HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/HB 727 (CS/SB 730)	**FINAL HOUSE FLOOR ACTION:**	
SPONSOR(S):	Health & Human Services Committee; Ingram (Health Regulation; Flores and others)	82 **Y's**	37 **N's**
COMPANION BILLS:	CS/SB 730	**GOVERNOR'S ACTION:**	Approved

SUMMARY ANALYSIS

CS/HB 727 passed the House on March 8, 2012 as CS/SB 730.

During the 2011 Session, the Legislature created the Statewide Medicaid Managed Care Program as an integrated managed care program for all covered services, including long-term care services. Implementation of the Long-Term Care Managed Care Program (LTC Program) will begin July 1, 2012, with full implementation by October 1, 2013. The Managed Medical Assistance Program (MMA Program) will begin by January 1, 2013, with full implementation by October 1, 2014. The bill makes changes to both the current Medicaid program and the Statewide Medicaid Managed Care Program.

Specifically, the bill:

- Authorizes AHCA to extend or modify current contracts for behavioral health care services to ensure continuity of care as the state transitions to statewide managed care.
- Removes the inadvertent repeal of AHCA's authority to impose fines and contract penalties on Medicaid providers and plans.
- Provides that, if required as a condition of a waiver, AHCA may calculate a medical loss ratio (MLR) for managed care plans.
- Clarifies that contracts between AHCA and Medicaid providers, including managed care plans, are not agency rules and are not subject to rule promulgation under Chapter 120, F.S.
- Modifies the preference given to managed care plans with a substantial presence in Florida when responding to the invitation to negotiate for Statewide Medicaid Managed Care.
- Clarifies the participation of Medicare plans in both the MMA Program and the LTC Program.
- Limits the participation of specialty plans in the MMA Program.
- Modifies the imposition of penalties on Medicaid managed care plans that withdraw from or reduce enrollment in a region.

The bill creates new internal claims review and external grievance procedures for health plans and HMOs. These new procedures will cause a decreased caseload to the Subscriber Assistance Program which is estimated to result in a recurring savings of $28,654 to AHCA.

The bill was approved by the Governor on April 6, 2012, ch. 2012-44, Laws of Florida. Except as expressly provided, the effective date of the bill is July 1, 2012.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

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, the Agency for Persons with Disabilities, and the Department of Elder Affairs. Florida's Medicaid program is estimated[1] to have 3.2 million enrolled recipients, and $20.2 billion in spending, in Fiscal Year 2011-2012.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government as a condition of receiving federal funds. 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: Some populations are entitled to enroll in the program; and enrollees are entitled to certain benefits.

Medicaid Managed Care

Florida, like other states, turned to managed care for improving access to care, containing costs and enhancing quality. As of March 1, 2011, 67% of Medicaid participants were enrolled in managed care, although these arrangements cover a broad range of managed care models. Florida uses at least 16 different managed care models, including prepaid health plans Health Maintenance Organizations (HMOs), primary care case management (MediPass)[2], provider service networks (PSNs)[3], Minority Provider Networks (MPNs), MediPass disease management, prepaid mental health plans, and prepaid dental health plans.

The Florida Medicaid Program pays for services in three ways: (1) fee-for-service reimbursement based on claims from health care providers who have signed Medicaid provider agreements; (2) per-member, per-month payments to certain managed care organizations which bear full risk for recipient care; and (3) fee-for-service reimbursement to PSNs which must meet and share savings targets or reimburse the Medicaid program for failure to meet the target.

Medicaid uses a per-member, per-month, or capitated, payment model for Health Maintenance Organizations (HMOs), capitated PSNs, Prepaid Behavioral Health programs, and Nursing Home Diversion programs. Under capitation, contracting organizations or health plans agree to provide or accept financial liability for a broad range of Medicaid covered services in return for a fixed monthly payment for each individual enrolled in the contracting organization's plan. The Florida Medicaid program has been using capitated payment systems since the early 1990s.

