HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

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

FINAL HOUSE FLOOR ACTION: 115 **Y's** 0 **N's** **GOVERNOR'S ACTION:** Approved

SUMMARY ANALYSIS

CS/HB 7047 passed the House on March 8, 2022, as CS/CS/SB 1950, as amended, and was returned to the Senate. On March 11, 2022, the Senate concurred in the House amendment, as amended by the Senate, and returned the bill to the House. The House concurred in the amendment, as amended by the Senate, and subsequently passed the bill, as amended, on March 11, 2022.

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 service regions into nine and adjusts the number of plans per region,
- Requires a single statewide procurement and authorizes regional or statewide contract awards,
- Removes a requirement to rebid the procurement, in part, in regions where a provider service network does not submit a responsive bid,
- Specifies procurement related data posting requirements,
- Expands the Healthy Behaviors Program to include focuses on smokeless tobacco and opioid abuse,
- Requires plans to contract with Florida cancer hospitals as statewide essential 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 plan,
- Provides times for AHCA to implement specific provisions of the bill, and
- Deletes obsolete provisions and makes conforming changes to reflect the bill's requirements.

The bill will have state or no fiscal impact on local government.

The bill was approved by the Governor on April 6, 2022, ch. 2022-41, L.O.F., and will become effective on July 1, 2022.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF 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. 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.[4]

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.[5] Medicaid is the second largest single program in the state, behind public education, representing approximately one-third of the total FY

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

2021-2022 state budget.[6] 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.[7]

Statewide Medicaid Managed Care (SMMC)

Florida delivers medical assistance to most Medicaid recipients – approximately 78% - using a comprehensive managed care model, the SMMC program.[8] 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[9] 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 & risk reduction
Optical services and supplies	Caregiver training
Optometrist services	Respite care
Physical, occupational, respiratory, speech therapies	Personal emergency response system
Physician services, including PA	Transportation
Podiatric services	Medical equipment and supplies

[6] 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).

[7] 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).

[8] *Supra*, FN 5.

[9] 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**
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[10]**	**Enrollment[11]**
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 AHCA's proposed procurement timeline.

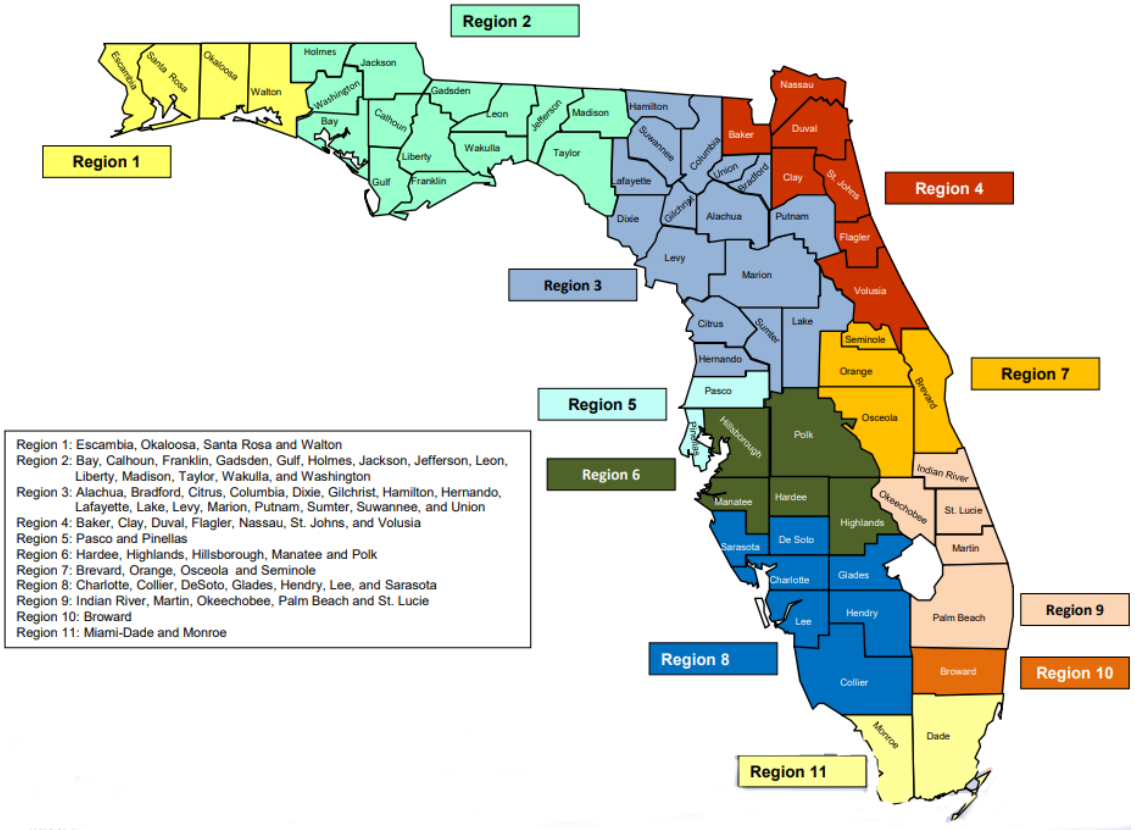
[10] Ch. 2020-36, L.O.F. https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=CRA_.pdf&DocumentType=Amendments&BillNumber=2500&Session=2021 (last visited January 6, 2022). MMA is appropriation 210, pg. 68, and LTC is appropriation 221, pg. 71.

