HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 7047 PCB FFS 22-01 Medicaid Managed Care
SPONSOR(S): Health & Human Services Committee, Finance & Facilities Subcommittee, Garrison
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1950

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Finance & Facilities Subcommittee	14 Y, 4 N	Lloyd	Lloyd
1) Health Care Appropriations Subcommittee	10 Y, 5 N	Nobles	Clark
2) Health & Human Services Committee	15 Y, 5 N, As CS	Lloyd	Calamas

SUMMARY ANALYSIS

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds.

Most Medicaid recipients receive services in a managed care model: the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: managed medical assistance (MMA) which provides traditional primary and acute care services; long-term care managed care (LTC), which provides residential and home care for people eligible for nursing home care; and dental. AHCA competitively procures contracts with managed care plans in each of 11 regions of the state to provide comprehensive health care coverage. The bill makes changes to the SMMC program in anticipation of the next procurement cycle, for plan year 2025. The bill:

- Consolidates the 11 regions into eight, and adjusting the minimum and maximum numbers of plans with which AHCA will contract to provide services to MMA and LTC enrollees;
- Creates requirements concerning the delivery of dental benefits;
- Requires AHCA to conduct a single statewide SMMC procurement, requires negotiation and selection on a regional basis, and authorizes statewide contract awards if deemed the best value;
- Prohibits AHCA from auto-enrolling recipients in a plan having a regional market share greater than 50 percent;
- Realigns Regional Perinatal Intensive Care Centers from statewide to regional essential providers;
- Requires AHCA to identify plans that lack required contracts with essential providers and apply contract financial enforcement measures on the plan in certain circumstances and such plans must mediate the network contract with the essential provider;
- Establishes requirements and timelines for required mediations and the publishing of the post-mediation report;
- Allowing certain plan contributions in support of medical education to be credited against medical loss ratio and the Achieved Savings Rebate;
- Expands the Healthy Behaviors Program to include focuses on smokeless tobacco and opioid abuse;
- Requires plans to contract with Florida cancer hospitals as essential statewide health care providers, and provides a payment rate for services provided without a contract;
- Allows children in the child welfare Guardian Assistance Program to enroll in the child welfare specialty plan, as an alternative to a non-specialty MMA plan;
- Requires regular AHCA testing of plan network adequacy;
- Provides times for AHCA to implement specific provisions of the bill; and
- Deletes obsolete provisions and makes conforming changes to reflect the provisions of the bill.

The bill will have a significant, negative, recurring fiscal impact on AHCA; see Fiscal Analysis. There is no fiscal impact on local government.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

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

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

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

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[4] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[5]

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. Some clinical eligibility provisions apply, as well.

The Florida Medicaid program covers approximately 5 million low-income individuals, including approximately 2.5 million, or 58.4%, of the children in Florida.[6] Medicaid is the second largest single

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] Id.
[6] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, December 2021, available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited January 18, 2022). United

program in the state, behind public education, representing approximately one-third of the total FY 2021-2022 state budget.[7] As of June 2021, Florida's program is the 4th largest in the nation by enrollment and, for FY 2019-2020, the program is the 5th largest in terms of expenditures.[8]

Statewide Medicaid Managed Care (SMMC)

Florida delivers medical assistance to most Medicaid recipients – approximately 78% - using a comprehensive managed care model, the SMMC program.[9] The SMMC program was intended to provide comprehensive, coordinated benefits coverage to the Medicaid population, leveraging economic incentives to ensure provider participation and quality performance impossible under the former, federally prescribed, fee-for-service delivery model.

The SMMC program has three components: the integrated Managed Medical Assistance (MMA) program that provides primary care, acute care and behavioral health care services; Long-Term Care (LTC) program[10] that provides long-term care services, including nursing facility and home and community-based services; and the dental component.

Medicaid covers mandatory benefits prescribed by s. 409.973, F.S., for the MMA program and s. 409.98, F.S., for the LTC program, as indicated below. Managed care plans also offer an expanded menu of optional benefits at no cost to the state.

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	**Long-Term Care**
Advanced registered nurse practitioner services	Nursing facility care
Ambulatory surgical treatment center services	Services provided in an ALF
Birthing center services	Hospice
Chiropractic services	Adult day care
Dental services	Personal care
Early periodic screening diagnosis & treatment (age<21)	Home accessibility adaption
Emergency services	Behavior management
Family planning services and supplies	Home-delivered meals
Healthy Start services (with exceptions)	Case management
Hearing services	Therapies
Home health agency services	Occupational therapy
Hospice services	Speech therapy
Hospital inpatient services	Respiratory therapy
Hospital outpatient services	Physical therapy
Laboratory and imaging services	Intermittent and skilled nursing
Medical supplies, equipment, prostheses, and orthoses	Medication administration
Mental health services	Medication management
Nursing care	Nutritional assessment and risk reduction
Optical services and supplies	Caregiver training

States Census Bureau, *QuickFacts, Florida*, https://www.census.gov/quickfacts/fact/table/FL/PST045221 (last visited January 18, 2022).

[7] Ch. 2020-111, L.O.F. See also *Fiscal Analysis in Brief: 2021 Legislative Session*, available at http://edr.state.fl.us/content/revenues/reports/fiscal-analysis-in-brief/FiscalAnalysisinBrief2021.pdf (last visited January 6, 2022).

[8] The Henry J. Kaiser Family Foundation, *State Health Facts, Total Medicaid Spending FY 2020 and Total Monthly Medicaid and CHIP Enrollment Jun. 2021*, available at http://kff.org/statedata/ (last visited January 18, 2022).

[9] *Supra*, FN 6.

[10] The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) provided in a recipient's home, an assisted living facility, or an adult family care home. Enrollment in the LTC program is based on a clinical priority system and includes a wait list. The state is approved for 62,000 recipients in the HCBS portion of LTC. In order to be eligible for the program, a recipient must be both clinically eligible under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

Mandatory Benefits - Statewide Medicaid Managed Care	
Managed Medical Assistance	**Long-Term Care**
Optometrist services	Respite care
Physical, occupational, respiratory, speech therapies	Personal emergency response system
Physician services, including PA	Transportation
Podiatric services	Medical equipment and supplies
Prescription drugs	
Renal dialysis services	
Respiratory equipment and supplies	
Rural health clinic services	
Substance abuse treatment services	
Transportation	

The chart below shows the current enrollment in MMA and LTC.

Statewide Medicaid Managed Care Enrollment, as of December 2021		
Component	**Budget[11]**	**Enrollment[12]**
Long-Term Care Plan	$5.25 billion	122,659
Managed Medical Assistance	$17.8 billion	3,982,511

Services in SMMC are delivered by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations, such as HMOs, are reimbursed as prepaid plans – they are risk-bearing entities that are paid capitated rates (prospective, per-member, per-month payments) by AHCA. PSNs are managed care plans controlled by health care providers, such as physician groups or hospitals. Because health care practitioners and facilities did not previously operate managed care plans or use capitated payment arrangements, SMMC allowed an alternative risk-bearing arrangement for PSNs.

Current law allowed PSNs to be reimbursed on a fee-for-service basis, but only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever was later. Under that option, PSNs bear risk through a shared savings model. AHCA conducted cost reconciliations for the fee-for-service PSNs to determine any savings or amounts owed by the PSN. PSNs in SMMC have fully transitioned to risk-bearing entities, when participating. No fee-for-service PSNs remain.

SMMC Plan Procurement

The SMMC uses managed care plans to provide services to recipients – both health maintenance organizations (HMOs) and provider service networks (PSNs), which are managed care plans majority-owned by health care providers.

AHCA initially procured SMMC contracts in 2012 for the LTC program and 2013 for the MMA program, completing the rollout of the first SMMC contract term in 2014. These contracts were re-procured in 2017 with implementation in 2018. In 2020, the Legislature extended the SMMC contract period from five to six years, resulting in contract expirations in 2024.

