A bill to be entitled

An act relating to the delivery of health care services; creating s. 624.1291, F.S., providing an exemption from the Insurance Code for certain health care services; creating part IV of ch. 641, F.S.; creating the "Provider Sponsored Organization Act"; providing legislative findings and purposes; providing definitions; prohibiting provider sponsored organizations from transacting insurance business other than the offering of Medicare Choice plans; providing for application of parts I and III of ch. 641, F.S., to provider sponsored organizations; providing exceptions; amending s. 641.227, F.S.; providing for deposits into the Rehabilitation Administrative Expense Fund by a provider sponsored organization; providing for reimbursements; amending s. 641.316, F.S.; providing for an exemption from s. 455.654, F.S., to provider sponsored organizations relating to certain financial arrangements; providing an exemption for group practices from s. 455.654(4), F.S., relating to certain financial arrangements; amending s. 409.912, F.S., directing the Agency for Health Care Administration to establish an outpatient specialty services pilot project; providing definitions; providing criteria for participation; requiring an evaluation and a report to the Governor and Legislature; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 624.1291, Florida Statutes, is created to read:

624.1291 Certain health care services; exemption from code.--Any person who enters into a contract or agreement with an authorized insurer, or with a health maintenance organization or provider sponsored organization that has obtained a certificate of authority pursuant to chapter 641, to provide health care services to persons insured under a health insurance policy, health maintenance organization contract, or provider sponsored organization contract, shall not be deemed to be an insurer and shall not be subject to the provisions of this code, regardless of any risk assumed under the contract or agreement, provided:

(1) The authorized insurer, health maintenance organization, or provider sponsored organization remains contractually liable to the insured to the full extent provided in the policy or contract with the insured.

(2) The person does not receive any premium payment or per-capita fee from the insured other than fees for services not covered under the insured's policy or contract, such as deductible amounts, co-payments, or charges in excess of policy or contract limits which are otherwise allowed to be collected.

(3) Any person who is an "administrator" as defined in s. 626.88 meets the requirements of part VII of chapter 626 and any person who is performing "fiscal intermediary services" as defined in s. 641.316 meets the requirements of that section.

Section 2. Part IV of chapter 641, Florida Statutes, consisting of sections 641.801, 641.802, 641.803, 641.804, 641.805, and 641.806, Florida Statutes, is created to read:

641.801 Short title.--This part may be cited as the "Provider Sponsored Organization Act."

641.802 Declaration of legislative findings and purposes.--

(1) The Legislature finds that a major restructuring of health care has taken place which has changed the way in which health care services are paid for and delivered and that today, the emphasis is on providing cost-conscious health care services through managed care. The Legislature recognizes that alternative methods for the delivery of health care are needed to promote competition and increase patients' choices.

(2) The Legislature finds that the United States Congress has enacted legislation that allows provider sponsored organizations to provide coordinated-care plans to Medicare enrollees through the Medicare Choice program. The federal legislation requires any organization that offers a Medicare Choice plan to be organized and licensed under state law as a risk-bearing entity eligible to offer health-benefit coverage in the state in which it offers a Medicare Choice plan.

(3) The Legislature finds that these plans, when properly operated, emphasize cost and quality controls, while ensuring that the provider has control over medical decisions.

(4) The Legislature declares the policy of this state is to:

(a) Eliminate legal barriers to the organization, promotion, and expansion of provider sponsored organizations that offer Medicare Choice plans in order to encourage the

development of valuable options for the Medicare beneficiaries of this state.

(b) Recognize comprehensive provider sponsored organizations as exempt from the insurance laws of this state except in the manner and to the extent set forth in this part.

641.803 Definitions.--As used in this part:

(1) "Affiliation" means a relationship between providers in which, through contract, ownership, or otherwise:

(a) One provider, directly or indirectly, controls, is controlled by, or is under common control with the other;

(b) Both providers are part of a controlled group of corporations under s. 1563 of the Internal Revenue Code of 1986;

(c) Each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations; or

(d) Both providers are part of an affiliated service group under s. 414 of the Internal Revenue Code of 1986.

(2) "Comprehensive health care services" means services, medical equipment, and supplies required under the Medicare Choice program.

(3) "Copayment" means a specific dollar amount that the subscriber must pay upon receipt of covered health care services as required or authorized under the Medicare Choice program.

(4) "Provider sponsored contract" means any contract entered into by a provider sponsored organization that serves Medicare Choice beneficiaries.

(5) "Provider sponsored organization" means any organization authorized under this part which:

(a) Is established, organized, and operated by a health care provider or group of affiliated health care providers.

(b) Provides a substantial proportion of the health care items and services specified in the Medicare Choice contract, as defined by the Secretary of the United States Department of Health and Human Services, directly through the provider or affiliated group of providers.

(c) Shares, with respect to its affiliated providers, directly or indirectly, substantial financial risk in the provision of such items and services and has at least a majority financial interest in the entity.

The term "substantial proportion" shall be defined by the Secretary of the United States Department of Health and Human Services after having taken into account the need for such an organization to assume responsibility for providing significantly more than the majority of the items and services under the Medicare Choice contract through its own affiliated providers and the remainder of the items and services under such contract through providers with which the organization has an agreement to provide such items and services. Consideration shall also be given to the need for the organization to provide a limited proportion of the items and services under the contract through entities that are neither affiliated with nor have an agreement with the organization.