[11] 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.[12]



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

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

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.[13] 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.[14]

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			

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

[14] 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).

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.[15]

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

Provider Networks

Essential Providers

[15] *Id.*, slide 45.

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.[16]

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).[17]

Plan networks must include all essential providers, by contract.[18]

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).

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.[19]

Financial Accountability – Supplemental Payment Programs

Federal Medicaid managed care programs are required 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

[16] Agency for Health Care Administration, *2022 Agency Legislative Bill Analysis, HB 7047*, pp. 8, (February 3, 2022), p. 11.
[17] 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 16, p. 12.
[18] S. 409.975(1), F.S.
[19] S. 409,973(3), F.S.

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.[20]

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.[21]

[20] Agency for Health Care Administration, Presentation to the Health Care Appropriations Subcommittee, *Medicaid Supplemental Payment Overview*, February 15, 2021, https://ahca.myflorida.com/Medicaid/recent_presentations/2021/House_Health_Care_Appropriations_Medicaid_Presentation_Supplemental_Payments_20210215.pdf (last visited January 24, 2022).
[21] *Supra*, FN 10.

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.[22]

To be eligible for supplemental payments, statutory teaching hospitals (if designated as a regional essential provider[23]), faculty plans of Florida medical schools, and specialty children's hospitals 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.[24] 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.[25]

Supplemental Payments to Florida Cancer Hospitals

Federal law allows a cancer hospital to be recognized as a National Cancer Institute–Designated Cancer Center (NCI-Cancer Center). There are 71 NCI-Cancer Centers, nationally.[26] Two are in Florida; Sylvester Cancer Center in Miami and Moffitt Cancer Center in Tampa. Currently, the Florida NCI-Cancer Centers are not Medicaid essential providers. However, they do receive Medicaid funds via supplemental payments, as follows.[27]

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.[28] Medicaid services make up 5 percent of Moffitt's case mix, which is disproportionately low compared to the percentage of Florida's population with Medicaid coverage.

