The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Health Policy Committee

BILL:	SB 2182
INTRODUCER:	Senator Bennett
SUBJECT:	Managed Health Care Entities
DATE:	April 6, 2007 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HP	**Pre-meeting**
2.			BI	
3.			HA	
4.				
5.				
6.				

I. Summary:

The bill prohibits the Agency for Health Care Administration (AHCA) from contracting with a health maintenance organization (HMO) to provide Medicaid services unless the HMO has demonstrated to the agency that it has a successful record of providing comprehensive health insurance coverage in this state for at least 3 years and has successfully contracted with this state, or another state, to provide comprehensive Medicaid services on a prepaid capitated basis for at least 3 years, or has successful experience providing comprehensive prepaid services in any state for a state child health insurance program or Medicare members for at least 3 years.

The bill requires provider service networks (PSNs) not operated by a hospital which are approved for participation in the Medicaid program (including in Medicaid reform areas) after July 1, 2007, to comply with surplus and other financial requirements of pt. I of ch. 641, F.S. The PSNs not operated by a hospital, which were approved on or before July 1, 2007, must comply with these surplus and other financial requirements before July 1, 2010. The bill also applies these same conditions to minority physician networks in Medicaid.

The bill prohibits the agency from contracting with any new managed care plan in an area where adding a new plan would cause the county to contain fewer than 35,000 recipients per each managed care plan eligible to receive an assignment of Medicaid recipients, except in a county that does not contain managed care plans that are eligible to receive an assignment of Medicaid recipients.

The bill also increases the surplus and other financial requirements for HMOs subject to pt. I of ch. 641, F.S. The bill increases the minimum surplus to $5 million (from $1.5 million), 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater. This

new surplus requirement applies immediately to all entities receiving a certificate of authority after July 1, 2007, and is effective July 1, 2010, for all entities that currently have a certificate of authority.

The bill specifies that PSNs participating in the Medicaid program that are operated by a hospital licensed under ch. 395, F.S., must meet the solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under ch. 409, F.S.

This bill amends ss. 409.912, 409.91211, 641.225, and 641.2261, F.S.

II. Present Situation:

The Florida Medicaid Program

Florida's Medicaid Program is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. The AHCA is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Some Medicaid services are mandatory services that must be covered by any state participating in the Medicaid program pursuant to federal law.[1] Other services are optional. A state may choose to include optional services in its state Medicaid plan, but if included, such services must be offered to all individuals statewide who meet Medicaid eligibility criteria as though they are mandatory benefits.[2] Payments for services to individuals in the optional categories are subject to the availability of monies and any limitations established by the General Appropriations Act or chapter 216, Florida Statutes.

For FY 2006-07, the Florida Medicaid Program is estimated to cover 2.1 million people[3] at a cost of $14.6 billion.[4]

Florida Medicaid Reform

On January 11, 2005, Governor Bush released a Medicaid reform proposal (originally called Empowered Care) for consideration by the Legislature. The proposal was based on data at the time demonstrating that the Medicaid budget was growing at an unsustainable rate and that a comprehensive overhaul of the system was necessary to improve care and provide predictability in the state Medicaid budget.

The Governor's proposal centered on the concept of moving Medicaid recipients out of the current fee-for-service system into a mostly managed care environment. In this new system, managed care plans (including traditional Medicaid HMOs and new provider service networks)

[1] These mandatory services are codified in s. 409.905, F.S.
[2] Optional services covered under the Florida Medicaid program are found in s. 409.906, F.S.
[3] http://edr.state.fl.us/conferences/medicaid/medcases.pdf (last visited on April 6, 2007)
[4] http://edr.state.fl.us/conferences/medicaid/medhistory.pdf (last visited on April 6, 2007)

will receive actuarially-sound, risk-adjusted capitation rates to provide all mandatory and optional services to Medicaid recipients.

The Legislature passed a Medicaid reform law in CS/CS/SB 838 (ch. 2005-133, L.O.F.). The provisions of the final bill offered opportunities to improve the current Medicaid program, while continuing a deliberative review of more comprehensive reform initiatives.

Provider Service Networks

The Florida Medicaid program continually works to limit increases in the cost of medical care in the program, often through the use of managed care. A PSN is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients, along with HMOs, MediPass, and the Children Medical Services Network.

In Florida, the PSN component of Medicaid started as a demonstration project in 2002, based on a model in which a provider organization, or network of organizations, provides care to a defined population and also agrees to perform associated "insurance" functions, such as enrollee services, provider credentialing, claims processing, and quality assurance. The concept is built on an assumption that health care costs can be contained when money flows directly from payer to provider, removing the insurance "middle man" from the transaction. [5]

Florida's PSN program uses a fee-for-service approach, with established payment limits and a linkage between payments and quality of care on a series of performance indicators. Additionally, the pilot program required implementation of disease state management programs in order to control costs and enhance outcomes for those patients with predictably expensive conditions.

Under Medicaid reform, the PSNs are allowed to participate alongside HMOs in the pilot counties (Baker, Broward, Clay, Duval, and Nassau Counties). The reform statute (s. 409.91211, F.S.) allows PSNs to bill fee-for-service for three years, but then must transition to the same risk-adjusted capitation arrangements that apply to the HMOs.

Provider Service Networks and Solvency Requirements

Currently, the PSNs (Medicaid Reform and non-reform) are exempt from surplus, solvency, and other financial requirements of pt. I of ch. 641, F.S., except that prepaid PSNs must meet the solvency requirements of 42 CFR s. 422.350, subpart H, and the solvency requirements established in approved federal waivers. There is no differentiation in these requirements between hospital based PSNs and non-hospital based PSNs.

