The Florida Senate

HOUSE MESSAGE SUMMARY

Prepared By: The Professional Staff of the Health Regulation Committee

[2012s0730.hms]

BILL:	CS/SB 730
INTRODUCER:	Health Regulation Committee and Senator Flores and others
SUBJECT:	Medicaid Managed Care Plans
DATE:	March 8, 2012

I. Amendments Contained in Message:

House Amendment 1 – 504515 (body with title)

II. Summary of Amendments Contained in Message:

House Amendment 1 contains the following provisions that are **not** in CS/SB 730:

- Authorizes the Agency for Health Care Administration (AHCA) to extend or modify current capitated, prepaid comprehensive behavioral health care services contracts prior to October 1, 2014, to ensure continuity of care as the state transitions to statewide managed care.
- Repeals the October 1, 2014, expiration date set for the statutory subsection in s. 409.912, F.S., that provides fines for Medicaid contract providers that violate the provisions of this section of statute or their contract.
- Authorizes the AHCA, if required as a condition of a Federal waiver for Medicaid reform (the pilot program), to calculate a medical loss ratio for managed care plans according to specified criteria.
- Specifies that Medicaid contracts necessary to administer the Medicaid program are not rules and are not subject to rule promulgation under ch. 120, F.S.
- Specifies that a comprehensive long-term care plan under the new statewide Medicaid managed care program includes a Medicare Advantage Special Needs Plan organized as a preferred provider organization, provider-sponsored organization, health maintenance organization, or coordinated care plan.
- Amends the section of law relating to preferences given in the selection of eligible plans under the statewide Medicaid managed care program to modify the treatment of managed care plans with a substantial presence in Florida when they are responding to the invitation to negotiate.
- Authorizes the AHCA, if required as a condition of a Federal waiver for the statewide Medicaid managed care program, to calculate a medical loss ratio for managed care plans according to specified criteria.
- Changes the term “primary care physician” to “primary care provider” in the section of law relating to the primary care initiative under the managed medical assistance program.

- Exempts specialty plans from the regional plan number limits, but specifies that the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region.

House Amendment 1 does **not contain** the following provisions that are in CS/SB 730:

- A requirement that the AHCA establish a per-member, per-month payment for enrollees in all Medicare Advantage Coordinated Care Plans, not just Medicare Advantage Special Needs Plans.
- A requirement for the AHCA to enroll dual eligibles who are currently receiving Medicare services from a Medicare Advantage plan into that plan for Medicaid services, if the plan is under contract with the AHCA.
- The inclusion of additional Medicare Advantage plans in the long-term care managed care component of the statewide Medicaid managed care program for purposes of recipients who are dually eligible for Medicare and Medicaid.

House Amendment 1 and CS/SB 730 contain an identical provision that reduces the penalty on plans in the statewide Medicaid managed care program that reduce enrollment levels or leave a region before the end of their contract term.

House Amendment 1 and CS/SB 730 contain similar, but not identical, provisions exempting Medicare Advantage plans from the procurement requirements under 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.

House Amendment 1 and CS/SB 730 both have a July 1, 2012 effective date.