[1] Social Services Estimating Conference, January 4, 2012; available at: http://edr.state.fl.us/Content/conferences/medicaid/index.cfm (last viewed February 24, 2012).
[2] MediPass is the Florida Medicaid primary care case management program. Services to MediPass members are reimbursed on a fee-for-service basis, and MediPass primary care providers (PCPs) are paid a $2.00 per member per month case management fee. PCPs are responsible for providing primary care and authorizing the specialty care provided to their enrollees. PCPs do not bear risk for their patients but do have requirements in place for case management, care coordination, and preventive care.
[3] S. 409.912(4)(d), F.S.

Rates for HMOs are set for specific demographic cohorts based on age, sex, geographic location and eligibility group. While these factors are linked with utilization patterns to some extent, they do not capture or reflect any detailed understanding of a person's clinical risk. The Medicaid reform pilot (see below) initiated a process for adjusting rates to reflect clinical risk. The adjustments were phased in over a three-year period with a 10% risk corridor to limit any dramatic changes in payment levels.

Medicaid uses fee-for-service reimbursement for PSNs, including MPNs. PSNs are required by contract to demonstrate savings over historic fee-for-service care, and savings achieved above a set goal are shared with the PSN. Historically, the contracts have provided that failure to achieve savings goals will result in reimbursement to Medicaid of a portion of the case management payments. While all minority physician networks have achieved savings to the Medicaid program, some networks have not met the savings goals set in their contracts.

Federal regulations require Medicaid beneficiaries to have a choice of managed care providers. This requirement may be satisfied by a choice of HMOs, or a choice between an HMO and MediPass, or a choice among MediPass providers. Upon enrollment in Medicaid, recipients have 30 days to exercise their choice of providers. Choice counseling is available during this period through a toll-free help line in non-reform counties. Those who select a managed care plan are enrolled for a 12-month period. After enrollment, beneficiaries have 90 days to try the plan and request a change. After 90 days, they must stay in the plan for the next nine months. For those who do not make a choice, current law requires AHCA in non-reform counties to assign recipients "until an enrollment of 35 percent in MediPass and 65 percent in managed care plans" is achieved. The law further requires enrollment procedures to maintain this same proportionate distribution over time. After these considerations, assignment procedures may consider past choices of the participants.

Managed Behavioral Health Care

AHCA provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs. Florida began testing managed care models for providing mental health care for Medicaid enrollees under a federal 1915(b) waiver, as a mental health carve-out demonstration project in 1996 in the Tampa Bay area. The purpose of the demonstration was to create a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the initial demonstration project, Florida continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the MediPass plan, both physical health and pharmacy benefits are paid for on a fee-for-service basis. For beneficiaries enrolled in a HMO, physical health and pharmacy benefits are paid for through a capitated arrangement.

In 2005, with federal approval, Florida expanded managed care for mental health coverage under capitated Medicaid managed care plans throughout the state to serve Medicaid recipients not enrolled in HMOs. Current law requires Medicaid to competitively procure a single prepaid behavioral health plan in each AHCA area, with a few exceptions.[4] AHCA has competitively procured a single prepaid behavioral health plan in each non-reform AHCA area. Those single plans currently exist in each AHCA area, with some exceptions and variances.[5]

[4] S. 409.912(4)(b), F.S.

[5] In AHCA Area 11, AHCA contracts with several managed care organizations. While many of these organizations provide comprehensive health care that includes physical and behavioral health, there are two prepaid mental health plans that provide comprehensive behavioral health care. One of the prepaid mental health plans is a public hospital-operated PSN providing behavioral health services to a minimum of 50,000 MediPass and PSN recipients. Initially, in AHCA Area 6, the comprehensive behavioral health providers already under contract with AHCA were used and their contracts were later amended to include substance abuse treatment services. For children enrolled in Home SafeNet, Florida Safe Families Network comprehensive behavioral health services are provided through a specialty prepaid plan operated by a community based lead agency pursuant to s. 409.912(8), F.S.