For non-reform PSNs, 42 CFR s. 422.350, subpart H, requires that PSNs must maintain a minimum surplus of an amount that is the greater of $1 million or 1.5 percent of projected annual premiums, and allows an exception for the PSNs operated by public or state agencies and include

[5] Agency of Health Care Administration.
http://www.fdhc.state.fl.us/Medicaid/quality_management/mrp/Projects/psn/index.shtml (last visited on April 6, 2007)

separate solvency requirements for federally qualified health centers (basically Medicare Plus Choice requirements).

Medicaid reform PSNs may contract with Medicaid to provide either comprehensive and catastrophic health care coverage or comprehensive health care coverage (non-catastrophic coverage) only. Non-reform PSNs are required to cover comprehensive and catastrophic health care coverage.

For Medicaid reform prepaid PSNs that provide comprehensive health care coverage only (non-catastrophic coverage), the Medicaid reform 1115 waiver requires that the PSNs maintain a minimum surplus of an amount that is the greater of $1 million or 1.5 percent of projected annual premiums and allows an exception for the PSNs operated by public or state agencies and includes separate solvency requirements for federally qualified health centers.

For Medicaid reform prepaid PSNs that provide comprehensive and catastrophic health care coverage, the Medicaid reform 1115 waiver requires that the PSNs meet the more stringent financial standards consistent with licensed HMOs in ch 641, F.S. Ch 641, F.S., requires that an entity 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 contract amount.

Medicaid and the Minority Physician Networks

Florida law requires the AHCA to contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the appropriate use of services, including inpatient hospital services and pharmaceuticals. The agency is also required to provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules.

In May 2001, the AHCA was authorized by the General Appropriations Act to establish pilot projects for improving the quality of care and the cost effectiveness of the MediPass program; and in particular, the agency was authorized to contract with physician-owned and operated organizations with experience managing care for Medicaid and Medicare recipients, utilizing at least one predominantly minority, physician network.

Three entities applied to operate under the pilot program and two minority physician networks were eventually awarded contracts: Florida Netpass and PhyTrust (now known as Access Health Solutions). These two minority networks of primary care physicians began operating in South Florida, Medicaid Areas 10 and 11, in 2001. In 2003, the networks expanded to the Tampa and St. Petersburg areas covering Medicaid Areas 5 and 6 under a 2-year contract with the AHCA.

As of March 2007, there are three Medicaid minority physician networks providing services in 26 counties with an enrollment of 138,568 Medicaid beneficiaries.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.912, F.S., to prohibit the AHCA from contracting with HMOs to provide Medicaid services unless the HMO has demonstrated to the agency that it has a successful record of providing comprehensive health insurance coverage in this state for at least 3 years and has successfully contracted with this state, or another state, to provide comprehensive Medicaid services on a prepaid capitated basis for at least 3 years, or has successful experience providing comprehensive prepaid services in any state for a state child health insurance program or Medicare members for at least 3 years.

The bill requires the PSNs not operated by a hospital, which is approved for participation in the Medicaid program after July 1, 2007, to comply with surplus and other financial requirements of part I of ch. 641, F.S. The PSNs not operated by a hospital, which were approved on or before July 1, 2007, must comply with these surplus and other financial requirements before July 1, 2010.

The bill requires minority physician networks that have been approved for designation or expansion in the Medicaid program (including in Medicaid reform areas) after July 1, 2007, to meet the surplus and other financial requirements of pt. I of ch. 641, F.S, as a condition of such designation or expansion. Minority physician networks approved on or before July 1, 2007, must comply with these surplus and other financial requirements before July 1, 2010.

The bill prohibits the agency from contracting with any new managed care plan in an area where adding a new plan would cause the county to contain fewer than 35,000 recipients per each managed care plan eligible to receive an assignment of Medicaid recipients, except in a county that does not contain managed care plans that are eligible to receive an assignment of Medicaid recipients.

Section 2. Amends s. 409.91211, F.S., to require PSNs not operated by a hospital, which are approved for designation in the Medicaid reform areas after July 1, 2007, to comply with surplus and other financial requirements of pt. I of ch. 641, F.S. The PSNs not operated by a hospital, which were approved on or before July 1, 2007, must comply with these surplus and other financial requirements before July 1, 2010.

Section 3. Amends s. 641.225, F.S., to increase the minimum surplus and other financial requirements to $5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater, for HMOs. The new surplus requirement applies immediately to all entities receiving a certificate of authority after July 1, 2007, and is effective July 1, 2010, for all entities that currently have a certificate of authority.

Section 4. Amends s. 641.2261(2), F.S., to specify that PSNs participating in the Medicaid program that are operated by a hospital licensed under ch. 395, F.S., must meet the solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under ch. 409, F.S.

Section 5. Provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The HMOs, non-hospital based PSNs, and minority physician networks will be significantly affected. The bill increases the minimum surplus the HMOs, or their guarantors must maintain and imposes significant surplus, solvency, and other financial requirements non-hospital based PSNs and minority physician networks. Non-hospital based PSNs would be put in an economic disadvantage compared to hospital-based PSNs due to these new requirements.

The increased regulatory and fiscal requirements in the bill may prevent new managed care entities from entering the Medicaid market and may cause smaller current managed care plans to withdraw. The bill also restricts the agency's ability to contract with managed care plans in counties with small Medicaid populations, which would restrict the establishment of new managed care plans and reduce Medicaid recipients' managed care choices.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.