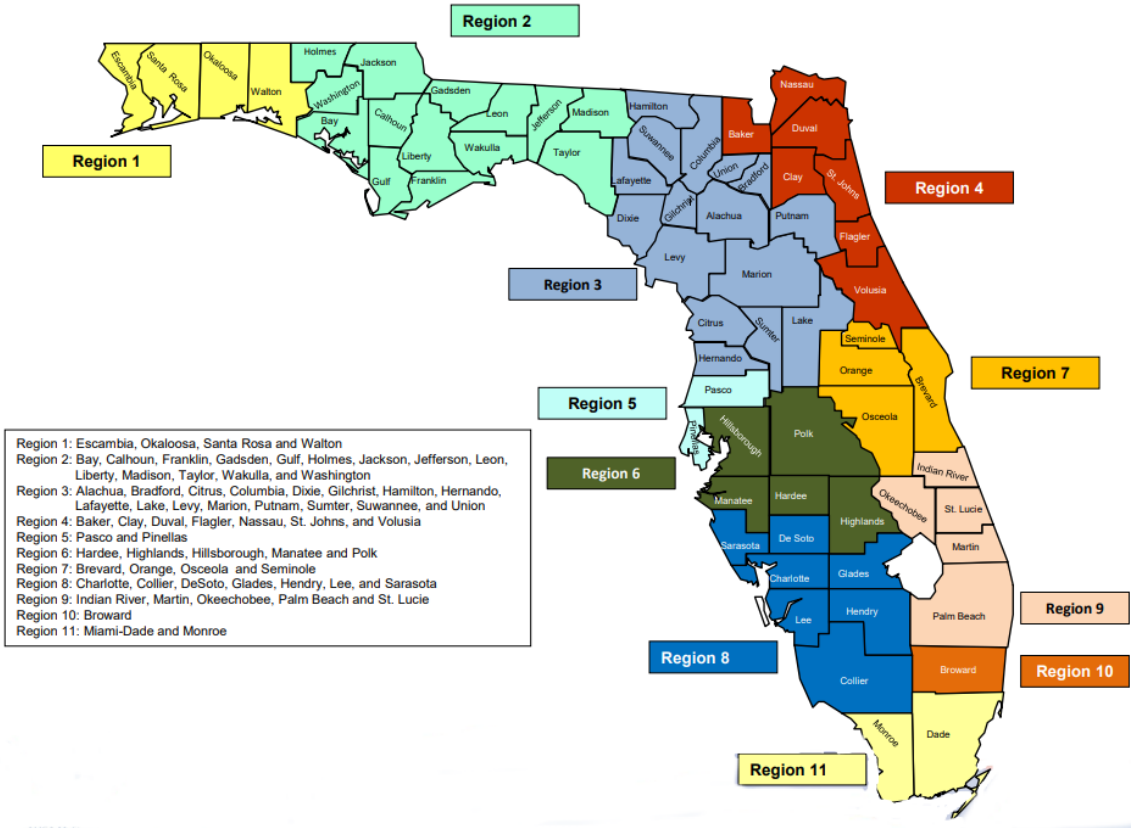
AHCA will begin the next procurement process in 2022 for implementation in the 2025 plan year. The following table illustrates the procurement timeline.

[11] Ch. 2020-36, L.O.F. https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=CRA_.pdf&DocumentType=Amendments&BillNumber=2500&Session=2021 (last visited January 6, 2022). MMA is appropriation 210, pg. 68, and LTC is appropriation 221, pg. 71.
[12] Agency for Health Care Administration, *SMMC MMA Enrollment by County by Plan* (as of December 2021), available at https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited January 22, 2022).

Procurement Timeline	
Activity	**Date**
Posting Date	Late Fall 2022
Q&A Posting Date	Winter 2023
Responses Due	Spring 2023
Responses Opened	Spring 2023
Evaluations Begin	Late Spring 2023
Evaluations End	Late Summer 2023
Negotiations Begin	Fall 2023
Negotiations End	Fall 2023/Winter 2024

Regional Procurement

Current law requires AHCA to competitively procure contracts with managed care plans in 11 regions of the state. The following map illustrates the current SMMC regions.[13]



Current law requires AHCA to issue a procurement in each region. To ensure recipient choice of plans while also ensuring enrollment levels significant enough to attract bidders, ss. 409.974 and 409.981, F.S., specifies the minimum and maximum number of plans AHCA must procure in each region for MMA and LTC, respectively. Currently, the same ranges apply for each program. The following table

[13] Agency for Health Care Administration, *https://ahca.myflorida.com/medicaid/statewide_mc/pdf/SMMC_Region_Map.pdf* (last visited January 22, 2022).

illustrates the number of plans allowed per region and the current regional enrollment for all plans, by program type.

SMMC Enrollment, by Region			
	Min/Max # Plans	MMA	LTC
Region 1	2	135,670	3,471
Region 2	2	142,006	3,602
Region 3	3 to 5	349,337	8,714
Region 4	3 to 5	417,654	9,633
Region 5	2 to 4	233,032	10,688
Region 6	4 to 7	568,861	14,316
Region 7	3 to 6	537,679	10,432
Region 8	2 to 4	272,543	7,234
Region 9	2 to 4	353,458	11,349
Region 10	2 to 4	338,684	10,240
Region 11	5 to 10	605,902	32,791

To bid for a SMMC contract, managed care plans must negotiate with AHCA over proposed benefits, rates, and provider networks. To facilitate the rate negotiations, current law requires AHCA to publish a databook of a comprehensive set of utilization and spending data for the most recent three contract years, including historic fee-for-service claims and validated encounter data.[14] AHCA must publish this databook at least 90 days before issuing the procurement. Plans submitting bids will use the databook to calculate proposed capitation rates for their bids.

MMA Plans

During the initial SMMC procurement, AHCA awarded contracts to 18 MMA plans, including seven PSNs. By the end of the first contract period, due to various mergers, acquisitions, and HMO conversions, only one PSN remained (South Florida Community Care Network, DBA Community Care Plan). During the second procurement, AHCA awarded contracts to 16 plans, including five PSNs, (Community Care Plan, Florida Community Care, Lighthouse, Miami Children's, and Vivida) but only three of the PSNs currently remain in the program due to mergers and acquisitions with a total of 10 health plans.

The following tables show the managed care plans currently participating in the MMA program, including the plans that offer a comprehensive plan, and the available specialty plans.[15]

[14] S. 409.966(2), F.S.

[15] Agency for Health Care Administration, Presentation to Finance & Facilities Subcommittee, November 3, 2021, *Medicaid Quality Updates*, slide 25, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3090&Session=2022&DocumentType=Meeting+Packets&FileName=ffs+11-3-21.pdf (last visited January 23, 2022); Agency for Health Care Administration, Specialty Plan Management, Specialty Plan Management (myflorida.com) (last visited January 20, 2022).

MMA Standard and Comprehensive Plans, by Region

SMMC PLANS	REGION										
	1	2	3	4	5	6	7	8	9	10	11
MMA HEALTH PLANS											
AmeriHealth Caritas									X		X
Community Care Plan										X	
Simply Healthcare	X	X							X		
Vivida Health								X			
COMPREHENSIVE PLANS MMA and LTC Combined											
Aetna Better Health						X	X				X
Humana Medical Plan	X	X	X	X	X	X	X	X	X	X	X
Molina Healthcare								X			X
Simply Healthcare					X	X	X			X	X
Sunshine Health	X	X	X	X	X	X	X	X	X	X	X
United Healthcare			X	X		X					X

MMA Specialty Plans, by Region

SMMC PLANS	REGION										
	1	2	3	4	5	6	7	8	9	10	11
SPECIALTY PLANS											
CMS Plan Children with Chronic Health Conditions	X	X	X	X	X	X	X	X	X	X	X
Clear Health Alliance HIV/AIDS Specialty	X	X	X	X	X	X	X	X	X	X	X
Molina SMI Specialty Serious Mental Illness				X	X		X				
Sunshine SMI Specialty Serious Mental Illness	X	X	X	X	X	X	X	X	X	X	X
Sunshine Child Welfare Child Welfare	X	X	X	X	X	X	X	X	X	X	X

LTC Plans

The LTC enrollees who are not eligible for Medicare also receive their medical services through an MMA plan. Some plans participate in both components in the same regions, and a recipient may elect the same managed care plan for both components. These plans are referred to as comprehensive plans. The following chart shows the managed care plans that participate in the LTC program.[16]

[16] *Id.*, slide 45.

