FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 815 **TITLE:** Patient Referrals by Medicaid Managed Care Organizations and Managed Care Plans **SPONSOR(S):** Basabe	**COMPANION BILL:** None **LINKED BILLS:** None **RELATED BILLS:** SB 1478 (Rodriguez)

Committee References

Health Care Facilities & Systems 17 Y, 0 N, As CS ➤ Health Care Budget ➤ Health & Human Services

SUMMARY

Effect of the Bill:

CS/HB 815 requires the Agency for Health Care Administration (AHCA) to contract for an analysis of Medicaid managed care plan (MCP) referrals to certain affiliated organizations, including the extent to which such referrals are made and a cost analysis comparing referrals to affiliated organizations and non-affiliated organization referrals.

Fiscal or Economic Impact:

The analysis required by the bill has an indeterminate, significant, negative fiscal impact on AHCA, which can be absorbed by the agency.

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ANALYSIS

EFFECT OF THE BILL:

Florida Medicaid

Managed Care Plans and Affiliated Organization Referrals

The CS/HB 815 requires the Agency for Health Care Administration (AHCA) to contract for an analysis of referrals by Medicaid managed care plans to their affiliated organizations. The bill requires the analysis to determine the extent to which the plans, or their subcontractors, maintain certain types of financial relationships with service providers, including:

- Ownership;
- A controlling interest; or
- A profit-sharing relationship.

The bill requires AHCA's contractor to determine the extent of each plan's referrals or steerage to such health care service providers, and conduct a cost-comparison review of each plan's related-entity referrals or steerage versus the costs of referrals to other, unrelated, providers under contract with the plan. (Section 1).

The bill exempts provider service networks (PSNs) from the scope of the analysis into the MCPs' referral business practices, because the statutorily required nature of PSNs is to operate as a group of affiliated providers and provide services using those affiliated relationships. (Section 1).

The bill requires AHCA to submit a report on its contractor's analysis to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than July 1, 2026. (Section 1).

The effective date of the bill is July 1, 2025. (Section 2).

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill has a significant, indeterminate negative fiscal impact on AHCA to contract for the analysis required by the bill. AHCA has sufficient contracted services funds to absorb these costs.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Florida 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 Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid Program, licensing and regulating health facilities, and providing health care quality and price information to Floridians.[1] The Department of Children and Families makes Medicaid eligibility determinations.[2]

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.[3] The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program.[4]

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[5] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program to provide long-term care services, including nursing facility and home and community-based services, to individuals age 65 and over and individuals age 18 and over who have a disability.[6]

The Florida Medicaid program covers over 4 million low-income individuals. AHCA uses a managed care model to provide services for approximately 70 percent of Medicaid enrollees; the remaining recipients receive services through the original, fee-for-service, Medicaid model.

Statewide Medicaid Managed Care (SMMC) Program

Florida delivers medical assistance to most Medicaid recipients using a comprehensive managed care model, the SMMC program. The SMMC program is intended to provide comprehensive, coordinated benefits coverage to the Medicaid population by leveraging economic incentives to ensure provider participation and quality performance, which was impossible under the former, federally prescribed, fee-for-service delivery model.

The SMMC program has three components: the integrated Managed Medical Assistance (MMA) program that provides primary care, acute care and behavioral health care services; the Long-Term Care (LTC) program[7] that

[1] Office of Program Policy Analysis and Government Accountability, *Agency for Health Care Administration*, https://oppaga.fl.gov/ProgramSummary/ProgramDetail?programNumber=5048 (last visited Mar. 6, 2025).
[2] Agency for Health Care Administration, Agency Analysis of 2025 House Bill 1085, pp. 1 (Mar. 3, 2025).
[3] Title 42 U.S.C. §§ 1396-1396w -5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725).
[4] S. 409.905, F.S. Florida Medicaid Managed Care sets a minimum benefit package that build on top of the federal minimum benefits package. S. 409.973, F.S.
[5] S. 409.964, F.S.
[6] *Id*.
[7] The LTC program provides services in two settings: nursing facilities or home and community based services (HCBS) provided in a recipient's home, an assisted living facility, or an adult family care home. Enrollment in the LTC program is based on a clinical priority system and includes a wait list. The state is approved for 62,000 recipients in the HCBS portion of LTC. In order to be eligible for the program, a recipient must be both clinically eligible under s. 409.979, F.S., and financially eligible for Medicaid under s. 409.904, F.S.

provides long-term care services, including nursing facility and home and community-based services; and the dental component.

