Committee on Health Regulation

CS/SB 730 — Medicaid Managed Care

by Health Regulation Committee and Senators Flores, Negron, and Gaetz

Effective May 12, 2012, the bill limits the scope of the Subscriber Assistance Program, which provides assistance to subscribers of certain managed care entities who have grievances that have not been resolved by the internal grievance process of the managed care entity. The bill limits review by the Subscriber Assistance Program to unresolved grievances from subscribers of prepaid health clinics certified under ch. 641, F.S., Florida Healthy Kids plans, and health insurance policies or health maintenance organization contracts that meet the grandfathered health plan coverage provisions under the federal Patient Protection and Affordable Care Act. However, the Subscriber Assistance Program is not applicable to such a health plan if the plan elects to have all of its policies or contracts subject to applicable internal grievance and external review processes by an independent review organization. Such a plan must notify the Agency for Health Care Administration (AHCA) in writing if it elects to have all of its policies or contracts subject to external review.

The bill authorizes the AHCA to extend or modify its current contracts, prior to October 1, 2014, with comprehensive behavioral health care providers that are reimbursed through a capitated, prepaid arrangement in order to ensure continuity of care as the state transitions to statewide managed care. The bill also repeals the October 1, 2014, expiration date set for s. 409.912(21), F.S., that authorizes the AHCA to impose a fine on a Medicaid contract provider that violates s. 409.912, F.S., or its contract with the AHCA.

The bill authorizes the AHCA to calculate a medical loss ratio for managed care plans in the existing Medicaid reform pilot program and the new statewide Medicaid managed care program, if required as a condition of a Medicaid waiver. Expenditures must be classified in a manner consistent with the medical loss ratio requirements under the federal Patient Protection and Affordable Care Act, except that funds provided by plans to graduate medical education institutions to underwrite the costs of residency positions are to be classified as medical expenditures under specified circumstances. Also, prior to final determination of the medical loss ratio, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure.

The bill specifies that contracts between the AHCA and a person or entity, including Medicaid providers and managed care plans, necessary to administer the Medicaid program are not rules and are not subject to ch. 120, F.S.

The definition of "comprehensive long-term care plan," as it is used in the statewide managed care program, is amended to include a Medicare Advantage Special Needs Plan organized as a preferred provider organization, provider-sponsored organization, health maintenance organization, or coordinated care plan. The definition of "eligible plan" is amended to include additional Medicare Advantage plans for purposes of the managed medical assistance program.

The bill modifies the criteria the AHCA must use in giving preferences in the selection of eligible plans in the new statewide managed care program. The bill clarifies the preference that is to be given to organizations that are based in and perform operational functions in this state to include corporate headquarters as an operational function. The term "corporate headquarters" is defined to mean the principal office of the organization.

The penalty provisions for plans in the statewide Medicaid managed care program that reduce enrollment levels or leave a region before the end of their contract term are modified to specify that all departing plans must pay a penalty of 25 percent of that portion of the minimum surplus required by law *which is attributable to the provision of coverage to Medicaid enrollees*, not all their lines of business.

The bill changes a reference to primary care *physician* to primary care *provider* in the primary care initiative under the statewide Medicaid managed care program. The change clarifies that primary care may be provided by a health care practitioner other than a physician, such as an advanced registered nurse practitioner.

The bill amends the requirements for participation of specialty plans in the statewide Medicaid managed care program to exempt specialty plans from the regional plan number limits, however the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region.

The bill specifies that participation of Medicare Advantage plans in the statewide Medicaid managed care program shall be pursuant to a contract with the AHCA that is consistent with the Medicare Improvement for Patients and Providers Act of 2008. Such plans are not subject to the procurement requirements of the statewide Medicaid managed care program if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits as of the date that the invitation to negotiate is issued. The participation of Medicare Advantage plans in the long-term care managed care component of the statewide Medicaid managed care program is limited to Medicare Advantage Special Needs Plans.

Effective May 12, 2012, the bill requires certain individual, group, blanket, and franchise health insurance policies to comply with the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act in accordance with rules adopted by the Office of Insurance Regulation (Financial Services Commission) and certain provisions of the Employee Retirement Income Security Act relating to internal grievances.

If approved by the Governor, these provisions take effect July 1, 2012, except that sections 1, 11, 12, and 13 take effect May 12, 2012.
Vote: Senate 40-0; House 82-37