LTC Plans, by Region

SMMC PLANS	REGION										
	1	2	3	4	5	6	7	8	9	10	11
LONG TERM CARE PLAN											
Florida Community Care	X	X	X	X	X	X	X	X	X	X	X
COMPREHENSIVE PLANS MMA and LTC Combined											
Aetna Better Health						X	X				X
Humana Medical Plan	X	X	X	X	X	X	X	X	X	X	X
Molina Healthcare								X			X
Simply Healthcare					X	X	X			X	X
Sunshine Health	X	X	X	X	X	X	X	X	X	X	X
United Healthcare			X	X		X					X

Dental Plans

Dental benefits have been available since the inception of the Medicaid program. From 2014 through 2018, dental coverage was integrated into the MMA health plans as part of the comprehensive, integrated approach to managed care created by the SMMC program.

Medicaid covers full dental services for children. However, adult dental benefits are limited to emergency treatment and dentures, and do not include preventive services. The chart below indicates the covered dental benefits.

Children		Adults
Ambulatory Surgical Center or Hospital-based Dental Services	Orthodontics	Dental Exams (emergencies and dentures only)
Dental Exams	Periodontics	Dental X-rays (limited)
Dental Screenings	Prosthodontics (dentures)	Prosthodontics (dentures)
Dental X-rays	Root Canals	Extractions
Extractions	Sealants	Sedation
Fillings and Crowns	Sedation	Ambulatory Surgical Center or Hospital-based Dental Services
Fluoride	Space Maintainers	
Oral Health Instructions	Teeth Cleanings	

In the initial contract term, all MMA plans incorporated full adult dental benefits as an enhanced benefit, at no cost to the state.

In 2016, the Legislature directed AHCA to separate the dental benefit into a stand-alone managed care program, rather than being integrated with the MMA coverage for all other forms of health care.[17] The stand-alone dental plans began operations between December 1, 2018 and February 1, 2019 in different regions of the state.

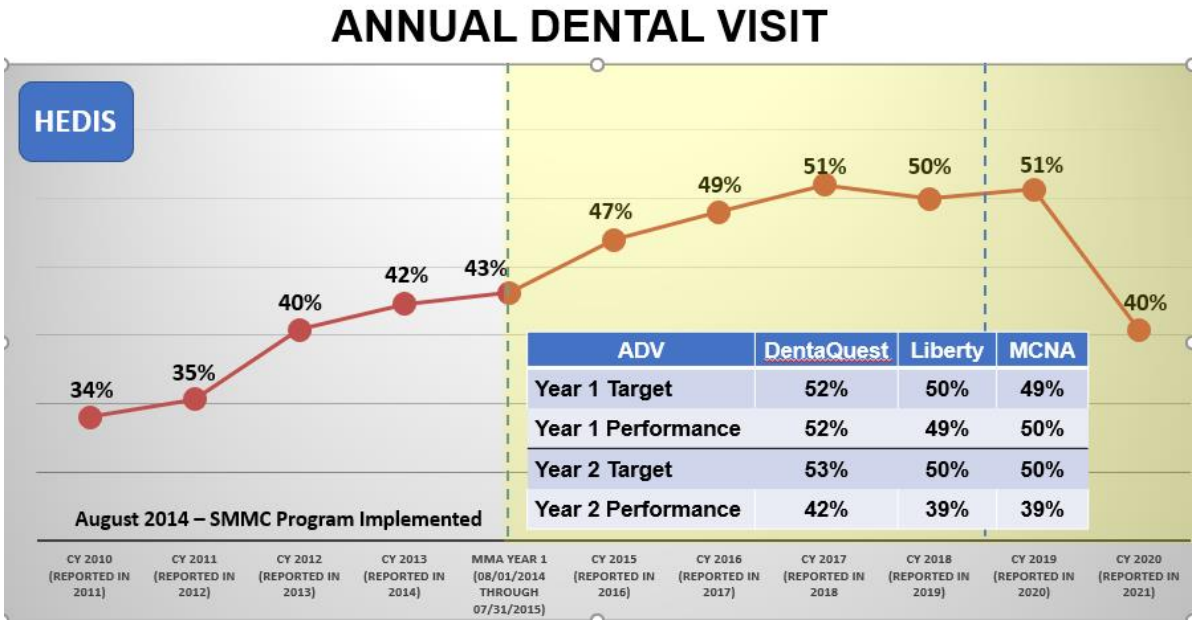
[17] Ch. 2016-109, L.O.F.

Presently, three dental plans are contracted; all operate statewide. The dental plans provide comprehensive dental services to children, required adult dental benefits, and expanded benefits to adults.

Dental Plans, by Region

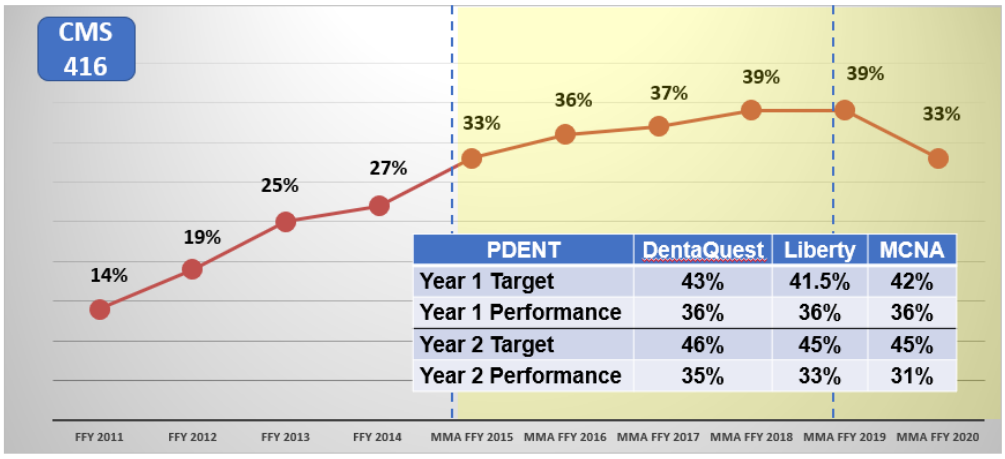
Dental Program Enrollment by Plan, as of October 1, 2021			
DentaQuest	1,773,102	Regions:	All
Liberty	1,367,714	Regions:	All
MCNA Dental	990,218	Regions:	All

When dental benefits were integrated into the MMA program, and for some years prior, Florida experienced consistent increases in child dental service performance in the federally-required measurements. After the separation of dental benefits from other benefits, improvement stalled or regressed in many categories, while complaints were higher. Some decline may be attributable to a decline in utilization in Summer, 2020, due to the pandemic-related lockdown and supply shortage. The following graphics illustrate the change.[18]



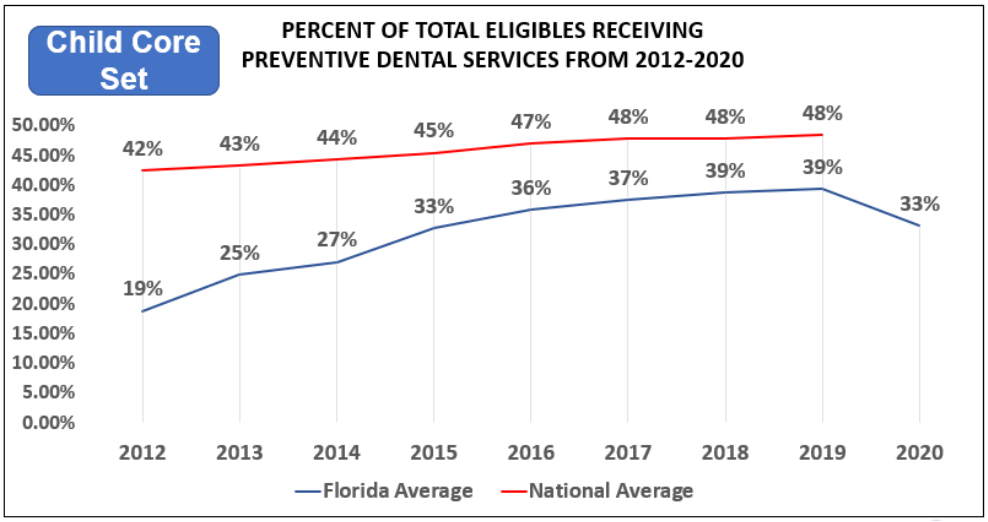
[18] Agency for Health Care Administration, Presentation to the Health & Human Services Committee, *Medicaid Dental Updates*, November 2, 2021, https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3085&Session=2022&DocumentType=Meeting+Packets&FileName=hhs+11-2-21.pdf (last visited January 23, 2022).