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[22] *Supra*, FN 16, p. 12.
[23] AHCA has never designated any provider as a regional essential provider.
[24] S. 409.908(26), F.S.
[25] *Supra*, FN 16, p. 12.
[26] Of the 71 NCI-Designated Cancer Centers, 12 are Cancer Centers, 52 are Comprehensive Cancer Centers, and 7 are Basic Laboratory Cancer Centers. NIH NATIONAL CANCER INSTITUTE, *NCI-Designated Cancer Centers*, https://www.cancer.gov/research/infrastructure/cancer-centers (last visited Mar. 28, 2022). Cancer Centers are recognized for their scientific leadership, resources, and the depth and breadth of their research in basic, clinical, and/or prevention, cancer control, and population science. Comprehensive Cancer Centers are also recognized for their leadership and resources, in addition to demonstrating an added depth and breadth of research, as well as substantial transdisciplinary research that bridges these scientific areas. Basic Laboratory Cancer Centers are primarily focused on laboratory research and often conduct preclinical translation while working collaboratively with other institutions to apply these laboratory findings to new and better treatments.
[27] Email from Agency for Health Care Administration staff, Re: [no subject], Feb. 4, 2022 (on file with the Finance & Facilities Subcommittee).
[28] Email from Agency for Health Care Administration staff, Re: [no subject], Feb. 15, 2022 (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.[29]

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.

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

The DCF Guardianship Assistance Program (GAP) is a federally-funded program to support relatives and fictive kin[30] who are guardians of children who were removed from their homes due to abuse or neglect.[31] 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.[32] 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.[33]

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 allows AHCA to award plan contracts on a regional or statewide basis. 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.

Regional Procurement

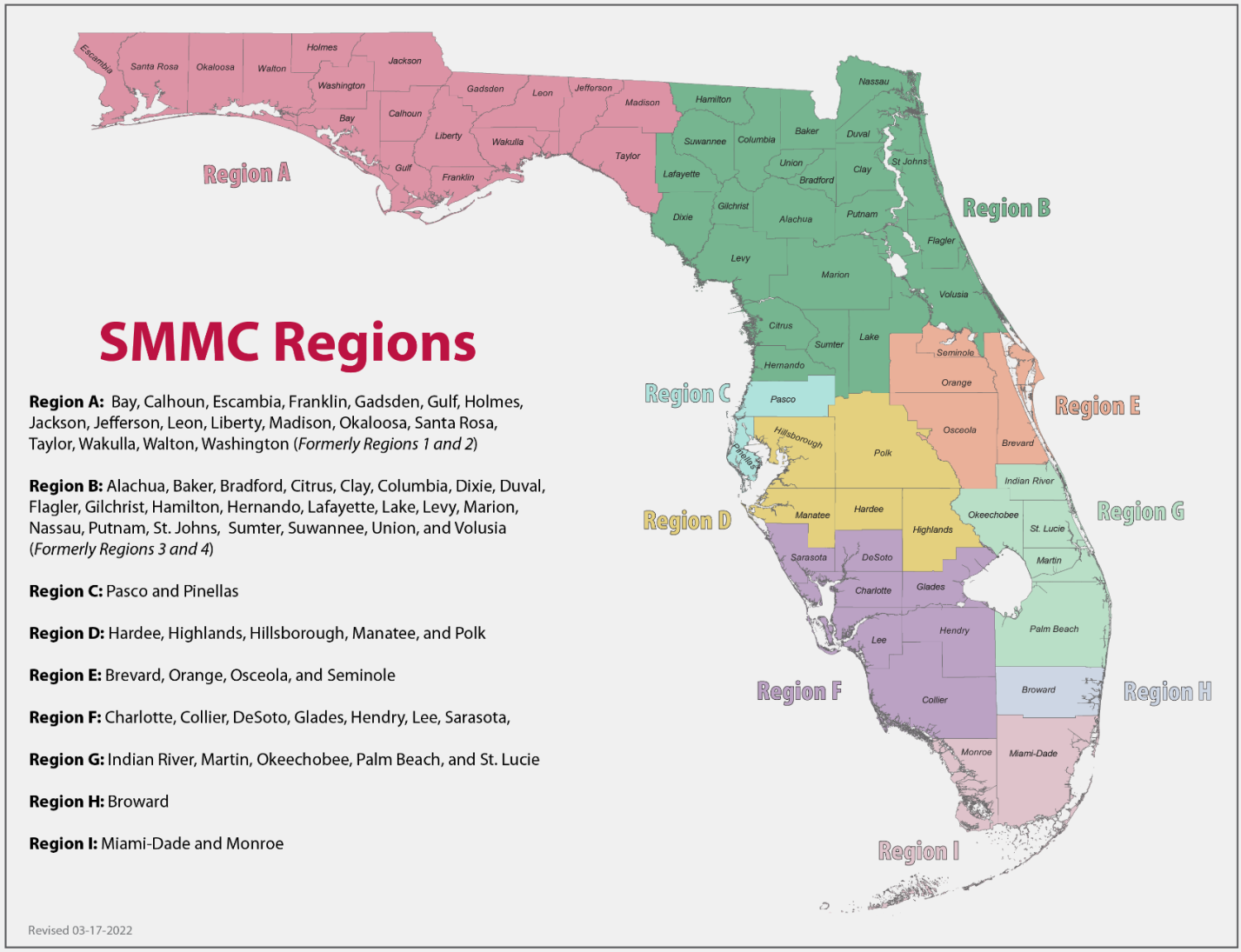
The bill proposes consolidating the eleven SMMC program regions into nine regions. According to AHCA, this configuration is based on enrollee utilization patterns and provider referral patterns over