- MMA: provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services.[8]
- LTC: provides Medicaid LTC services like care in a nursing facility, assisted living, or at home. To get LTC you must be at least 18 years old and meet nursing home level of care (or meet hospital level of care if you have Cystic Fibrosis).[9]
- Dental: provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.[10]

Two types of managed care plans deliver services in the SMMC: traditional managed care organizations such as health maintenance organizations (HMOs) regulated under ch. 641, F.S., and provider service networks (PSNs) authorized under ch. 409. Both types of Medicaid plans are risk-bearing entities that are paid capitated rates (prospective, per-member, per-month payments) by AHCA.

The SMMC program includes extensive statutory and contract requirements for plan accountability, including network adequacy standards, financial accountability, provider compensation and prompt payment requirements, encounter data, program integrity, transparency, and performance metrics.[11]

AHCA contracts with managed care plans on a statewide and regional basis, in sufficient numbers to ensure choice. The cyclical Medicaid procurement process ensures plans offer competitive benefit designs and prices. In addition, plans compete for consumer choice: while Medicaid requires a basic benefit package, and regulates the adequacy of plans' provider networks, plans can add to their benefit packages and offer provider networks attractive to Medicaid recipients when choosing a plan.

On February 1, 2025, AHCA implemented new managed care contracts with health and dental plans for each region, depicted in the chart below.[12]

[8] Agency for Health Care Administration, *Statewide Medicaid Managed Care, Health Plans and Programs*, available at Florida State Medicaid Managed Care - Health - Health Plans and Program (last visited Mar. 10, 2025).
[9] *Id.*
[10] *Id.*
[11] *See,* ss. 409.967, 409.975, 409.982, F.S.
[12] Agency for Health Care Administration, Statewide Medicaid Managed Care Plan Poster, https://ahca.myflorida.com/content/download/25039/file/27061%20SMMC%20Plan%20Poster%2002042025.pdf (last visited Mar. 9, 2025). COMP+ = Comprehensive Long-Term Care Plus Plan; MMA+ = Managed Medical Assistance Plus Plan; Select Comp = Select Comprehensive Plan; Specialty Services = C (Child Welfare), H (HIV/AIDS), and S (Serious Mental Health Illness).

SMMC HEALTH PLANS (2025-2030)									DENTAL PLANS (2025-2030)	
REGION	AETNA BETTER HEALTH (AET)	COMMUNITY CARE PLAN (CCP)	FLORIDA COMMUNITY CARE (FCC)	HUMANA MEDICAL PLAN (HUM)	MOLINA HEALTHCARE (MOL)	SIMPLY HEALTHCARE (SHP)	SUNSHINE HEALTH (SUN)	UNITED HEALTHCARE (URA)	DENTAQUEST (DQT)	LIBERTY (LIB)
A			FCC COMP+ (H, S)	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
B			FCC COMP+ (H, S)	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)	URA COMP+ (H, S)	DENTAQUEST (DENT)	LIBERTY (DENT)
C			FCC COMP+ (H, S)	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
D	AET COMP+ (H, S)		FCC COMP+ (H, S)	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)	URA COMP+ (H, S)	DENTAQUEST (DENT)	LIBERTY (DENT)
E	AET COMP+ (H, S)	CCP MMA+ (S)	FCC SELECT COMP	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
F		CCP MMA+ (S)	FCC SELECT COMP	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
G		CCP MMA+ (S)	FCC SELECT COMP	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
H		CCP MMA+ (S)	FCC SELECT COMP	HUM COMP+ (H, S)		SHP COMP+ (H, S)	SUN COMP+ (C, H, S)		DENTAQUEST (DENT)	LIBERTY (DENT)
I	AET COMP+ (H, S)	CCP MMA+ (S)	FCC COMP+ (H, S)	HUM COMP+ (H, S)	MOL COMP+ (H, S)	SHP COMP+ (H, S)	SUN COMP+ (C, H, S)	URA COMP+ (H, S)	DENTAQUEST (DENT)	LIBERTY (DENT)