PREVENTIVE SERVICES FOR CHILDREN



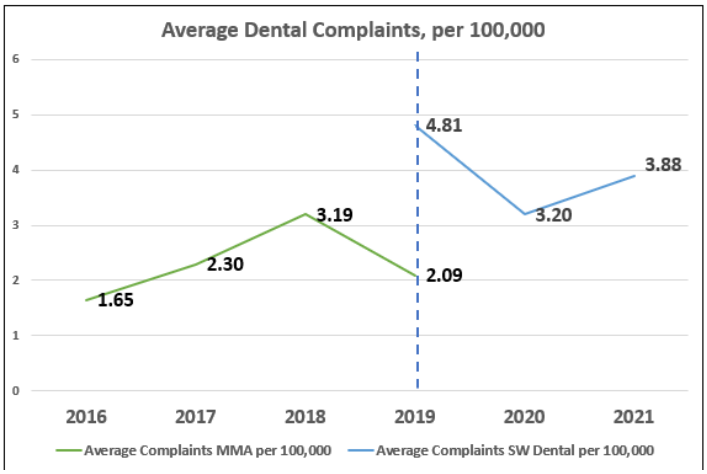
PDENT	DentaQuest	Liberty	MCNA
Year 1 Target	43%	41.5%	42%
Year 1 Performance	36%	36%	36%
Year 2 Target	46%	45%	45%
Year 2 Performance	35%	33%	31%

FLORIDA VS. NATION ON PREVENTIVE SERVICES



CONSUMER SATISFACTION

The Agency tracks complaints received about dental services.



- Plans are required to survey their members on their experiences with care on an annual basis.
- Dental plans are required to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys.
- In 2021, parents of child enrollees rated the following aspects of care as an 8 or higher (on a scale of 0 to 10).

Survey Item	Respondents
Dentist	88%
Overall Plan Satisfaction	85%
Quality of Care Received	86%

Provider Networks

Network Adequacy

Current law requires AHCA to establish standards for the number, type, and regional distribution of health care providers in managed care plan networks to ensure access to care for recipients. Plans must meet these network requirements to maintain their Medicaid contracts, and must publish their provider network information online for recipients to access; including performance data, a recipient feedback function, licensure information, and location information.[19]

AHCA receives a provider network report from plans weekly. The agency uses this report to facilitate its review of the plan's network adequacy. The reported ratio of enrollees to providers and the enrollees' time and distance necessary to visit listed providers is analyzed and failures to meet standards are identified and communicated. Plans may respond with feedback on the findings and AHCA provides technical assistance to the plans, as necessary. Monetary penalties are issued by AHCA against the plans when warranted for failures to meet network adequacy requirements.

The plan's provider network report is also used to develop secret shopper efforts to confirm provider availability to enrollees. AHCA randomly selects providers within select services or specialties and directs the plans to conduct secret shopper calls on a monthly basis. The plans conduct the calls, record the data, and reports it back to AHCA. Deficiencies found through the secret shopper activity results in monetary penalties against the plan.[20] AHCA's network adequacy confirmation process is not comprehensively designed to regularly confirm the adequacy of network providers across all medical services, and is not systematized to address all provider types within a set period of time.[21]

Current law requires AHCA to systematically and continuously test the plan provider networks to confirm accuracy, that the providers are accepting enrollees, and that recipients have access to services. However, this requirement is limited to mental health provider networks, and does not apply to all Medicaid plan providers.[22]

Essential Providers

Current law considers some health care providers "essential providers" in the Medicaid program. These providers offer services not available from other providers within a reasonable access distance within a region, or are unique or rare statewide.

Regional essential providers include the following, as individually designated by AHCA:

- Federally qualified health centers;
- Statutory teaching hospitals;
- Hospitals that are trauma centers; and
- Hospitals located at least 25 miles from any other hospital with similar services.

AHCA has not designated any provider as a regional essential provider, so there are none with which plans are required to contract.[23]

[19] SS. 409.967, 409.975, F.S.
[20] Agency for Health Care Administration, *2022 Agency Legislative Bill Analysis, HB 7047*, pp. 8, (February 3, 2022).
[21] Email from Kristin Sokoloski, AHC Administrator, Agency for Health Care Administration, Re: [email not titled] (February 4, 2022) (Email on file with the Finance & Facilities Subcommittee).
[22] S. 409.967(2), F.S.
[23] *Supra*, FN 20, p. 11.

Statewide essential providers include the following:

- Faculty plans of Florida medical schools.
- Regional perinatal intensive care centers as defined in s. 383.16(2).
- Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).[24]

Plan networks must include all essential providers, by contract.[25]

If plans selected through the procurement process do not already have contracts with *regional* essential providers, they must negotiate with them for one year or until an agreement is reached. The non-participating payment rates during the negotiation process are set at 100 percent of the Medicaid rate. After one year, the plan may request agency approval of an alternative arrangement; but, if that alternative is not approved, the new payment rate is set at 110 percent of the Medicaid rate. For *statewide* essential providers, the plans must continue to negotiate in good faith, and the non-participating payment rate is set at 100 percent of the Medicaid rate (or, in the case of children's hospitals, the highest rate established in an existing Medicaid plan contract with that facility).

Current law does not require AHCA to regularly assess the contract status of essential providers and plans, and AHCA has no ability to compel the providers and plans to contract.

MEDICAL SCHOOL FACULTY PLAN CONTRACT COMPLIANCE

As of October 2021, four of seven medical school faculty plans lacked the required contracts with at least one plan from among the 15 plans, as follows:[26, 27, 28]

- The University of Miami faculty plan was not in contract with one plan.
- The USF faculty plan was not in contract with two plans.
    - One of these was uncontracted for more than a year, since prior to October 2021.
- The FSU Medical Practice faculty plan was not in contract with five plans.
    - Three of these were uncontracted for more than a year, since prior to October 2021.
- The UCF faculty plan was not in contract with 14 plans.
    - All of these were uncontracted for more than a year, since prior to October 2021.

As of February 2022, three of the seven are still out of compliance, as follows: [29]

- The USF faculty plan was not in contract with two plans.
- The FSU Medical Practice faculty plan was not in contract with four plans.
- The UCF faculty plan was not in contract with 14 plans.

[24] S. 409.975(1)(b), F.S. A fourth provider type is listed in statute, but AHCA states that no provider has met the statutory qualifications, which follow: Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care. *Supra*, FN 20, p. 12.
[25] S. 409.975(1), F.S.
[26] Email from Patrick Steele, Deputy Legislative Affairs Director, Agency for Health Care Administration, RE: SB 1950 Bill Analysis (February 1, 2022) (Email on file with the Finance & Facilities Subcommittee).
[27] Email from Cody Farrill, Chief of Staff, Agency for Health Care Administration, RE: Essential Providers Contract Statuses_SFY21.22.xlsx (February 15, 2022) (Email on file with the Finance & Facilities Subcommittee).
[28] The Florida International University, University of Florida – Jacksonville, and University of Florida – Gainesville faculty plans were all contracted with every plan, as of October, 2021. In February 2022, these three, plus the University of Miami faculty plan were contracted with all 15 plans.
[29] *Supra*, FN 20, page 13.

As of October 2021, two of the four children's hospitals lacked one or more of the required contracts among 14 plans,[30] as follows:[31]

- Johns Hopkins Children's hospital was not in contract with one plan.
- Wolfson Baptist Medical Children's hospital was not in contract with three plans.

As of February 2022, the same children's hospitals are still out of compliance: Wolfson had added a contract and so was not in contract with two plans; Johns Hopkins still lacked a contract with one plan.

All of the essential providers without contracts received supplemental Medicaid payments regardless of contract status.

The lack of change for some providers indicates a need for ongoing and more frequent monitoring.

