPL	0% FPL

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. As the single state agency, the AHCA has the lead responsibility for the overall program.[4]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures also varies and is largely determined by the federal government. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits are provided in statute under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

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]

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[7] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[8] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic and Treatment services, which are those health care and diagnostic services and treatment and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services, consistent with federal law.[9]

Waivers to the state plan may be requested and negotiated by the state through the federal Centers for Medicare and Medicaid Services (CMS) by the AHCA. Florida has several such Medicaid waivers, including one which implemented the SMMC program. Current federal law requires the state to obtain a waiver to implement managed care. Through these waivers, the

[3] 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 Mar. 17, 2017).
[4] *See* s. 409.963, F.S.
[5] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 4 (April 2016) http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last visited Mar. 21, 2017).
[6] Id.
[7] Section 409.905, F.S.
[8] Section 409.906, F.S.
[9] *See* Section 1905 9(r) of the Social Security Act.

states have limited flexibility to design their Medicaid programs; however, even within waiver authorities, federal regulations prescribe requirements for benefits, delivery systems, cost sharing limitations, and population coverages.

Statewide Medicaid Managed Care (SMMC)

The SMMC program is designed for the AHCA to issue invitations to negotiate and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid 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.[10]

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the SMMC program. The LTC component began enrolling in August 2013, and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014, and finished its roll-out in August 2014.

Services are delivered through six managed care plans which vary based on the recipient's region; however, each region has at least two plans. Plans are paid on a capitated basis meaning that a LTC plan must pay for all covered services under the contract regardless of whether the capitated rate covers the cost of services for that recipient. For nursing facilities and hospices, the plans are required to pay those designated providers a rate set by the AHCA.

Of those recipients enrolled in the LTC waiver, more than half or 47,465 recipients are receiving home and community based services (HCBS) as of February 1, 2017. The remaining enrollees are receiving nursing facility services.[11]

Statewide Medicaid Managed Care - February 1, 2017			
Component	**Enrollment Start Date**	**Budget[12]**	**Enrollment[13] *(as of Feb. 2017)***
Long-Term Care Plan	August 2013	$3.97 billion	94,844
Home & Community Based Services			*47,465[14]*
Managed Medical Assistance	May 2014	$14.4 billion	3,237,296

[10] The current Managed Medical Assistance waiver is approved as an 1115 waiver and was last approved for the time period of 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.
[11] Agency for Health Care Admin., *Senate Bill 682 Analysis* (Feb. 13, 2017), pg. 2, (on file with the Senate Committee on Health Policy).
[12] Agency for Health Care Admin., *Statewide Medicaid Managed Care (Presentation to House Health and Human Services Committee - Jan. 10, 2017)*, slide 2, http://ahca.myflorida.com/medicaid/recent_presentations/House_Health_Human_Services_Med_101_2017-01-10.pdf (last visited Mar. 1, 2017).
[13] Agency for Health Care Admin., *SMMC MMA Enrollment by County by Plan* (as of February 1, 2017), *http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml* (last visited Mar. 1, 2017).
[14] Agency for Health Care Admin., *Senate Bill 682 Analysis* (Feb. 13, 2017), pg. 2, (on file with Senate Committee on Health Policy).

The LTC program provides services in two settings: nursing facilities or HCBS such as a recipient's home, an assisted living facility, or an adult family care home. Nursing facility services are an entitlement program for eligible enrollees and no waitlist exists; however, HCBS are delivered through waivers and are dependent on the availability of annual funding in the General Appropriations Act (GAA).

Enrollment in the HCBS portion of LTC is managed based on a priority system and wait list. For the 2016-2017 waiver year, the state is approved for 62,500 unduplicated recipients in the HCBS portion of the program.[15] In order to be eligible for the program, a recipient must be both clinically eligible as required under s. 409.979, F.S., and financially eligible for Medicaid.