Medicaid Reform

In 2005, the Legislature enacted laws to revise the delivery of and payment for health care services in Medicaid, and authorized AHCA to seek and implement a federal waiver for a managed care pilot program. AHCA received approval for the five-year pilot and began implementing reformed Medicaid in 2006 in Broward and Duval Counties, adding Baker, Clay and Nassau Counties in 2007, pursuant to statutory direction. The reform is characterized by:

- A managed, coordinated system of care.
- Choices and new options for recipients:
  - Different managed care plans, which can offer additional and varying benefits
  - Different models of managed care - between a traditional HMO model and a new provider-based model
  - Opt-out – opportunity to use Medicaid dollars to purchase employer-based insurance
  - Enhanced benefits - opportunities to be rewarded for healthy behaviors
- Actuarially sound, risk-adjusted, capitated premiums based on encounter data.
- A Low-Income Pool for distributing supplemental payments to providers serving Medicaid and uninsured patients.

The law set a goal of statewide expansion by 2011, and the approved federal waiver required it; however, the Legislature did not approve expansion. The original five-year waiver would have expired on June 30, 2011. In 2010, the Legislature directed AHCA to seek an extension of the waiver from the Centers for Medicare and Medicaid Services (CMS). Extension of the waiver was granted and the waiver has been extended through June 30, 2014.[6] As a condition of the extension, CMS required that Florida impose a medical loss ratio on participating plans. CMS did not mandate the method for calculation of the medical loss ratio.

Medical Loss Ratio

A medical loss ratio (MLR) is a comparison of expenditures for medical services and premium revenue expressed as a ratio. For example, if a plan takes in $100 in premium and spends $80 dollars on health services and $20 on administration, the MLR is 80%.

MLRs were originally internal accounting statistics developed by insurance companies to measure what fraction of premium revenues were paid out in claims.[7] States began to require insurers to file loss ratio information as part of their documentation of solvency.[8] There has been a movement by policy makers toward using the MLR as an indication of plan quality.

One of the major difficulties in using a MLR as an indicator for any measure is there is no uniform method used to calculate a MLR. The MLR can vary greatly depending on what is counted as medical claims and what is counted as administrative expenses. MLRs may vary from one accounting period to another for many reasons. Among small plans, this volatility is exaggerated even further.

Statewide Medicaid Managed Care

During the 2011Session, the Legislature created the Statewide Medicaid Managed Care Program[9] as an integrated managed care program for all covered services, including long-term care services.

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[6] Letter from CMS to AHCA, dated December 15, 2011; available at: http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/CMS_Approval_Letter_12-15-2011.pdf.

[7] J.C. Robinson, *Use and Abuse of Medical Loss Ratios to Measure Health Plan Performance*, HEALTH AFFAIRS, 16, no.4 (1997):176-187; available at: http://content.healthaffairs.org/content/16/4/176 (last viewed February 26, 2012).

[8] *Id*.

[9] Ch. 2011-124, L.O.F.

Medicaid will consist of two managed care programs:

- The Medicaid Managed Medical Assistance Program (MMA Program)[10] – primary and acute care
- The Long-Term Care Managed Care Program (LTC Program)[11] – residential and home and community based care, alone or paired with primary acute care for comprehensive coverage

The statewide managed care program has the following characteristics:

- Care and services provided in a managed care model.
- Mandatory participation for most populations, voluntary participation for some, and some populations excluded.
- Competitive, negotiated selection of qualified managed care plans that meet strict selection criteria.
- Regionalized plan selection of a limited number of plans to ensure coverage in rural areas.
- Limited plan numbers in the 11 regions to ensure stability but allow significant patient choice.
- Varying models of managed care, including HMOs, PSNs, specialty plans, and medical home plans.
- Specific plan accountability measures, including network standards, achieved savings rebates, encounter data, performance measures, and fraud and abuse measures.
- Negotiated payments based on risk-adjusted rates.
- Customized benefits to allow meaningful recipient choice.
- Opt Out Program for recipients who would rather use their Medicaid dollars to purchase other forms of coverage.