Recipient Enrollment

Medicaid recipients have a 30-day period to choose a plan, and a 90-day period following enrollment during which they can change their plan for any reason. In addition, recipients are allowed to change plans during regularly scheduled open enrollment periods or with a state-approved "for cause" reason at any time following their initial choice period.[32] For recipients who do not make a choice, AHCA must automatically enroll them into plans.

AHCA may not enroll a recipient in a plan with deficient quality performance, and must enroll a recipient in a specialty plan if one is available for that recipient's condition. For LTC recipients also in Medicare, AHCA must enroll the recipient in a plan that is also a Medicare plan, if one is available.[33]

AHCA must consider the following factors when automatically enrolling recipients in plans:

- Network capacity of available plans;
- Whether the recipient has a prior relationship with a plan's primary care providers (or home and community-based services providers, for LTC); and
- Geographic proximity of a plan's primary care providers (or home and community-based services providers, for LTC) to the recipient.[34]

Other than these statutory factors, AHCA is statutorily prohibited from engaging in practices that favor one managed care plan over another.

A recent merger of two large Medicaid managed care plans has resulted in a new level of market participation for the resulting company. On January 23, 2020, Centene Corporation (owner of Sunshine Health) completed the acquisition of WellCare/Staywell Health Plan.[35] The result is a plan provider that has the most enrollees, per region, in eight of the eleven Medicaid regions and overall, statewide (by more than double). The following table illustrates the first and second largest plan, by total enrollees, in each region and statewide:[36]

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[30] One plan does not serve children, so a children's hospital contract is not required.
[31] *Supra*, FN 20, page 13. Nemours and Nicklaus Children's hospitals were contracted with all plans.
[32] S. 409.969, F.S.
[33] Ss. 409.977 and 409.984, F.S.
[34] Id. Agency for Health Care Administration, Recent Medicaid Presentations and Reports, *Florida Medicaid Managed Care Auto-Assignment Methodology*, https://ahca.myflorida.com/Medicaid/recent_presentations/2019/Auto-Assignment_Report_100119_Final.pdf (last visited January 26, 2022).
[35] Centene Completes Acquisition of WellCare, Centene Corp., Jan. 28, 2020, https://www.centene.com/news/centene-completes-acquisition-of-wellcare.html (last visited January 26, 2022).
[36] *Supra*, FN 20,p. 7.

MMA Plan (% of Mkt Share)		
Region	**Largest**	**Second Largest**
Region 1	Humana (45.86%)	Sunshine (25.67%)
Region 2	Sunshine (61.2%)	Humana (16.03%)
Region 3	Sunshine (50.32%)	United (24.59%)
Region 4	Sunshine (48.06%)	United (29.29%)
Region 5	Sunshine (43.85%)	Simply (33.49%)
Region 6	Sunshine (37.44%)	Simply (27.45%)
Region 7	Sunshine (48.71%)	Simply (20.73%)
Region 8	Sunshine (51.59%)	Molina (20.09%)
Region 9	Sunshine (36.35%)	Humana (25.77%)
Region 10	Simply (27.39%)	Humana (25.49%
Region 11	Simply (23.41%)	Sunshine (16.78%)
Statewide	Sunshine (38.61%)	Humana (16.77%)

Current law does not address plan regional market share related to automatic enrollment.

Healthy Behaviors Program

Each plan operating in the MMA program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program. Each plan must identify enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse, in order to establish written agreements to secure the enrollees' commitment to participation in these programs.[37]

Financial Accountability – Workforce Expenditures

Medical Loss Ratio

Section 409.9122, F.S., authorizes AHCA to calculate a medical loss ratio (MLR) for the SMMC plans, consistent with federal requirements. An MLR measures the percentage of premium dollars that a health plan spends on medical expenses. A high MLR means the plan spends a large percentage of premium dollars on medical expenses, which may mean the plan is not spending enough on enrollees, or may mean the plan is not managing care well and incurring a large amount of catastrophic care expenses. The inverse is true for a low MLR.

Current law authorizes plans to count certain expenditures as medical expenses, for purposes of the MLR calculation:

- Contributions to support indigent care
- Funds provided to support graduate medical education to underwrite physician residency programs, if the residents actively provide care to Medicaid and uninsured patients.

Financial support for education of other health care industry occupations does not count as medical expenditures for MLR calculation purposes.

[37] S. 409,973(3), F.S.

Achieved Savings Rebate

Current law requires AHCA to establish a uniform method for the plans to use for annually reporting, premium revenue, medical and administrative costs, and income or losses. Using the reporting method, the plans calculate whether they have achieved a savings for the reporting year and whether they must pay a rebate to the state, called an achieved savings rebate.

This achieved savings rebate is calculated by determining pre-tax income as a percentage of revenues and applying the following income sharing ratios:

- 100% of the income up to and including 5% of the revenue will be retained by the plan,
- 50% of the income above 5% and less than 10% of the revenue will be retained by the plan with the other 50% refunded to the state, and
- 100% of the income above 10% will be refunded to the state.

If the plan meets or exceeds quality measures defined by AHCA, then the plan may retain an additional 1% of revenue.

Rebates, bonuses, fines, and lobbying expenses are not included in the calculation. Additionally, the agency sets maximums for administrative expenses, reinsurance, and outstanding claims expenses.

Unlike the MLR calculation, investments in graduate medical education (or other health care workforce development) are not included in ASR calculations as medical costs, or used an offset to rebate obligations.

Financial Accountability – Supplemental Payment Programs

Federal Medicaid managed care programs to use actuarily sound capitation rates which represent the entirety of the Medicaid expenditures for such services. However, federal law or Florida waiver approvals authorize certain exceptions, allowing additional Medicaid payments to take place outside the managed care relationship for some provider types. These arrangements are called supplemental payment programs.

Florida currently has ten supplemental payment programs to fund payments to Medicaid providers that are in addition to reimbursement they receive for services rendered to Medicaid enrollees. They are either authorized by statute or by the General Appropriations Act and are approved by the federal government. The payments are generally funded through non-General Revenue sources to make up the state share of Medicaid funds, which is used to draw down the federal matching payment. However, some supplemental payments are funded through General Revenue.

AHCA collects local intergovernmental transfers (IGTs) to fund the state share of the Medicaid match funds. IGTs come from counties, local health care taxing districts, and publicly operated providers. Governmental sources of IGTs sign pledge letters with AHCA specifying their contribution amount. AHCA then uses the IGTs to draw down the federal matching funds. AHCA then distributes the combined local (state share) and federal funds through a legislatively approved funding model.

Use of local funds to assist with funding Medicaid began in 1992 with the Disproportionate Share Hospital (DSH) supplemental payment. DSH provides supplemental payments to facilities that bear a disproportionate share of indigent care costs. In FY 1992-93, three local governments contributed IGTs. The Low Income Pool (LIP) was created as part of the initial Medicaid managed care waiver in 2006. LIP is used to provide supplemental payments to providers who provide services to Medicaid and uninsured patients. In FY 2017-18, 41 local government contributed IGTs to help fund DSH, LIP, and other supplemental payment programs. As of FY 2020-21, 97 local governments were providing IGTs.[38]

[38] Agency for Health Care Administration, Presentation to the Health Care Appropriations Subcommittee, *Medicaid Supplemental Payment Overview*, February 15, 2021,

Florida's Medicaid supplemental payment programs (along with their FY 2021-22 funding) are listed in the tables below.

State Share Funded by IGTs	
Program	FY 21-22 Funding
Low Income Pool (LIP)	$1.5 *billion*
Physician Supplemental Payment (PSP)	$404.7 million
Multi-Visceral Transplant	$7.4 million
Florida Cancer Hospital Program (FCHP)	$154.0 million
Public Emergency Medical Transportation (PEMT)	$136.1 million
Hospital Directed Payment Program (DPP)	$1.8 *billion*
Indirect Medical Education (IME)	$500.9 million

State Share Funded by IGT and General Revenue	
Program	**FY 21-22 Funding**
Disproportionate Share Hospital (DSH)	$338.9 million
Medical Education (GME)	$283.9 million
Hospital Automatic Rate Enhancements	$309.6 million

Total funds distributed in supplemental payments for FY 2021-22 were $5.488 billion.[39]

Supplemental Payments and Essential Providers

Some supplemental payment recipients are also statewide essential providers, with which all Medicaid plans must contract to meet network adequacy requirements. Supplemental payment program participation varies by provider type. For example, medical school faculty plans receive supplemental payments through PSP and LIP, while children's hospitals receive supplemental payments through LIP, DSH, and GME, as follows.[40]

https://ahca.myflorida.com/Medicaid/recent_presentations/2021/House_Health_Care_Appropriations_Medicaid_Presentation_Supplemental_Payments_20210215.pdf (last visited January 24, 2022).