Eligibility and Enrollment

The AHCA is the single state agency for Medicaid; however, through an interagency agreement with the Department of Elderly Affairs (DOEA), the DOEA is Florida's federally mandated pre-admission screening program for nursing home applicants through its Long-Term Care Services (CARES) program, including for LTC.[16] The CARES program has 18 field offices across the state which are staffed with physicians, nurses, and other health care professionals who evaluate the level of care an individual may or may not need. The frailty-based assessment results in a priority score for an individual, who is then placed on the wait list based on his or her priority score.

To receive nursing facility care, an individual must also be determined to meet the requirements of s. 409.985(3), F.S. This subsection requires:

> The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4), F.S. When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:
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> (a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment,

[15] 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 (December 19, 2016), http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Approval_Letter_2016-12-19.pdf (last visited Mar. 1, 2017).

[16] Florida Dep't of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, http://elderaffairs.state.fl.us/doea/cares.php (last visited Mar. 1, 2017).

planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

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.[17] 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 priority enrollment into the HCBS portion of the program. Exemptions from the wait list also exist under s. 409.979(3)(f), F.S. Those exempted individuals include:

- Persons who are 18, 19, or 20 years of age who have a chronic, debilitating disease or condition of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision, or intervention;
- Nursing facility residents who request to transition into the community and who have resided in a Florida-licensed skilled nursing facility for at least 60-consecutive days; or
- Persons referred by the DCF pursuant to the Adult Protective Services, ss. 415.101-415.113, F.S., as high risk and who are placed in an assisted living facility temporarily funded by the DCF.

Before being released from the waitlist, however, individuals must meet the following eligibility requirements to enroll in the program:[18]

- Be age 65 years or older or age 18 and eligible for Medicaid by reason of a disability; and
- Be determined by the CARES preadmission screening program to require nursing facility care as defined in s. 409.985(3), F.S.

Some individuals who are enrolled in waiver programs or other coverages may enroll in the LTC program, but are not required to, and those are:

- Developmental Disabilities waiver program;
- Traumatic Brain and Spinal Cord Injury waiver;

[17] *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).
[18] *See* s. 409.979, F.S.

- Project AIDS Care (PAC) waiver;
- Adult Cystic Fibrosis waiver;
- Program of All-Inclusive Care for the Elderly (PACE);
- Familial Dysautonomia waiver;
- Model waiver; or
- Other creditable coverage excluding Medicare.[19]

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.[20]

Delivery System and Benefits

The AHCA conducted a competitive procurement to select LTC plans in each of the 11 regions in 2012. Contracts were awarded to health maintenance organizations (HMOs) and provider service networks (PSNs). Six non-specialty plans are currently contracted, including one PSN that is available in all 11 regions and one HMO that is in 10 regions. Recipients receive choice counseling services to assist them in selecting the plan that will best meet their needs.

Each plan under LTC is required to provide a minimum level of services. These services include:

- Adult companion care;
- Adult day health care;
- Assisted living;
- Assistive care services;
- Attendant care;
- Behavioral management;
- Care coordination and case management;
- Caregiver training;
- Home accessibility training;
- Home-delivered meals;
- Homemaker;
- Hospice;
- Intermittent and skilled nursing;
- Medical equipment and supplies;
- Medication administration;
- Medicaid management;
- Nursing facility;
- Nutritional assessment/risk reduction;
- Personal care;
- Personal emergency response system;
- Respite care;

[19] *See* s. 409.972, F.S.
[20] 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 Mar. 1, 2017).

- Therapies; and
- Non-emergency transportation.[21]

An LTC plan may elect to offer expanded benefits to its enrollees. Some of the approved expanded benefits within LTC include:

- Cellular phone service;
- Dental services;
- Emergency financial assistance;
- Hearing evaluation;
- Mobile personal emergency response system;
- Non-medical transportation;
- Over-the-counter medication and supplies;
- Support to transition out of a nursing facility;
- Vision services; and
- Wellness grocery discount.[22]

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 choose the same managed care plan for both components, known as a comprehensive plan.

