The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 306
INTRODUCER:	Senators Sharief and Gaetz
SUBJECT:	Managed Care Plan Network Access
DATE:	March 31, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 306 amends ss. 409.967 and 409.975, F.S., to require Medicaid managed care plans to allow enrollees to receive care from nonparticipating Medicaid providers under certain circumstances.

The bill also requires the plan to reimburse the nonparticipating Medicaid provider at the applicable Medicaid rate for such services under the plan.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

The Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA) is created under s. 20.42, F.S., to be the chief health policy and planning entity for the state, responsible for health facility licensure, inspection, and regulatory enforcement,[1] as well as the administration of Florida's Medicaid program.[2]

The Florida Medicaid Program

The Medicaid program is a voluntary, federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[3] The federal Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services is responsible for administering the Medicaid

[1] Florida Agency for Health Care Administration, *Health Quality Assurance, available at* https://ahca.myflorida.com/health-quality-assurance (last visited Mar. 27, 2025).
[2] Section 409.902, F.S.
[3] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid (last visited Mar. 27, 2025).

program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians and is financed through state and federal funds.[4]

Statewide Medicaid Managed Care

Approximately 72.5 percent of Florida Medicaid recipients[5] receive services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[6] The SMMC program has three components: Managed Medical Assistance (MMA), Long-Term Care (LTC), and the Prepaid Dental Health program.[7] Among these three components, Florida's SMMC program offers a health care package covering acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S.[8]

The AHCA awarded contracts to the current SMMC managed care plans through a competitive procurement process called an Invitation to Negotiate (ITN). The AHCA awarded and executed new contracts for SMMC 3.0 in October 2024 and officially rolled out the new SMMC 3.0 program on February 1, 2025.[9] The rate year for the SMMC contracts is October 1 through September 30 of each contract year.[10]

Managed care plans providing MMA program services are required to cover acute, preventive, and other health care services, such as:[11]

- Hospital services;
- Physician services;
- Pharmacy services;
- Behavioral health services;
- Transportation to medical services;
- Nursing facility services; and
- Other service benefits, including, but not limited to, medical equipment and supplies, therapies, and home health services.

[4] Section 20.42, F.S.
[5] The other 27.5 percent of recipients receive Medicaid services through the fee-for-service (FFS) delivery model, where providers contract directly with the AHCA to render services, billing and receiving reimbursement directly from the AHCA; Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[6] Florida Agency for Health Care Administration, *Florida Statewide Medicaid Enrollment Report As of February 28, 2025 (including Medikids Population), available at* https://ahca.myflorida.com/content/download/26230/file/ENR_202502.xls (last visited Mar. 27, 2025).
[7] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Mar. 27, 2025).
[8] Florida Agency for Health Care Administration, *Senate Bill 306* (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[9] *Id*.
[10] Florida Agency for Health Care Administration, *Senate Bill 1060* (Feb. 28, 2025) (on file with Senate Committee on Health Policy).
[11] *Supra* note 8.

The AHCA contracts with LTC plans in each region to provide LTC services, including all home and community-based waiver services, through their provider networks. Currently, all of the LTC plans contracted with the AHCA are also contracted to provide MMA services, streamlining care with a more comprehensive enrollment approach where a Medicaid recipient can enroll with one plan for all services.[12]

SMMC Capitation Payments

In a managed care delivery model, managed care plans contract with the AHCA and are paid a per-member, per-month (PMPM) capitation rate for each plan enrollee to provide medical, dental, or home and community-based care, depending on the type of managed care plan. The capitation rates reflect historical utilization and spending for covered services projected forward, and the PMPM capitation rate is paid to each plan each month regardless of the actual expenditure or level of claims of an individual enrollee. Providers contract with managed care plans, negotiating mutually agreed-upon rates for most services, and bill the plans for services rendered to enrollees.[13]

Provider Networks

A provider network is a list of doctors, hospitals, and other health care providers that a plan contracts with to provide medical care to its enrollees. These providers are commonly known as participating providers, and a provider that is not contracted with the plan is called a nonparticipating provider.[14]

