March 14, 2011

The Honorable Robert C. Schenck
Chairman, House Health and Human Services Committee
The Capitol
214 House Office Building
Tallahassee, Florida 32399

Dear Chairman Schenck:

Thank you for the opportunity to present before the House Health and Human Services Committee this afternoon at the Workshop on the Medicaid proposed committee bills. As I indicated during my testimony, the Florida Association of Health Plans (FAHP) has developed the following list of issues of critical importance for consideration as your committee crafts the important legislation that will transition Florida Medicaid to a statewide, integrated managed care program. Our member health plans are very supportive of your efforts and want to ensure an environment that will make the transition to a redesigned Medicaid system successful. It is the view of our member plans that the following issues are critical to success.

1) **Ensure a level playing field in the bid process, regardless of type of managed care entity.**
   
   We support several different types of health plans being allowed to participate, as long as all are required to meet the same performance, quality, and fiscal qualifications. More specifically:
   
   - No single type of health plan should be given preferential treatment over another type of health plan.
   - No particular type of health plan should be guaranteed a “slot” in the bid process.
   - Provider sponsored networks (PSNs) must be required to assume full risk immediately.
   - Data should be provided at least 90 days prior to the submission deadline of the bid.
   - Rather than accept negative comments about health plans precious performance, plans should be allowed to show “letters of reference” from providers indicating their good standing. These comments should be factored in the weighting of the bid.
   - A plan “winning” a bid in a given region should be allowed to retain recipients already enrolled in the plan to ensure continuity of care (unless the person requests to change plans).
   - Also, in the companion bill (PCB HHS 11-02) there is language favoring a particular PSN by awarding a contract as a third-party administrator (TPA) for MediPass during the transition to the bid process. Rather than awarding the contract to a singular PSN, the contract should be open to any type of health plan and awarded utilizing a procurement process.
2) **Ensure actuarial soundness in rate setting process and procurement process.** To make this transition work, the risk plans are assuming must be covered based on sound fiscal and actuarial principles.

- All parts of the bid process should be verified by an objective, 3rd party actuary with no involvement in the development of any part of the bid.
- Rates should be annually adjusted, on a rolling basis, with a consistent differential applied throughout the contract period (i.e., a plan that comes in 20 percent lower than all the other plans should remain 20 percent lower in any future rate adjustments).
- Payments for non-contracted emergency department utilization should be applied for the entire course of treatment.
- Any achieved savings rebate or MLR process should use NAIC definitions of medical and administrative costs.
- If a PSN contracts with another type of health plan in a region, the fair payment requirements in this bill should apply to all providers in the network, not just those with controlling interest.
- Provide a definition of “good faith” rather than directing the Agency to determine the standard.

3) **Eligibility, enrollment, and benefit standards.** There are several provisions where changes will help ensure a successful program moving forward. These include:

- Require persons currently in skilled nursing facilities to be enrolled in the new program immediately.
- Rather than include the Medically Needy into managed care plans as designed in the bill, establish the plans as an ASO arrangement where the recipients would utilize the plans’ networks and the plan would process any Medicaid payments to the providers from the state.
- Include transportation services in the comprehensive set of services health plans are responsible for providing. Ensuring managed care plans are able to administer this services is an important component enabling plans to facilitate access to physician and other medical services.

There are several other technical changes which we believe will improve the ability of the state to provide all medically necessary levels of care in a predictable fiscal environment. We will share those ideas in separate materials with professional staff for your consideration. Also, other issues may arise as additional testimony brings aspects of the bill to light which we may have missed during our initial analysis. We ask for your consideration as these issues may come to our attention.

Again, thank you for your committee’s efforts and for the consideration of these important issues. Please let me know if I can be of further assistance.

Sincerely,