[39] *Supra*, FN 11.

[40] *Supra*, FN 20, p. 12.

Essential Providers Supplemental Payments FY 2020-21					
Essential Provider Type	**PSP**	**LIP**	**DSH**	**GME**	**Total**
Medical School Faculty Plans					
FSU Medical Practice Plan	$ 298,545	n/a	n/a	n/a	**$ 298,545**
Florida International University	$ 316,443	n/a	n/a	n/a	**$ 316,443**
University of Central Florida	$ 61,635	n/a	n/a	n/a	**$ 61,635**
University of Florida Jacksonville	$61,322,442	$31,630,323	n/a	n/a	**$ 92,952,765**
University of Florida Gainesville	$90,661,648	$23,059,330	n/a	n/a	**$113,720,978**
University of South Florida	$52,558,502	$ 6,836,716	n/a	n/a	**$ 59,395,218**
University of Miami	$76,585,333	$42,657,091	n/a	n/a	**$119,242,424**
Children's Hospitals					
Wolfson Baptist Medical Hospital	n/a	$ 3,091,956	n/a	n/a	**$ 3,091,956**
Johns Hopkins Children's Hospital	n/a	$ 3,631,288	$7,728,543	$1,455,930	**$ 12,815,761**
Nemours Children's Hospital	n/a	$ 1,865,302	$3,479,923	$ 809,734	**$ 6,154,959**
Nicklaus Children's Hospital	n/a	$ 124,903	$7,043,199	$2,957,066	**$ 10,125,168**
Total	**$281,804,548**	**$112,896,909**	**$18,251,665**	**$5,222,730**	**$418,175,852**

To be eligible for supplemental payments the essential providers must *offer* to contract with all applicable Medicaid plans. In the event of a failure to contract, AHCA must evaluate whether the providers negotiated in good faith and withhold supplemental payments if the provider has negotiated in bad faith.[41] In the last two years, AHCA developed a process for assessing compliance with this law and identified three providers acting in bad faith. AHCA did not withhold supplemental payments from them, finding they were making progress in contract negotiations with plans.[42]

Supplemental Payments to Florida Cancer Hospitals

Currently, Florida cancer hospitals are not Medicaid essential providers. However, they do receive Medicaid funds via supplemental payments, as follows.[43]

Cancer Hospital Supplemental Payments FY 2020-21						
Provider	**FCHP**	**LIP**	**DSH**	**IME**	**GME**	**Total**
Sylvester Cancer Center	$104,590,018	$ 6,007,767	$3,191,548	$ 743,462	$13,798,598	**$128,331,393**
Moffitt Cancer Center	$ 32,457,037	$11,467,051	$2,694,650	$ 312,358	$ 4,380,728	**$ 51,311,824**
Total	**$137,047,055**	**$17,474,818**	**$5,886,198**	**$1,055,820**	**$18,179,326**	**$179,643,217**

Of the 15 plans operating in the state, Sylvester Cancer Center contracts with three plans. Moffitt Cancer Center is contracted with two plans.[44] Medicaid services make up 5 percent of Moffitt's cases mix, which is disproportionately low compared to the percentage of Florida's population with Medicaid coverage.

[41] S. 409.908(26), F.S.
[42] *Supra*, FN 20, p. 12.
[43] *Supra*, FN 21.
[44] Email from Cody Farrill, Chief of Staff, Agency for Health Care Administration, [No Subject Line Content] (February 15, 2022) (Email on file with the Finance & Facilities Subcommittee).

Child Welfare Specialty Plan

The Sunshine Health Child Welfare Specialty Plan serves children in Florida's child welfare system of care. It is available statewide to children in the child welfare system until age 21 and children adopted from the child welfare system through the child's 18th birthday, if the adopted family is receiving a state adoption subsidy.[45]

All children with an open child welfare case become eligible for the child welfare specialty plan upon their entry into the child welfare system. Children are automatically enrolled in the child welfare specialty plan unless a different MMA plan is selected. Under s. 409.977, F.S., specialty plans serving children in the care and custody of the DCF may serve such children as long as they remain in care, including those remaining in extended foster care or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903, F.S.

Like an MMA plan, the child welfare specialty plan must cover the minimum benefits outlined in s. 409.973, F.S. The following benefits are available under the child welfare specialty plan:

- Medical foster care
- Statewide Inpatient Psychiatric Program (SIPP)
- Specialized therapeutic foster care and therapeutic group care
- Targeted case management
- Private duty nursing
- Individual and family therapy
- Behavioral Health Overlay Services
- Comprehensive behavioral health assessments
- Emergency transportation
- Non-medical/non-emergency transportation with up to three round trips per month
- Care grants of up to $150 per child per calendar year for services and supplies for social or physical activities, such as gym memberships, swim lessons, sports equipment, art supplies or application fees for post high school
- Transition assistance up to $500 in one-time assistance for young adults transitioning out of foster care at age 18 or extended foster care at age 21
- Life skills development education for children ages 12 and up with developmental disabilities to help them keep, learn, or improve skills and functioning for daily living
- Over-the counter medication up to $25 per household per month
- Home-delivered meals for 10 days after being discharged from a facility
- Doula services
- A 24-hour nurse advice line
- A 24-hour behavioral health line

Because children in the child welfare system have greater clinical and behavioral health needs, the capitated rate for the specialty plan is higher than for children in regular MMA plans.

Child Welfare Guardianship Assistance Program

Florida's child welfare system, administered by the Department of Children and Families (DCF), identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect, and works with those families to address the problems that are endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

[45] S. 409.977(5), F.S.

The DCF Guardianship Assistance Program (GAP) is a federally-funded program to support relatives and fictive kin[46] who are guardians of children who were removed from their homes due to abuse or neglect.[47] GAP was implemented in Florida in 2019. Section s. 39.6225, F.S., sets the eligibility requirements to participate in Florida's GAP. In keeping with federal requirements, for a guardian to qualify to receive benefits on behalf of the child, the guardian must:

- Have the child's placement approved by the court;
- Have the court grant legal custody of the child to the guardian;
- Be licensed as a Level I provider of foster care under s. 409.175, F.S.; and,
- Be a guardian for the child who was eligible for federal foster care maintenance payments under Title IV-E for at least six consecutive months while the child resided in the home of the guardian and the guardian was licensed as a provider of foster care.

DCF provides GAP participants assistance payments of $4,000 annually, or another amount specified in a written agreement, paid on a monthly basis.[48] Participants are also eligible for a one-time payment of up to $2,000 for expenses associated with obtaining legal guardianship of a child.

As of November 2021, there are 1,122 children in Florida's GAP program.[49]

Under current law, children in GAP are not eligible to continue in the child welfare specialty plan. A child's dependency case is closed to permanent guardianship by the court when it grants legal custody to the guardian who is participating in GAP. Because current law limits specialty plan eligibility to children in DCF custody, permanent guardianship causes the child to lose eligibility for that plan, and enroll in a regular MMA plan.

Effect of Proposed Changes

SMMC Plan Procurement

The bill requires AHCA to conduct a single, statewide procurement; rather than separate and simultaneous regional procurements. However, it requires AHCA to negotiate and select plans on a regional basis. If AHCA finds that a statewide contract award to a particular plan is the best value for the state and recipients, AHCA is permitted to make such an award. This preserves regional competition and bidding, while allowing AHCA to negotiate based on statewide effect for a plan that would win in all regions, and issue a single statewide contract award instead of separate regional contracts. It also avoids a systemic shift that could favor large, market dominant plans if procurement were entirely conducted based on a statewide focus, to the detriment of regional preferences or conditions.