SMMC Plan Accountability – Network Access & Adequacy

The SMMC plans must adhere to all requirements as specified in their contract with the AHCA, including requirements to enter into provider agreements with a sufficient number of providers to deliver all covered services to enrollees and ensure that each medically necessary covered service is accessible and provided with reasonable promptness, including the utilization of nonparticipating providers.[15] If the managed care plan declines to include individual or group providers in its provider network, the plan is required to give written notice to the affected provider(s) of the reason for its decision.[16,17]

Prior to implementation of SMMC 3.0 on February 1, 2025, the AHCA indicated that the network sufficiency of each plan was assessed to ensure an adequate number of available providers exists within the plans' provider networks. Managed care plans are contractually required to develop a printed and online (electronic) provider network directory to assist enrollees in selecting from qualified providers. The plans must update their online provider database at least weekly and provide printed copies of provider directories to enrollees upon

[12] *Id*.
[13] *Id*.
[14] U.S. Department of Health & Human Services, Health Insurance Marketplace, *What You Should Know About Provider Networks, available at* https://www.cms.gov/marketplace/outreach-and-education/what-you-should-know-provider-networks.pdf (last visited Mar. 27, 2025).
[15] 42 C.F.R. § 438.206(b)(4)
[16] 42 C.F.R. § 438.12(a)(1)
[17] *Supra* note 8.

request, at no charge. The plans must have procedures to inform current enrollees and potential enrollees, upon request, of any changes to service delivery and/or provider network.

On a regional basis, managed care plans must notify the AHCA within seven business days of a decrease in the total number of primary care providers by more than five percent. Moreover, the plans are required to submit an Annual Network Development Plan[18] that includes a description or explanation of the current status of their network for each service covered.[19]

Additionally, the plans are required to submit weekly Provider Network Verification (PNV) files,[20] which include information on each plan's provider network. The AHCA monitors the PNV files to ensure contractually required provider network standards are being met. If a plan is not compliant with these standards, the AHCA has actions available through its contracts that can be applied, including liquidated damages.[21] Managed care plans online and printed provider directories are monitored monthly for accuracy and completeness. Furthermore, the AHCA monitors the networks to ensure that contractual provider-specific geographic access (time and distance) standards for enrollees in urban or rural counties are maintained.[22]

The required regional provider ratios and network adequacy standards, as well as the time and distance standards for covered services, providers, and facilities, are contained within the contracts between the AHCA and the Medicaid managed care plans.[23,24,25]

SMMC Plan Reimbursement of Nonparticipating Providers

Currently, unless otherwise specified in its contract with the AHCA, a managed care plan is not liable for the costs of covered nonemergency services rendered to an enrollee by a

[18] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 236 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[19] *Supra* note 8.
[20] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 234 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[21] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Attachment II – Core Contract Provisions* (Feb. 2025), Page 201 of 267, *available at* https://ahca.myflorida.com/content/download/26116/file/Attachment%20II%20-%20Core%20Contract%20Provisions.pdf (last visited Mar. 27, 2025).
[22] *Supra* note 8.
[23] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Pages 55-58, 60-61, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).
[24] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Pages 70-72, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).
[25] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-B – Long-Term Care (LTC) Program* (Feb. 2025), Pages 32-34, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).

nonparticipating provider, unless the plan referred the enrollee to the nonparticipating provider or authorized the out-of-network service.[26]

Federal "Free Choice of Provider" Requirement

Under s. 1902(a)(23) of the Social Security Act, Medicaid recipients generally have the right to obtain medical services from any institution, agency, community pharmacy, or person qualified to perform the service(s). This provision is often referred to as the "any willing provider" or "free choice of provider" provision. Implementing regulations at 42 C.F.R. § 431.51(b)(1) require a state plan[27] to allow a recipient to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to furnish services and willing to furnish them to that particular recipient. There is an exception for recipients enrolled in certain managed care plans, authorizing the restriction of recipients to providers in the plan network, except that such plans cannot restrict free choice of family planning providers.[28]

III. Effect of Proposed Changes:

The bill amends ss. 409.967 and 409.975, F.S., to require Medicaid managed care plans to allow enrollees to receive care from Medicaid providers not under contract with the plan if an enrollee is unable to receive care from a participating provider under the plan in a timely manner consistent with a reasonable access standard, as determined by rule, or there is another appropriate Medicaid provider in a location more geographically accessible to the enrollee's residence than those under the plan.