Health Maintenance Organizations

An HMO is an organization authorized under the Florida Insurance Code which provides health care coverage by contracts or other arrangements with providers, to which subscribers are entitled to receive pursuant to a contract with the subscriber or employer (or, in this case, the Medicaid program).[13]

To operate, an HMO must obtain a Health Care Provider Certificate from AHCA, by providing information to AHCA that demonstrates its competence to provide a quality of care that meets the prevailing standards of care.[14] A certified HMO may contract to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or a prepaid aggregate fixed sum.[15]

Current law allows HMOs to contract with affiliated entities. However, the Office of Insurance Regulation (OIR) may order an HMO to cancel its contract with an affiliated entity if the fees paid by the HMO to that affiliated entity are "so unreasonably high" as to be detrimental to the interests of the HMOS's subscribers, stockholders, investors or creditors. Current law requires OIR to consider the HMO's similarly situated contracts, and industry custom across all similarly situated HMO contracts, when making a determination whether the standard is met.[16]

Provider Service Networks

In the SMMC program, a provider service network (PSN) is a model of Medicaid service delivery that relies on affiliated providers. A PSN is a network established by, or organized and operated by, a health care provider or a group of affiliated health care providers which provides a substantial proportion of the health care items and

[13] S. 641.19, F.S.
[14] S. 641.495, F.S.
[15] S. 641.19(4), F.S., s. 641.31(1), F.S.
[16] S. 641.234(2), F.S.

services under a contract directly through the provider or affiliated group of providers.[17] The provider or group of providers must have the controlling interest in the governing body of the PSN.

PSNs are unique to Medicaid,[18] and are not regulated as HMOs under ch. 641; however, they must comply with the solvency requirements applicable to HMOs under that chapter, and with AHCA requirements for financial reserves, quality assurance, and patient rights.[19]

A PSN is, by law, a network of affiliated providers. This is in contrast to an HMO, which is not controlled by providers and not required by law to be a network of affiliated providers.

Value-Based Purchasing

Value-based purchasing (VBP) is a payment model that incentivizes providers to improve the quality and efficiency of service delivery by paying for that value, rather than paying by the quantity of services performed. Plans and providers customize their VBP arrangements by choosing one or more performance-based payment strategies, including pay-for-performance programs, accountable care organizations, and bundled payment programs.[20] VBP models may also include risk-sharing and profit-sharing.[21]

In the Medicaid program, AHCA requires the managed care plans to use VBP payment models in their contracts with providers which include shared savings; that is, profit-sharing. Plans must meet certain targets for the amount of VBP they use which increase over the term of their contracts with AHCA, and must submit their VBP agreements to AHCA for approval.[22]

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	17 Y, 0 N, As CS	4/2/2025	Calamas	DesRochers
THE CHANGES ADOPTED BY THE COMMITTEE:	Requires the Agency for Health Care Administration (AHCA) to contract for an analysis of Medicaid managed care plan (MCP) referrals to certain affiliated organizations, including the extent to which such referrals are made and a cost analysis comparing referrals to affiliated organizations and non-affiliated organization referrals.			
Health Care Budget Subcommittee				
Health & Human Services Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

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[17] S. 409.912(1), F.S.

[18] S. 409.912(1), F.S., *see* s. 409.966, F.S.

[19] S. 409.912(1), F.S., *see* s. 641.18, F.S., *see* 641.2261, F.S., *see* s. 641.48, F.S.

[20] Damberg C., et al, "Measuring Success in Health Care Value-Based Purchasing Programs", Rand Health Quarterly 4(3):9, Dec. 30 2014, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC5161317/ (last viewed April 1, 2025).

[21] Cattel D., at al, "Value-Based Provider Payment Initiatives Combining Global Payments With Explicit Quality Incentives: A Systematic Review", Med Care Res Rev. 2019 Jun 19;77(6):511–537. doi: 10.1177/1077558719856775, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7536531/ (last viewed April 1, 2025).

[22] Agency for Health Care Administration, Value-Based Purchasing Performance Targets, 2025-2030 Model Health Plan Contract, Attachment I - Scope Of Services, Exhibit I-E, Nov. 2024. *See,* Agency for Health Care Administration, Statewide Medicaid Managed Care (SMMC) New Program Highlight: Value - Based Purchasing, available at https://ahca.myflorida.com/content/download/25260/file/SMMC%20Value%20Based%20Purchasing%20Highlight_10182024.pdf (last viewed April 1, 2025).