[30] 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.
[31] 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).
[32] S. 39.6225(5)(d), F.S.
[33] Email from Department of Children and Families staff, Re: GAP, Jan. 20, 2022 (on file with the House Finance & Facilities Subcommittee).

recent years.[34] The chart and map below show the current regions and the proposed consolidated regions.

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

[34] *Supra,* FN 16, 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. 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.[35]

[35] 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.

			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	3 - 6	766,991	153,398	127,832	18,347	6,116	3,058
Region C	Region 5: 2 - 4	3-5	229,734	77,677	46,606	10,688	3,563	2,138
Region D	Region 6: 4 - 7	4-7	558,316	142,215	81,266	14,316	3,579	2,045
Region E	Region 7: 3 - 6	3-6	537,679	179,226	89,613	10,432	3,477	1,739
Region F	Region 8: 2 - 4	3-4	272,543	90,848	68,136	7,234	2,411	1,809
Region G	Region 9: 2 - 4	3-5	353,458	117,819	70,692	11,349	3,783	2,270
Region H	Region 10: 2 - 4	MMA 3-5 LTC 3-4	338,684	112,895	67,737	10,240	3,413	2,560
Region I	Region 11: 5 - 10	5-10	605,902	121,180	60,590	32,791	6,558	3,279

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.

It removes a requirement for AHCA to under award the maximum number of contracts by one in any region where no PSN submits a responsive bid. However, it retains the requirement that the award must include at least one PSN in each region.

Essential Providers

The bill adds Florida's NCI-Cancer Centers to the statutory list of statewide essential providers, requiring all plans in the state to contract with them. Currently, there are two NCI-Cancer Centers: 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. Qualifying Florida cancer hospitals are not added to the list of providers whom AHCA must suspend supplemental payments to for lack of required plan network contracts nor are their supplemental payments made contingent upon providing covered Medicaid services to plan participants.

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.

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 the health behaviors program, designation of NCI-Cancer Centers as essential providers, and child welfare plan eligibility. It also directs AHCA to implement the procurement-related provisions for the 2025 plan year.

Miscellaneous

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, removing a preference for plans that with provider networks in which over 10 percent of the providers use electronic health records, and repealing a managed care rate statute applicable to pre-SMMC managed care, which is no longer operable.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

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).[36]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   None.

D. FISCAL COMMENTS:

   None.

[36] *Supra*, FN 16, p. 21.