The AHCA's contract with the LTC plans include a statutorily required incentive payment adjustment to encourage increased utilization of HCBS services and a matching reduction in nursing facility placements. The incentive adjustment must be modified in each successive rate period in accordance with s. 409.983, F.S., as follows:

> (5) The agency shall make an incentive adjustment in payment rates to encourage the increased utilization of home and community-based services and commensurate reduction of institutional placement. The incentive adjustment shall be modified in each successive rate period during the first contract period, as follows:
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> (a) A 2-percentage point shift in the first rating-setting period;
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> (b) A 2-percentage point shift in the second rate-setting period, as compared to the utilization mix at the end of the first rate-setting period; or
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> (c) A 3-percentage point shift in the third rate-setting period, and in each successive rate setting period during the first contract period, as compared to the utilization mix at the end of the immediately preceding rate-setting period.
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> The incentive adjustment shall continue in subsequent contract periods, at a rate of three percentage points per contract year as compared to the utilization mix at the end of the immediately preceding rate-setting period, until no more than 35 percent of the plan's enrollees' are placed in institutional settings. The agency shall annually report to the Legislature the actual change in the utilization mix of home and community-based services

[21] *See* s. 409.98, F.S.

[22] Agency for Health Care Administration, MMA - Model Contract - Attachment I - Scope of Services (effective date Feb. 1, 2017) pp. 4-6, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_MODEL_Attachment_I-Scope_of_Services.pdf (last visited Feb. 1, 2017).

compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.

During the first year of the LTC program, the AHCA reports a 12.1 percent decrease in the number of Medicaid recipients residing in a nursing facility.[23]

Reprocurement of the SMMC Contracts

The AHCA has started the process for the re-procurement of the managed care contracts for the SMMC program. The contracts were initially procured in 2012 and became effective in 2013 as 5-year contracts. An invitation to negotiate (ITN) will be released in the summer of 2017.[24] The AHCA posted a request to receive non-binding Letters of Intent to Bid on its website with a deadline of February 13, 2017. The AHCA received 41 total responses from interested providers and plans for the ITN.[25] The databook will be posted to AHCA's website on March 30, 2017, and a public meeting to review the databook with the AHCA's contracted actuary is scheduled for April 12, 2017.

American with Disabilities Act

In June of 2009, the United States Supreme Court held that public entities must provide community-based services to persons with disabilities when such services would be appropriate; when affected persons are not opposed to such treatments; and when such services can be reasonably accommodated. To not provide the opportunity for persons with disabilities to receive services in the community constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA).[26]

The *Olmstead* decision is further supported through federal regulation which states:

> No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any public entity.[27]

The Department of Justice's (DOJ) Civil Rights Division has conducted more than 40 *Olmstead* review cases in 25 states from 2009 to 2012, including cases in Florida.[28] Intervention from the DOJ may come through two different forms: A statement of interest where the DOJ intervenes in

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[23] Agency for Health Care Adm., *Senate Bill 682 Analysis* (Feb. 13, 2017) (on file with Senate Committee on Health Policy).
[24] Agency for Health Care Administration, *AHCA Announces Start of Re-Procurement Process for Statewide Medicaid Managed Care Program* (Feb. 3, 2017) http://ahca.myflorida.com/Executive/Communications/Press_Releases/pdf/ReprocurementPressRelease.pdf (last visited: Mar. 21, 2017).
[25] 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*, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Intent_to_Bid_Responses.pdf (last visited Mar. 21, 2017).
[26] Olmstead v. L.C., 527 U.S. 581(1999);138 F.3d 893, affirm in part, vacated, and remanded.
[27] 28 CFR section 35.130(a) (2016).
[28] MaryBeth Musumeci and Henry Claypool, KFF.org, *Olmstead's Role in Community Integration for People with Disabilities under Medicaid: 15 Years after the Supreme Court's Olmstead's Decision* (June 18, 2014) http://kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief (last visited Mar. 3, 2017).