AHCA was directed to apply for state plan amendments or waivers of applicable federal laws necessary to implement the program by August 1, 2011.[12] Subject to federal approval, Implementation of the LTC Program will begin July 1, 2012, with full implementation by October 1, 2013.[13] Subject to federal approval, AHCA will begin implementing the MMA Program by January 1, 2013, with full implementation by October 1, 2014.[14]

Plan Selection

Medicaid managed care must be provided by an eligible plan.[15] Eligible plans include health insurers, exclusive provider organizations, health maintenance organizations, and provider service networks. These organizations are required to meet relevant statutory solvency and regulatory requirements. A provider service network must be capable of providing all covered services or may limit the provision of services to a specific target population based on age, chronic disease, or medical condition. Eligible plans include accountable care organizations which meet federal requirements and qualify as provider service networks.

In addition to the types of plans that are generally qualified to participate, plans that offer managed care for Medicare recipients may participate in the LTC Program.[16] These plans include Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans. If their enrollees consist exclusively of dual eligibles, these plans do not count toward the regional plan number limits for the LTC Program.

[10] S. 409.971, F.S.
[11] S. 409.987, F.S.
[12] S. 409.964, F.S.
[13] S. 409.978, F.S.
[14] S. 409.971, F.S.
[15] S. 409.962(6), F.S.
[16] S. 409.981, F.S.

AHCA will select a limited number of qualified plans to participate in the Medicaid managed care program using invitations to negotiate (ITNs).[17] The number of plans varies by region, and between the three programs. The bill divides the state into eleven regions by counties. Separate and simultaneous procurements shall be conducted in each of the regions.

AHCA shall specify in the ITNs the criteria and the relative weight of the criteria that will be used in the selection of organizations to engage in negotiations. In addition to criteria established by AHCA, AHCA must consider[18]:

- Accreditation by the National Committee for Quality Assurance, The Joint Commission, or another nationally recognized accrediting body.
- Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.
- Availability and accessibility of primary care and specialty physicians in the provider network.
- Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.
- Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.
- Provision of additional benefits, particularly dental care and disease management, and other enhanced benefit programs.
- Evidence that the plan has contracts or has made substantial progress in obtaining contracts with needed providers.
- Comments by Medicaid providers relating to the plan.
- Fraud and abuse prevention policies and procedures.
- The business relationships the plan has with any other plan who responds to the invitation to negotiate.

AHCA is prohibited from selecting a plan that has a business relationship with another bidding plan in the same region. Plans which fail to disclose its business relationships with other bidders will be disqualified from participation in any region for the next full (five-year) contract period.

At the conclusion of the negotiations, AHCA will select the plans that provide the best value to the state. If all other factors are equal, preference shall be given to plans that:

- Have signed contract with sufficient numbers of primary and specialty physicians.
- Recognize and compensate medical homes or accountable care organizations.
- Provide greater economic benefit to Florida through employment of or subcontracts with Floridians.
- Have a cancer disease management program meeting certain criteria.
- Have disease management programs meeting certain criteria.
- Have prompt payment processes for provider claims.

Additional, program-specific, criteria applies to the ITN process for the two managed care programs.

MMA Program Benefits[19]

Plans selected to serve recipients in the MMA program must cover, at a minimum, the following benefits:

- Advanced registered nurse practitioner services
- Ambulatory surgical treatment center services

[17] S. 409.966(2), F.S.
[18] S. 409.966(3), F.S.
[19] S. 409.973, F.S.

- Birthing center services
- Chiropractic services
- Dental services
- Early periodic screening diagnosis and treatment services for recipients under age 21
- Emergency services
- Family planning services and supplies
- Healthy start services
- Hearing services
- Home health agency services
- Hospice services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory and X-ray services
- Medical supplies, equipment, prostheses, and orthoses
- Mental health services
- Nursing care
- Optical services and supplies
- Optometrist services
- Physical, occupational, respiratory, and speech therapy services
- Physician services
- Podiatric services
- Prescription drugs
- Renal dialysis services
- Respiratory equipment and supplies
- Rural health clinic services
- Substance abuse treatment services
- Transportation to access covered services

Plans can customize the benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The agency must evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

Plans may opt out of providing family planning services on moral or religious grounds, pursuant to 42 C.F.R. s. 438.102. In such an instance, these services would be provided through fee-for-service payments.