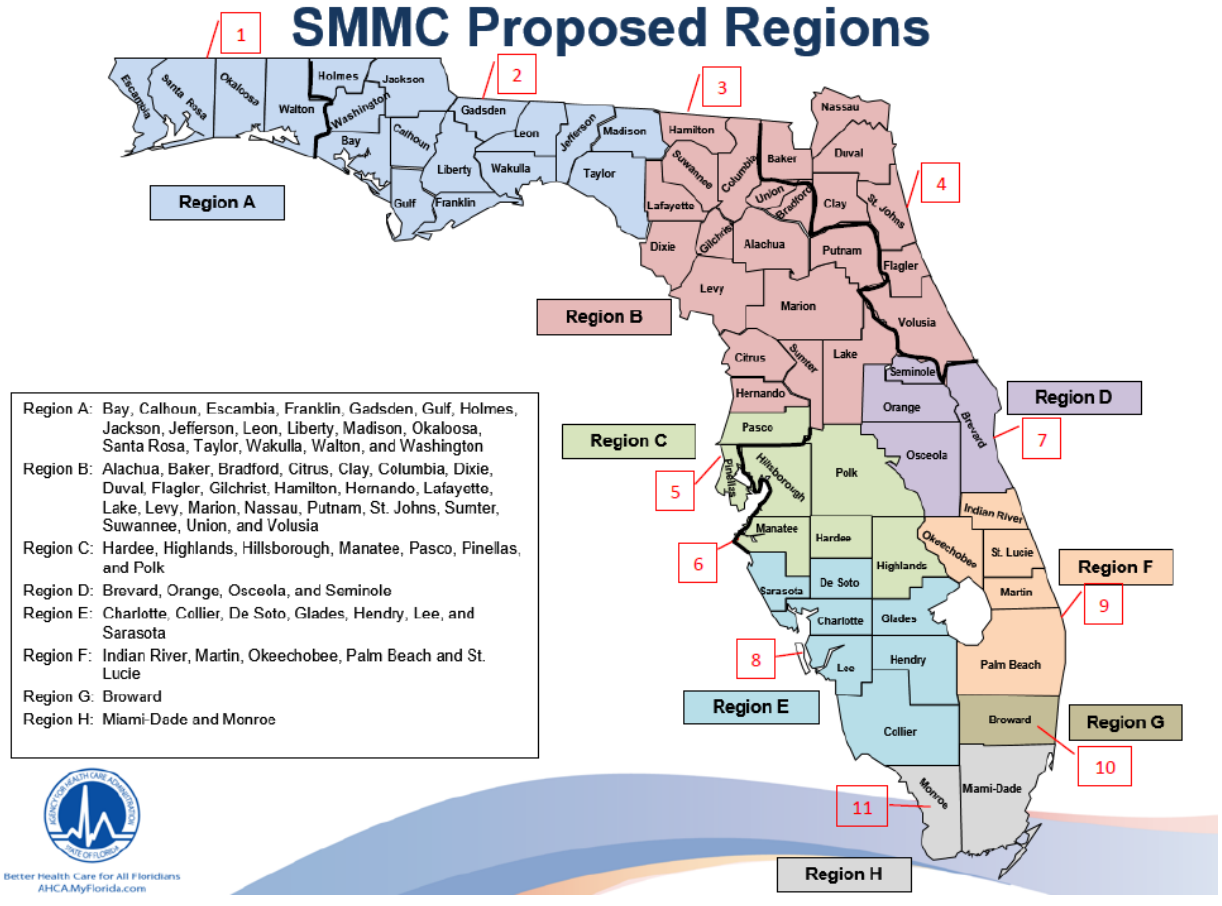
Under current law, at least 90 days before issuing an ITN to procure MMA and LTC plans under the SMMC program, AHCA compiles and publishes a databook that includes utilization and spending data for the program from the 3 most recent contract years and includes historic fee-for-service claims The bill requires AHCA to produce data for at least the most recent 24 months, eliminates the obsolete requirement to include fee-for-service data, and requires the data to be presented consistent with actuarial rate-setting practices and standards.

[46] S. 39.01(28), F.S., defines "fictive kin" as a person who is unrelated to the child but has such a close emotional relationship with the child that he or she may be considered family.
[47] Florida Department of Children and Families, Office of Children Welfare, Guardianship Assistance Program (GAP), Guardianship Assistance Program Community Supports - Florida Department of Children and Families (myflfamilies.com) (last visited January 20, 2022).
[48] S. 39.6225(5)(d), F.S.
[49] Email from John Paul Fiore, Legislative Director, Florida Department of Children and Families, Re: GAP, January 20, 2022 (on file with the House Finance & Facilities Subcommittee).

Regional Procurement

The bill proposes consolidating the eleven SMMC program regions into eight regions. According to AHCA, which proposed the region redesign, this configuration is based on enrollee utilization patterns and provider referral patterns over recent years.[50] The chart and map below show the current regions and the proposed consolidated regions.

SMMC Proposed Regions		
Current Region 1	Escambia, Okaloosa, Santa Rosa, Walton	REGION A
Current Region 2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	
Current Region 3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Levy, Marion, Putnam, Sumter, Suwannee, Union	REGION B
Current Region 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	
Current Region 5	Pasco, Pinellas	REGION C
Current Region 6	Hardee, Highlands, Hillsborough, Manatee, Polk	
Current Region 7	Brevard, Orange, Osceola, Seminole	REGION D
Current Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	REGION E
Current Region 9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	REGION F
Current Region 10	Broward	REGION G
Current Region 11	Miami-Dade, Monroe	REGION H



[50] *Supra*, FN 20, pp. 16-17.

The bill proposes to increase the minimum or maximum number of plans with which AHCA will contract to provide services to MMA and LTC enrollees. The limits for the award of plans within a region is inclusive of any statewide plans awarded. So, a statewide award will credit as one plan award in every region for the purposes of regional plan award limitations.

Each region will have at least three plans to provide services in the SMMC program, to ensure recipient choice of plans and increase AHCA's ability to enforce contract requirements. Enforcing contract requirements in a region with only two plans presents difficulties. For example, an enrollment freeze sanction would eliminate recipients' ability to have a choice of at least two plans, which is a federal requirement. With at least three plans, AHCA will be able to impose the full range of penalties available against noncompliant plans, including imposing an enrollment freeze.

The chart below shows the current number of plans and the proposed number of plans in each region. The chart also demonstrates enrollment distribution based on the proposed minimum and maximum number of plans per region, per program.[51]

			MMA			LTC		
Proposed Regions	Current Min/Max # Plans	Proposed Min/Max# Plans	Regional Enrollment	Enrollment: Proposed Minimum # Plans	Enrollment: Proposed Maximum # Plans	Regional Enrollment	Enrollment: Proposed Minimum # Plans	Enrollment: Proposed Maximum # Plans
Region A	Region 1: 2 Region 2: 2	3 - 4	277,676	92,559	69,419	7,073	2,358	1,768
Region B	Region 3: 3 - 5 Region 4: 3 - 5	MMA 5 - 6 LTC 3 - 6	766,991	153,398	127,832	18,347	6,116	3,058
Region C	Region 5: 2 - 4 Region 6: 4 - 7	MMA 6 - 10 LTC 5 - 10	801,893	133,648	80,189	25,004	5,001	2,500
Region D	Region 7: 3 - 6	MMA 5 - 6 LTC 6 - 6	537,679	107,535	89,613	10,432	3,477	1,739
Region E	Region 8: 2 - 4	3 - 4	272,543	90,848	68,136	7,234	2,411	1,809
Region F	Region 9: 2 - 4	3 - 5	353,458	117,819	70,692	11,349	3,783	2,270
Region G	Region 10: 2 - 4	3 - 5	338,684	112,895	67,737	10,240	3,413	2,048
Region H	Region 11: 5 - 10	5 - 10	605,902	121,180	60,590	32,791	6,558	3,279

Dental Benefits

The bill requires plans to establish programs to improve outcomes and increase utilization of preventative services, including a patient education component and a patient incentive program. AHCA is required to establish and regularly assess dental performance and outcome measures, which must be published. Medical and dental plans are required to collaborate on improving patient care. It also requires AHCA to reconcile dental-related emergency room costs against dental plan capitation rates and set and enforce network adequacy requirements for sedation dentistry.