an existing lawsuit, but is not a party, or secondly, the DOJ investigates allegations and issues a letter of findings and a settlement agreement. A DOJ investigation or intervention may also result in litigation to enforce a mandate.[29]

In July 2013, the federal DOJ filed a lawsuit against the State of Florida alleging that the state had failed to move nearly 200 disabled children from nursing homes and institutional care to less restrictive environments in violation of the ADA.[30] The complaint included other allegations relating to the state's policies, procedures, reimbursement levels, method of service denials, and network capacity issues in its programs for children with significant medical needs.

A previous December 2011, investigation by the DOJ is detailed in the complaint, including notice that the parties met on several occasions to attempt resolution of the issues.[31] The DOJ complaint sought a declaratory judgement that the state had violated Title II of the ADA, to award compensatory damages, and any other relief as the court may find appropriate.[32] The case has been consolidated with a private lawsuit against the state alleging similar issues, that the state's practices and policies have unnecessarily placed children with disabilities in nursing facilities or placed them at risk of placement in nursing facilities.[33] Litigation may also be brought by individuals to enforce a mandate.

The state has disputed the allegations in the DOJ complaint and argued that with the implementation of managed care and other policy changes in Medicaid, these issues are moot. The court has rejected these arguments thus far. Florida has most recently sought partial summary judgement to remove monetary damages as a legal remedy.[34]

Guidance from the federal CMS stresses that all waiver programs for long-term care support programs, such as LTC, "must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation."[35] Consistency with the *Olmstead* decision is found in every "essential element" of the guidance document.

The CMS guidance document also indicates that states will be expected to incorporate all services into the managed care plan capitation payment and that any exemptions will require comprehensive justification of how the goals of integration, efficiency and improved health and

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[29] *Id.*
[30] *U.S. v. Florida*, No. 12-CV-60460, (SD. Fla., filed July 22, 2013).
[31] *U.S. v. Florida*, No. 12-CV-60460, (SD. Fla., filed July 22, 2013), 21.
[32] *Id.* at 23.
[33] U.S. Dep't of Justice, *Americans with Disabilities Act - Olmstead Enforcement,* https://www.ada.gov/olmstead/olmstead_cases_list2.htm#fla (last visited Mar. 3, 2017); *see A.R. v. Dudek,* No. 12-CV 60460 (S.D. Fla. 2012).
[34] U.S. Dep't of Justice, *Americans with Disabilities Act - Olmstead Enforcement,* https://www.ada.gov/olmstead/olmstead_cases_list2.htm#fla (last visited Mar. 3, 2017).
[35] Centers for Medicare and Medicaid Services, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (5/20/13), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf, p. 8, (last visited Mar. 3, 2017).

quality of life will be achieved.[36] Exclusion of any services will require routine re-assessment to ensure no violations of any federal laws, including the ADA or *Olmstead* requirements.[37]

Prompt Payment of Claims

Florida's prompt pay laws govern payment claims submitted to insurers and HMOs, including Medicaid managed care plans in accordance with ss. 641.315, 641.3155, and 641.513, F.S.[38] These provisions establish HMO provider contract requirements, prompt payment guidelines for provider payments, and requirements for the provision of emergency services and care for HMO enrollees. An HMO or insurer 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., or ch. 459, F.S., (physicians), 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, and a 40-day timeline for providers to pay, deny, or contest the claim for overpayment.[39] 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. The statutes do not include any provisions for the imposition of fines for non-compliance; however, the AHCA enforces these standards through the imposition of liquidated damages or sanctions, including fines.[40]

III. Effect of Proposed Changes:

Section 1 amends s. 400.141, F.S., effective October 1, 2018, to add a requirement for nursing home facilities to confirm for the AHCA whether a nursing home facility resident who is a Medicaid recipient, or whose Medicaid eligibility is pending, is a candidate for home and community-based services (HCBS) under s. 409.965(3)(c), not later than the resident's 50th consecutive day of residency in the nursing home facility. The nursing home facility's notice to the AHCA is to assist in the identification of nursing home residents who may be eligible for both HCBS and the LTC component.

