By the Committee on Health Regulation; and Senators Flores, Negron, and Gaetz

588-02046A-12 2012730c1

A bill to be entitled

An act relating to Medicaid managed care plans; amending s. 409.9122, F.S.; requiring the Agency for Health Care Administration to establish per-member, per-month payments; substituting the Medicare Advantage Coordinated Care Plan for the Medicare Advantage Special Needs Plan; amending s. 409.962, F.S.; revising the definition of "eligible plan" to include certain Medicare plans; amending s. 409.967, F.S.; limiting the penalty that a plan must pay if it leaves a region before the end of the contract term; amending s. 409.974, F.S.; correcting a cross-reference; providing that certain Medicare plans are not subject to procurement requirements or plan limits; amending s. 409.977, F.S.; requiring dually eligible Medicaid recipients to be enrolled in the Medicare plan in which they are already enrolled; amending s. 409.981, F.S.; revising the list of Medicare plans that are not subject to procurement requirements for long-term care plans; amending s. 409.984, F.S.; revising the list of Medicare plans in which dually eligible Medicaid recipients are enrolled in order to receive long-term care; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (15) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(15) The agency shall ~~may~~ establish a per-member, per-month payment for enrollees who are enrolled in a Medicare Advantage Coordinated Care Plan and who ~~Medicare Advantage Special Needs members that~~ are also eligible for Medicaid as a mechanism for meeting the state's cost-sharing obligation. The agency may also develop a per-member, per-month payment only for Medicaid-covered services for which the state is responsible. The agency shall develop a mechanism to ensure that such per-member, per-month payment enhances the value to the state and enrolled members by limiting cost sharing, enhances the scope of Medicare supplemental benefits that are equal to or greater than Medicaid coverage for select services, and improves care coordination.

Section 2. Subsection (6) of section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, ~~or~~ a provider service network authorized under s. 409.912(4)(d), or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391. For purposes of dually eligible Medicaid and Medicare recipients enrolled in the managed medical assistance program and the long-term care managed care program, the term also includes entities

qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, ~~and~~ Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

Section 3. Paragraph (h) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(h) *Penalties.*—

1. Withdrawal and enrollment reduction.—Managed care plans that reduce enrollment levels or leave a region before the end of the contract term must reimburse the agency for the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per-enrollee ~~per enrollee~~ penalty of up to 3 months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained ~~requirement~~ pursuant to s. 641.225(1) which is attributable to the provision of coverage to Medicaid enrollees. Plans shall provide at least 180

days' notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions~~,~~ pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to provide for the transition of enrollees to other plans, and phase in ~~phase-in~~ the terminations over a time period sufficient to ensure a smooth transition.

Section 4. Subsection (2) of section 409.974, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

409.974 Eligible plans.—

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitted ~~submitting~~ a response.

The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as determined ~~defined~~ by the agency pursuant to s. 409.975(1) ~~409.975(2)~~. The agency shall exercise a preference for plans with a provider network in which more than ~~over~~ 10 percent of the providers use electronic health records, as defined in s. 408.051. When all other factors are equal, the agency shall consider whether the organization has a contract to provide managed long-term care services in the same region and shall exercise a preference for such plans.

(5) MEDICARE PLANS.—Participation by an entity qualified under 42 C.F.R. PART 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and is not subject to the procurement requirements or regional plan limits of this section if the plan's Medicaid enrollees in the region consist exclusively of its current Medicare enrollees who are dually eligible for Medicaid and Medicare services. Otherwise, such organizations and plans are subject to all procurement requirements.

Section 5. Subsection (1) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s.

409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If ~~When~~ a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available. If a recipient is dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity listed in s. 409.974(5), the agency shall automatically enroll the recipient in that plan for Medicaid services if the plan is currently under contract with the agency pursuant to s. 409.974(5). Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Section 6. Subsection (5) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(5) MEDICARE PLANS.—Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and is not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of its current Medicare enrollees ~~recipients~~ who are deemed dually eligible for Medicaid and Medicare services.

Otherwise, such organizations and plans ~~Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans~~ are subject to all procurement requirements.

Section 7. Subsection (1) of section 409.984, Florida Statutes, is amended to read:

409.984 Enrollment in a long-term care managed care plan.—

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, Medicare Advantage Health Maintenance Organization, Medicare Advantage Coordinated Care Plan, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is under contract with the agency ~~currently participating in the long-term care managed care program~~. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Section 8. This act shall take effect July 1, 2012.