Primary Care Initiative[20]

Each plan participating in the MMA Program must establish an initiative to encourage enrollees to establish a relationship with a primary care provider. Plans must provide information to enrollees about the importance of having a primary care physician, and on how to select a primary care provider. Plans must assign a primary care provider to any enrollee who fails to do so. For new Medicaid recipients, plans must assist the recipient in scheduling an appointment with the primary care provider. Plans must report data on primary care assignments, enrollees who have not had a primary care appointment in their first year of enrollment, and on emergency room visits by those enrollees.

[20] S. 409.973(4), F.S.

LTC Program Benefits[21]

Participating LTC Program managed care plans are required to provide minimum benefits that include nursing home as well as home and community based services. Plans will be free to customize and offer additional serves. The minimum benefits include:

- Nursing home
- Services provided in assisted living facilities
- Hospice
- Adult day care
- Medical equipment and supplies, including incontinence supplies
- Personal care
- Home accessibility adaptation
- Behavior management
- Home delivered meals
- Case management
- Therapies: physical, respiratory, speech, and occupational
- Intermittent and skilled nursing
- Medication administration
- Medication management
- Nutritional assessment and risk reduction
- Caregiver training
- Respite care
- Transportation
- Personal emergency response system

Medicare Advantage Plans

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services.

Medicare has four different parts that cover specific services:

- *Part A* (Hospital Insurance) helps cover inpatient care in hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care.
- *Part B* (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps cover some preventive services that help people maintain their health and keep certain illnesses from getting worse.
- *Part C* (Medicare Advantage Plans) covers Part A, Part B, and usually Part D services provided by Medicare-approved private insurance companies.
- *Part D* (Prescription Drug Coverage) helps cover the cost of prescription drugs through Medicare-approved private insurance companies.

The Balanced Budget Act of 1997 established a new Part C of the Medicare program, known then as the Medicare+Choice program, effective January 1999. The act authorized the CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans, Medicare Medical Savings Account plans, private-fee-for-service plans, and

[21] S. 409.98, F.S.

Religious Fraternal Benefit plans. These health plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the original Medicare program.

The Medicare+Choice program in Part C of Medicare was renamed the Medicare Advantage Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which was enacted in December 2003. This act updated and improved the choice of plans for beneficiaries under Part C. Beneficiaries may now choose from additional plan options, including regional preferred provider organization plans and special needs plans. The act also established the Medicare prescription drug benefit (Part D) program, and amended the Part C program to allow (and, for organizations offering coordinated care plans, require) most Medicare Advantage plans to offer prescription drug coverage.

Coordinated care plans are plans that include a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by the CMS. They may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. Coordinated care plans include plans offered by any of the following:

- Health maintenance organizations (HMOs);
- Provider-sponsored organizations (PSOs);
- Regional or local preferred provider organizations (PPOs);
- Other network plans, except for private-fee-for-service plans; and
- Specialized Medicare Advantage plans for special needs individuals, which include any type of coordinated care plan that exclusively enrolls special needs individuals.[22] Special needs individuals are Medicare Advantage eligible individuals who are institutionalized, have severe or disabling chronic conditions, or qualify both for Medicare and Medicaid benefits (dual eligibles).[23]

Specialized Medicare Advantage plans for special needs individuals must provide Part D benefits. They must be designated by the CMS as meeting the requirements of a Medicare Advantage special needs plan as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.
The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandates that Medicare Advantage organizations seeking to offer a Special Needs Plan serving beneficiaries eligible for both Medicare and Medicaid must have a contract with the State Medicaid agency (the AHCA).[24] Medicare Advantage organizations currently offering these plans can continue to do so through Plan Year 2012 without a contract so long as they do not change the plan type or seek to expand the plan's service area.

A Medicare Advantage Special Needs Plan:

- Enrolls special needs individuals entitled to medical assistance under Medicaid;
- Provides dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;
- Has a capitated contract with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services;
- Coordinates the delivery of covered Medicare and Medicaid health and long-term care services using aligned care management and specialty network methods for high-risk beneficiaries; and

[22] 42 C.F.R. 422.4 (2010).
[23] 42 C.F.R. 422.2 (2010).
[24] 42 C.F.R. 422.107 (2010).