(6) "Subscriber" means a Medicare Choice enrollee who is eligible for coverage as a Medicare beneficiary.

(7) "Surplus" means total assets in excess of total liabilities as determined by the federal rules on solvency standards established by the Secretary of the United States

Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget of 1997, for provider sponsored organizations that offer the Medicare Choice plan.

641.804 Applicability of other laws.--Except as provided in this part, provider sponsored organizations shall be governed by this part and are exempt from all other provisions of the Florida Insurance Code.

641.805 Insurance business not authorized.--The provisions of the Florida Insurance Code or this part do not authorize any provider sponsored organization to transact any insurance business other than to offer Medicare Choice plans pursuant to s. 1855 of the Balanced Budget Act of 1997.

641.806 Applicability of parts I and III; exceptions.--The provisions of parts I and III of this chapter apply to provider sponsored organizations to the same extent such sections apply to health maintenance organizations, except:

(1) The definitions used in this part shall control to the extent of any conflict with the definitions used in s. 641.19.

(2) The certificate of authority, application for certificate, and all other forms issued or prescribed by the department pursuant to this part shall refer to a "provider sponsored organization" rather than a "health maintenance organization."

(3) Such provisions shall not apply to the extent of any conflict with ss. 1855 and 1856 of the Balanced Budget Act of 1997 and rules and regulations adopted by the Secretary of the United States Department of Health and Human Services, including, but not limited to, requirements related to surplus, net worth, assets, liabilities, investments, provider

sponsored organization contracts, payment of benefits, and procedures for grievances and appeals.

(4) Such provisions shall not apply to the extent of any waiver granted by the Secretary of the United States Department of Health and Human Services under s. 1856(a)(2) of the Balanced Budget Act of 1997.

(5) Such provisions shall not apply to the extent that they are unrelated to, or inconsistent with, the limited authority of provider sponsored organizations to offer only Medicare Choice plans.

(6) Section 641.228, relating to the Florida Health Maintenance Organization Consumer Assistance Plan, shall not apply.

(7) Such provisions shall not preclude a provider-sponsored organization from contracting with one or more companies to provide all necessary administrative and management services.

Section 3. Section 641.227, Florida Statutes, is amended to read:

641.227 Rehabilitation Administrative Expense Fund.--

(1) The department may ~~shall~~ not issue or permit to exist a certificate of authority to operate a health maintenance organization or provider sponsored organization in this state unless the organization has deposited with the department $10,000 in cash for use in the Rehabilitation Administrative Expense Fund as established in subsection (2).

(2) The department shall maintain all deposits received under this section and all income from such deposits in trust in an account titled "Rehabilitation Administrative Expense Fund." The fund shall be administered by the department and shall be used for the purpose of payment of the

administrative expenses of the department during any rehabilitation of a health maintenance organization or provider sponsored organization, when rehabilitation is ordered by a court of competent jurisdiction.

(3) Upon successful rehabilitation of a health maintenance organization or provider sponsored organization, the organization shall reimburse the fund for the amount of expenses incurred by the department during the court-ordered rehabilitation period.

(4) If a court of competent jurisdiction orders liquidation of a health maintenance organization or provider sponsored organization, the fund shall be reimbursed for expenses incurred by the department as provided for in chapter 631.

(5) Each deposit made under this section shall be allowed as an asset for purposes of determination of the financial condition of the health maintenance organization or provider sponsored organization. The deposit shall be refunded to the organization only when the organization both ceases operation as a health maintenance organization or provider sponsored organization and no longer holds a subsisting certificate of authority.

Section 4. Paragraph (b) of subsection (2) and subsection (5) of section 641.315, Florida Statutes, are amended to read:

641.316 Fiscal intermediary services.--

(2)

(b) The term "fiscal intermediary services organization" means a person or entity that ~~which~~ performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance

organizations or provider sponsored organizations other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization or provider sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f).

(5) Any fiscal intermediary services organization, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization or provider sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f), must register with the department and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the department determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the department may revoke or suspend the registration. In lieu of revocation or suspension of the registration, the department may levy an administrative penalty in accordance with s. 641.25.

Section 5. A provider sponsored organization is exempt from s. 455.654, Florida Statutes, for the provision of health care services to enrollees of a Medicare Choice plan.

Section 6. Group practices, as defined in s. 455.654(3)(f), Florida Statutes, are exempt from the provisions of s. 455.654(4), Florida Statutes, when providing designated health services. This exemption is forfeited if the group practice accepts a referral from a physician who is not a member of the group practice but who has an investment interest in or is an investor in the group practice.

Section 7. New subsection (33) is added to section 409.912, Florida Statutes, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(33) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory,



**CODING:** Words ~~stricken~~ are deletions; words underlined are additions.

diagnostic imaging, and specified home medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services shall, at a minimum, meet the following criteria:

1. The entity shall be licensed by the Department of Insurance under part II of chapter 641.

2. The entity shall be experienced in providing outpatient specialty services.

3. The entity shall demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity shall demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of three years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality-assurance review of the prepaid limited health service organization each year that the demonstration program is in effect. The prepaid limited health service organization is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall

report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(f) Nothing in this subsection is intended to conflict with the provision of the 1997-98 General Appropriations Act which authorizes competitive bidding for Medicaid home health, clinical laboratory, or x-ray services.

Section 8. Except as otherwise provided herein, this act shall take effect October 1 of the year in which enacted.