Section 2 amends s. 409.964, F.S., to remove obsolete dates relating to the submission of state plan amendments or waivers by a date certain, all of which have passed.

Section 3 amends s. 409.965, F.S., to create a new exemption from mandatory enrollment in the LTC program. Effective October 1, 2018, the bill exempts persons who are assigned into level of care 1 under s. 409.983(4), F.S., and have resided in a nursing facility for 60 or more consecutive days. The exemption shall become effective on the first day of the first month after the person

[36] *Id.* at 12.
[37] *Id.*
[38] 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.
[39] Section 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.
[40] Agency for Health Care Administration, *Senate Bill 682 Analysis* (Feb. 2, 2017), p. 6, (on file with the Senate Committee on Health Policy).

meets the criteria for the exemption. An exemption under this section has no bearing on an individual's eligibility for the MMA program.

An exemption from mandatory participation in LTC program is also created for recipients receiving hospice care while residing in a nursing facility. The exemption shall become effective on the first day of the first month after the person meets the criteria for the exemption. An exemption under this section has no bearing on an individual's eligibility for the MMA program.

The effect of these exemptions is that nursing homes and hospices will be paid on a fee-for-service basis from the AHCA for these Medicaid recipients rather than receiving payment from the managed care plans.

Notwithstanding the exemptions provided above, the agency shall authorize the enrollment or continued enrollment of a Medicaid recipient in or into the LTC program who:

- Is eligible for the LTC program under s. 409.979, F.S., is 18 years of age or older, and is eligible for Medicaid by reason of disability;
- A person who is given priority enrollment for HCBS under s. 409.979(3)(f), F.S., or
- A person who has been identified as a candidate for HCBS by the nursing facility administrator and any long-term care plan case manager assigned to the resident.

The identification of the resident as a candidate for HCBS must be made in consultation with:

- The resident or the resident's legal representative or designee;
- The resident's personal physician or, if the resident does not have a personal physician, the facility's medical director; and
- A registered nurse who has participated in developing, maintaining, or reviewing the indivdiual's resident care plan[41] as defined in s. 400.021, F.S.

Before determining that a nursing home resident is exempt from the long-term care managed care program, the agency is required to confirm whether the person has been identified as a candidate for HCBS services. If a nursing facility resident who has been identified as exempt is later identified as a candidate for HCBS, the nursing facility administrator must promptly notify the AHCA to ensure candidates are transitioned smoothly between programs, if appropriate.

Section 4 amends s. 409.967, F.S., relating to managed care plan accountability, to direct the AHCA to impose fines, and to authorize the imposition of other sanctions on a plan that willfully fails to comply with the managed care plan accountability provisions of ss. 641.315 (provider contracts), 641.3155 (prompt payment of claims), 641.513 (requirements for providing emergency services and care), and the added cross-referenced provision, s. 409.928(5), F.S., (long-term care managed care plan accountability provisions).

[41] A resident care plan is a written plan which must be reviewed not less than quarterly by a registered nurse, with participation by other staff and the resident or his or her legal representative, which includes, a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided; and an explanation of goals.

Section 5 amends s. 409.979, F.S., relating to the pre-requisite criteria for eligibility for enrollees in the LTC program. The bill clarifies that only those Medicaid recipients who are not exempt under s. 409.965, F.S., and who meet all of the criteria under this section may be eligible to receive long-term care services by participating in the LTC program. The amended language aligns the eligibility with the modifications made in Section 2 of the bill.