- Employs policies and procedures approved by the CMS and the State to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.[25]

Dual Eligibles

Dual eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage. Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing, and - for those below certain income and asset thresholds - long-term care services. The term "dual eligible" encompasses all Medicare beneficiaries who receive Medicaid assistance, including those who receive the full range of Medicaid benefits and those who receive assistance only with Medicare premiums or cost sharing. Currently, dual eligibles cannot be mandatorily assigned to managed care.

Subscriber Assistance Program

The Subscriber Assistance Program[26] provides assistance to subscribers who grievance has not been resolved by a managed care entity. Subscribers of HMOs, prepaid health plans, and exclusive provider organizations may utilize the program only after they have completed their managed care plan's internal review process.

AHCA implements the program and provides a panel[27] to hear grievances. The panel makes recommendations to AHCA or the Office of Insurance Regulation for any action that should be taken on individual cases.

Internal Claims Review and External Review

The Patient Protection and Affordable Care Act (PPACA)[28], as amended by the Health Care and Education Reconciliation Act of 2010[29], created Sec. 2719 of the Public Health Service Act.[30] This new section imposes requirements related to internal claim and appeal processes and external review processes for group health plans and health insurance coverage. On July 23, 2010, regulations[31] were issued implementing the section.

Starting with plan years that begin after July, 1, 2011, health plans must have internal claims review procedures that meet the requirements of the ERISA claim procedure rules found in 29 CFR s. 2560.503-1.

For plan years that begin after July 1, 2011, these federal regulations[32] require group health plans to comply with a state's external review process to the extent the process uses a similar process to the National Association of Insurance Commissioners (NAIC)[33] Uniform Health Carrier External Review

[25] 42 C.F.R. 422.2 (2010).
[26] S. 408.7056, F.S.
[27] S. 408.7056(11)(a), F.S., provides the panel shall consist of the Insurance Consumer Advocate, or designee thereof, established by s. 627.0613; at least two members employed by the agency and at least two members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and, if necessary, physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director, a primary care physician, or both, who shall provide additional technical expertise to the panel but shall not be voting members of the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.
[28] P.L. 111-148, 124 Stat. 119 (2010).
[29] P.L. 111-152, 124 Stat. 1029 (2010).
[30] 42 U.S.C. 300 gg-19
[31] "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act" 75 Federal Register 141 (July 23, 2010) pp. 43330-43364.
[32] 45 C.F.R. 147.136
[33] NAIC is "the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories." See NIAC's webpage, available at: http://www.naic.org (last viewed on March 14, 2012).

Model Act [34]. If the Secretary of the United States Department of Health and Human Services finds a state's external review process does not meet the minimum standards, insurers must use an HHS-supervised review process.

The Secretary of the United States Department of Health and Human Services has found that Florida's external review process does not meet the minimum NAIC Uniform Model Act standards.[35]

Effect of Proposed Changes

The bill provides that, effective July 1, 2012, AHCA is authorized to extend or modify current contracts for behavioral health care services to ensure continuity of care as the state transitions from the current Medicaid program to the Statewide Managed Care Program.

Chapter 2011-135, L.O.F., inadvertently repealed, effective October 1, 2014, AHCA's authority to impose fines and contract penalties on Medicaid providers and plans. The bill removes the sunset date.

The bill provides that, if required as a condition of a waiver, AHCA may calculate a MLR for managed care plans. The calculation shall use data collected from all plans and be computed for each plan on a statewide basis. In developing the MLR, AHCA shall classify expenditures in a manner consistent with federal rules. However, the following expenditures by a managed care plan will also be included as medical expenditures:

- Funds provided to graduate medical education institutions, if the funding is sufficient to sustain the residency position for the number of years needed to complete the residency requirements and the positions funded are active providers to Medicaid and uninsured patients.
- Funds provided to a designed state trust fund for the purpose of supporting Medicaid and indigent care.