Provider Service Networks

The bill removes the option for new PSNs to be paid under a fee-for-service/shared savings model, for the first two years of operation, after which they would be capitated. PSNs will be paid on a capitated basis from the beginning of their contract terms.

[51] Note that this simple demonstration assumes equal enrollment in each plan, which is highly unlikely, but is used to demonstrate recipient distribution across regions based on the plan numbers.

Enrollment

The bill prohibits AHCA from automatically enrolling participants in a plan if the plan has more than 50 percent of the enrollees in a region. As of November 30, 2021, the were three regions with an MMA plan and three regions with a dental plan that had more than 50 percent of the enrollees in the applicable region.[52] The bill does not impose a cap on enrollment by recipient choice; only on AHCA's auto enrollment for recipients who do not make a choice.

Provider Networks

Essential Providers

The bill adds Florida cancer hospitals that meet specified federal criteria to the statutory list of statewide essential providers, requiring all plans in the state to contract with them. Currently, there are two such hospitals that meet the federal criteria: Moffitt Cancer Center (Tampa) and Sylvester Comprehensive Cancer Center (Miami). As with other statewide essential providers, the bill sets the payment rate in the event these hospitals do not enter into a network contract with a plan: the highest Medicaid payment rate they have contracted for with another Medicaid plan.

The bill moves Regional Perinatal Intensive Care Centers (RPICC) from the list of statewide essential providers and makes them regional essential providers. The bill expressly requires each plan operating in a region to have a network contract with all RPICCs within that region, and does not require agency designation for RPICCs to make them essential providers.

The bill requires AHCA to assess plan compliance with essential provider contracting requirements at least quarterly and identify the plans that do not have required contracts with essential providers.

Supplemental Payments and Essential Providers

The bill requires essential providers to have a network contract with all plans in their region (or statewide, as applicable), rather than merely making an effort to contract, and eliminates the requirement that AHCA assess the good faith effort of the provider's negotiations. Instead, AHCA must determine whether network contracts exist prior to releasing supplemental payments to the provider. It also requires AHCA to impose contract financial enforcement measures, by January 1 each year, against any plan that does not have a required network contract with an essential provider that receives supplemental payments.

For an essential provider that receives supplemental Medicaid payments but does not contract with all plans, the bill requires the plan and the essential provider to enter into mediation on the network contract. The mediation must begin by July 30 and conclude by September 30 of each fiscal year for which there is a network contract gap. A post-mediation report must be provided to AHCA by the mediator, which must include:

- The outcome of the mediation, and
- If the result was an impasse, it must include:
    - The mediator's conclusions and recommendations regarding the cause of the impasse,
    - The party most responsible for the impasse, and
    - Whether the mediator believes either party negotiated in bad faith.

If the mediator believes one or both parties negotiated in bad faith, the post-mediation report must include the basis for that belief and all relevant documentation. AHCA must promptly publish the post-mediation report online. However, no specific action is required in relation to the post-mediation report.

[52] *Supra*, FN 20, p. 7. All three prepaid dental plans have statewide contracts; recipients in every region have a choice of three plans.

Absent such contracts, AHCA is directed to withhold the supplemental payments as of January 1 of each year until such contracts are in place. Similarly, the bill also provides a contracting enforcement tool applicable to the plans. As described above, no later than January 1 each year, the bill requires AHCA to administer contract financial enforcement measures against plans that have network contract gaps. This gives AHCA the ability to act on both parties, in such circumstances.

This will ensure that essential providers receiving Medicaid dollars are fully available to all Medicaid patients as plan network participants.

Financial Accountability – Workforce Expenditures

The bill expands the type of education funding that may be allowed as a medical expense for calculation of the medical loss ratio. Currently, plan investments in graduate medical education institutions for residency positions are allowed as a medical expense. The bill expands this to allow funds provided for positions:

- Graduate student nursing education positions,
- Undergraduate student nursing education positions, and
- Student positions in any degree or technical program deemed critical shortage by AHCA.

Further, the bill allows these investments, and plan contributions to designated state trust funds that support Medicaid and indigent care as a credit against the Achieved Savings Rebate.

Healthy Behaviors Program

The bill expands the required scope of the Healthy Behaviors program to include:

- Cessation of tobacco use, rather than merely smoking cessation. This addresses the use of smokeless and other non-smokable tobacco products.
- A focus on opioid abuse recovery within the medically approved alcohol and substance recovery program.

Child Welfare Specialty Plan and Guardianship Assistance

The bill authorizes a child welfare specialty care plan under contract with the MMA program to serve a child who continues to be eligible for Medicaid and whose parents or guardians receive GAP payments. This allows a child in the GAP program to choose either a child welfare specialty plan or an MMA plan.

Finally, the bill deletes obsolete provisions, such as the use of fee-for-service contracts to transition PSNs to the risk bearing capitated contract model; removing a reference to the defunct Florida Health Choices Program, and repealing a managed care rate statute applicable to pre-SMMC managed care, which is no longer operable.

Implementation Timeline

The bill directs AHCA to amend existing managed care contracts to implement specific provisions of the bill that affect current performance obligations, such as the provisions addressing dental performance improvement, essential provider network contract requirements, and child welfare plan eligibility. It also directs AHCA to implement the procurement-related provisions for the 2025 plan year.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 2: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 3: Amends s. 409.964, F.S., relating to managed care program; state plan; waivers.

Section 4: Amends s. 409.966, F.S., relating to eligible plans; selection.
Section 5: Amends s. 409.967, F.S., relating to managed care plan accountability.
Section 6: Amends s. 409.968, F.S., relating to managed care plan payments.
Section 7: Amends s. 409.973, F.S., relating to benefits.
Section 8: Amends s. 409.974, F.S., relating to eligible plans.
Section 9: Amends s. 409.975, F.S., relating to managed care plan accountability.
Section 10: Amends s. 409.977, F.S., relating to enrollment.
Section 11: Amends s. 409.981, F.S., relating to eligible long-term care plans.
Section 12: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

AHCA may receive less Achieved Savings Rebate funds due to plan donations in medical education that are eligible for credit against the Achieved Savings Rebate calculation.

Since 2015 AHCA has received over $440 million in achieved savings rebates. See table below.

Achieved Savings Rebate (2015-2020)

2015	2016	2017-2018	2019	2020
$ 2,373,946	$ 30,440,542	$ 12,517,103	$ 129,298,856	$ 274,856,893

Federal CMS requires the state to remit the federal share of rebates received which reduces the net benefit to the state. For the 2020 year, the state added $88.5 million to the general revenue fund. The change to the achieved savings rebate will have an impact to general revenue collections, however, the impact is indeterminate.

2. Expenditures:

AHCA estimates that allowing the GAP children to select the child welfare specialty plan, rather than remaining in or selecting a non-specialty MMA plan, may result in a negative fiscal impact of $4.6 million, annually ($1.8 million, General Revenue).[53]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

[53] *Supra*, FN 20, p. 21.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 23, 2022, the Finance & Facilities Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Removes the reintegration of dental benefits.
- Imposes additional requirements for dental services:
  - Requires medical and dental plans to collaborate on improving patient care
  - Requires AHCA to reconcile dental-related emergency room costs against dental plan capitation rates
  - Requires AHCA to set and enforce network adequacy requirements for sedation dentistry
- Requires AHCA to identify essential providers that do not have required network contracts.
- Requires plans, and essential providers eligible for supplemental payments that do not have required plan contracts, to enter into mediation; establishes mediation timelines; requires a post-mediation report with certain content; and requires AHCA to publish the report online.
- Requires AHCA to impose contract financial enforcement measures against plans without required network contracts with essential providers.
- Makes Regional Perinatal Intensive Care Centers regional essential providers for mandatory network contracting, rather than statewide essential providers.
- Changes the non-participating cancer center reimbursement rate to the highest rate the center negotiated with any Medicaid plan.
- Freezes automatic enrollment for plans with more than 50 percent of the market, rather than 45 percent.
- Requires AHCA to amend existing contracts to implement specific provisions of the bill; directs AHCA to implement the procurement-related provisions for the 2025 plan year.

This analysis is drafted to the committee substitute as passed by the Health & Human Services Committee.