Section 6 amends s. 409.982, F.S., relating to provider networks of a long-term care managed care plan. The bill requires the managed care plans to offer a network contract to all nursing homes and hospices for the first 12 months of a contract period in a region if that region was not served by that plan after the most recent procurement, i.e., under the prior contract period. The nursing homes and hospices must meet the credentialing and recredentialing requirements specified in the plan's contract with the agency.

After the 12-month period, the plan may exclude any nursing home or hospice for failure to meet quality or performance standards; however, the plan must provide 30 days' written notice before the effective date to all affected recipients. If the plan excludes providers from its network or fails to renew a provider's contract, the AHCA must require a report from that plan which shows the quality or performance indicators used to exclude the provider and demonstrates how the provider failed to meet the plan's criteria.

Section 7 provides that except as otherwise provided in this act, and except for this section, which shall take effect upon becoming a law, this act shall take effect July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The *Olmstead* decision requires the state to deliver services "in the most integrated setting appropriate to meet the needs of qualified individuals with disabilities." The requirement applies whether the state delivers those services using a managed care delivery system or fee-for-service process. However, as noted earlier, the federal CMS has also released guidance statements since that 1999 decision about the exclusion of services from managed care and how the agency will review those actions. Such action by states will receive strict scrutiny from federal CMS and require justification that services are still being rendered in the most integrated manner.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 682 changes how services are delivered for the LTC component when the new contracts are effective under the invitation to negotiate which will be conducted this summer. Changes in the delivery of benefits may impact private providers that are currently providing services to recipients in the program now; however, that may have occurred regardless with any changeover in managed care contracts. There is no guarantee that the same providers will receive contracts in the same areas of the state.

The revisions to the prompt-pay section of the bill may impact the private sector to a larger degree if it results in providers and facilities receiving payment for services on a more expedient basis. The AHCA indicates that the statutes already permit the imposition of sanctions for noncompliance with the prompt pay requirements and that sanctions have been applied. A more aggressive enforcement effort may have been lacking due to the inability to determine from the available claims data that the prompt pay provision has been violated.

Requiring managed care plans to contract with all nursing facilities and hospices that meet credentialing requirements in an awarded region for 12 months following any new procurement for the LTC program may require the plans to contract with providers that they previously non-renewed or terminated 4-5 years ago. The AHCA indicates that this number of non-renewed or terminated providers is low.

C. Government Sector Impact:

A revised bill analysis and fiscal impact statement reflecting the changes in CS/SB 682 have not been received by publication date of this analysis.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The CS/SB 682 includes a requirement for the long-term care managed care plans to offer a contract to all nursing homes and hospices in a region which meet the recredentialing or credentialing requirements of the plan's contract with the AHCA if that the region was not served by that plan after the most recent procurement. This language may be confusing as to which procurement process is the baseline for determining which nursing and hospices must be offered a contract and in which regions the mandatory contracting would be applicable. It may be better to reference those providers who did not have contracts immediately prior to the most recently concluded procurement process.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.964, 409.965, 409.967, 409.979, and 409.982.

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 Health Policy on March 27, 2017:

The CS:

- Requires a nursing home to be prepared to confirm for the AHCA whether a nursing home resident, who is a Medicaid recipient or whose Medicaid eligibility is pending, is a candidate for HCBS, by the resident's 50th consecutive day of residency in the nursing home facility;
- Establishes the effective date for those exempted from the LTC managed care program;
- Provides that a nursing facility resident is not exempt from the LTC managed care program if the resident has been identified as a candidate for HCBS by the nursing facility administrator and any LTC case manager assigned to the resident;
- Establishes an identification and evaluation process for nursing facility residents for HCBS;
- Requires confirmation from the AHCA as to whether the person has been identified as a candidate for HCBS before a determination can be made that an individual is exempt from the LTC managed care program;
- Requires nursing facility administrators to promptly notify the AHCA of any exempt nursing home residents who have later been identified as candidates for HCBS; and
- Requires a plan to contract with all credentialed nursing homes and hospices if a new region is awarded under a new procurement cycle.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.