The bill clarifies that contracts between AHCA and Medicaid providers, including managed care plans, are not agency rules and are not subject to rule promulgation under Chapter 120, F.S.

The bill modifies the preference given to managed care plans with a substantial presence in Florida when responding to the invitation to negotiate for Statewide Medicaid Managed Care. Under current law, preference will be given to a plan that is based in and performs operational functions in Florida. The bill amends the definition of "operational functions" to include corporate headquarters, which is defined to mean the plan's principal office.

The bill clarifies the participation of Medicare plans in both the MMA Program and the LTC Program. The bill provides that the following plan types may participate:

- Medicare Advantage Preferred Provider Organizations
- Medicare Advantage Provider-sponsored Organizations
- Medicare Advantage Health Maintenance Organizations
- Medicare Advantage Coordinated Care Plans
- Medicare Advantage Special Needs Plans

The above types of Medicare plans may participate in the MMA Program in two ways depending on which Medicaid participants they want to be able to enroll. One way is to submit a bid through the invitation to negotiate. If selected, the Medicare plan would be able to accept any Medicaid enrollee.

[34] NAIC issued the Uniform Health Carrier External Review Model Act in April, 2010, available at: http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf (last viewed March 14, 2012).
[35] Letter dated July 29, 2011, to Kevin McCarty, Insurance Commissioner, State of Florida, from Steve Larsen, Director, Center for Consumer Information and Insurance Oversight (on file with the HHS Committee).

The second option is for the Medicare plan to contract with AHCA under terms consistent with the Medicare Improvement for Patients and Providers Act of 2008. Medicare plans participating through this second method can only enroll Medicaid recipients who are already in their plans for the purpose of receiving Medicare benefits as of the date the invitation to negotiate is issued. The same two methods are permitted for the LTC Program, but only Medicare Special Needs Plans can participate in the second method.

Under current law, a managed care plan that reduced enrollment in or leaves a region before the end of the contract will be charged a penalty by AHCA. The plan will pay a per-enrollee penalty of up to 3 months' payment and must continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan. Departing plans must pay an additional penalty of 25 percent of that portion of the minimum surplus required under s. 641.225(1), F.S.[36] The bill provides that the penalty is calculated only using the minimum surplus which is attributable to the provision of coverage to Medicaid enrollees.

A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis. Examples include HIV/AIDS plans and plans that serve children. Under current law a specialty plan would be able to participate in the MMA Program and not be subject to the limitation of number of plans in a region, if its target population includes no more than 10 percent of the enrollees of a region. The bill repeals this exception and provides that the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of the region.

The bill changes a reference from “primary care physician” to “primary care provider” for purposes of the Primary Care Initiative in Statewide Medicaid Managed Care.

Effective May 12, 1012, the bill provides that the Subscriber Assistance Program shall only apply to prepaid health clinics, Florida Healthy Kids plans, and health plan health insurance policies or health maintenance contracts that are exempt[37] from federal external review requirements. The program does not apply to these exempt health plans if they elect to use an independent review organization for internal grievance and external review processes.

Effective May 12, 1012, the bill provides individual and group health insurers, which are not exempt, must have internal claims review procedures that meet the requirements of the ERISA claim procedure rules found in 29 CFR s. 2560.503-1.

Effective May 12, 1012, the bill provides that Office of Insurance Regulation may adopt rules for health plans to implement an external grievance review process based on the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act. The bill also provides that health insurers and HMOs, which are not exempt, must comply with these rules.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

[36] S. 641.225(2), F.S., provides that each health maintenance organization shall at all times maintain a minimum surplus in an amount that is the greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total annualized premium

[37] 45 C.F.R. s. 147.140 provides the criteria to be considered a “grandfathered” plan under PPACA. Grandfathered plans are exempt from the internal grievance and external review processes.

The Agency for Health Care Administration estimates that the Subscriber Assistance Program may experience a recurring savings of $28,654. The Program is projected to receive 441 cases in FY 2011-12 and has a budget of $58,492. AHCA estimates that the new external review procedures will result in a 41.5% reduction in cases with corresponding savings for OPS services, court reporting, and postage.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.