The bill requires the plan to reimburse the nonparticipating Medicaid providers for such services at the applicable Medicaid rate for such services under the plan.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[26] Florida Agency for Health Care Administration, *2025-2030 Model Health Plan Contract Exhibit II-A – Managed Medical Assistance Program* (Feb. 2025), Page 19 of 133, *available at* https://ahca.myflorida.com/content/download/26117/file/Exhibit%20II-A%20-%20Managed%20Medical%20Assistance%20%28MMA%29%20Program.pdf (last visited Mar. 27, 2025).

[27] A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements; Medicaid.gov, *Medicaid State Plan Amendments*, *available at* https://www.medicaid.gov/medicaid-state-planamendments/index.html (last visited Mar. 28, 2025).

[28] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *State Medicaid Director Letter # 16-005, Re: Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers* (Apr. 19, 2016), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf (last visited Mar. 27, 2025).

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires Medicaid managed care plans to reimburse nonparticipating Medicaid providers that render services to enrollees under certain circumstances. The plans must reimburse for such services at the applicable Medicaid rate under the plan. As the plans would have paid for these services if rendered by a participating provider at the same rates, no fiscal impact is anticipated; however, assuming enrollee utilization of nonparticipating Medicaid providers increases and more services are rendered, a nominal negative fiscal impact to the plans could occur.

C. Government Sector Impact:

The bill may result in a negative indeterminate fiscal impact on the Florida Medicaid program. Since PMPM capitation rates reflect historical utilization and spending, assuming an increase in the provision of services to enrollees, these rates will need to be increased.[29]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill requires that Medicaid managed care plans reimburse the nonparticipating Medicaid providers at the applicable Medicaid service rate under the plan. However, in managed care, for

[29] *Supra* note 8.

most services, the plans negotiate mutually agreed upon rates with the providers they choose to contract with.[30] These rates may vary by provider; therefore, it is unclear exactly what the plans would pay the nonparticipating Medicaid provider rendering services to the enrollee.

According to the AHCA, the ability for enrollees to bypass their managed care plan's provider network, even when the network meets provider adequacy and established time and distance standards, is counter to the primary principles of the managed care delivery system and what gives the model its value. Allowing enrollees to receive services from nonparticipating Medicaid providers and requiring the plans to reimburse these providers circumvents the plan's ability to negotiate rates with its network providers and may disincentivize providers from joining plans' provider networks altogether. Essentially, this leads to an any willing provider situation, making SMMC an "open network" program, which is more aligned with the FFS model.[31]

According to the AHCA, a closed provider network allows the plans to exert more cost control by limiting enrollees to services primarily rendered by participating providers and enables the plans to negotiate lower provider payment rates or enter into value-based purchasing arrangements.[32] A closed provider network also helps the plans to better manage care coordination within their networks and assists in effectively monitoring quality standards. The less opportunity the plans have to competitively select providers, the more the plans' ability to meet the AHCA's quality standards and benchmarks included in the new SMMC 3.0 contracts could be impacted. This could require the renegotiation of contract terms between the AHCA and the plans, and lead to lower quality standards and higher program costs.[33]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967 and 409.975.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[30] *Id*.
[31] *Id*.
[32] Value-based purchasing (VBP) is a reimbursement strategy that links payments to high quality performance by health care providers. VBP arrangements include contractual agreements between payers, in this instance the plans, and health care providers. This agreement holds the providers accountable, potentially resulting in more predictable costs, improved financial stability (cost savings), higher quality of care, and better health outcomes for enrollees; Florida Agency for Health Care Administration, *Senate Bill* 306 (Feb. 7, 2025) (on file with Senate Committee on Health Policy).
[33] *Supra* note 8.