By the Committee on Health Care

317-535A-98

A bill to be entitled

An act relating to public assistance; amending s. 409.908, F.S.; requiring the agency to establish a reimbursement methodology for long-term-care services for Medicaid-eligible nursing home residents; specifying requirements for the methodology; providing legislative intent; providing certain limitations on payments made by the agency for Medicare services rendered to Medicaid-eligible persons; amending s. 409.912, F.S.; authorizing the agency to include disease-management initiatives in providing and monitoring Medicaid services; authorizing the agency to competitively negotiate home health services; authorizing the agency to seek necessary federal waivers that relate to the competitive negotiation of such services; amending s. 409.9122, F.S.; specifying the departments that are required to make certain information available to Medicaid recipients; extending the period during which a Medicaid recipient may disenroll from a managed care plan or MediPass provider; deleting authorization for the agency to request a federal waiver from the requirement that a Medicaid managed care plan include a specified ratio of enrollees; amending s. 409.910, F.S.; requiring that certain third-party benefits received by a Medicaid recipient be remitted within a specified period; amending s. 414.28, F.S.;

revising the order under which a claim may be made against the estate of a recipient of public assistance; amending s. 198.30, F.S.; requiring that each circuit judge provide a report of decedents to the Agency for Health Care Administration; amending s. 733.212, F.S.; requiring that a personal representative serve a copy of the notice of administration on the agency; providing an effective date.

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

Section 1. Subsections (2) and (13) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or

making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing

services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. Effective not later than the rate-setting period beginning January 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term-care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the

methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(13) Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid-eligible ~~Medicaid eligible~~ persons shall be reimbursed in accordance with fees established by Title XVIII of the Social Security Act. However, any payment by the agency for deductibles, coinsurance, or copayments for a Medicare service rendered to a Medicaid-eligible person may not exceed the amount that may be made for such service under the Medicaid state plan.

Section 2. Subsection (13) of section 409.912, Florida Statutes, is amended, and subsection (34) is added to that section, 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.

(13) The agency shall identify health care utilization and price patterns within the Medicaid program which ~~that~~ are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease-management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(34) The agency may provide for cost-effective purchasing of home health services through competitive negotiation pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid home health services.

Section 3. Subsection (2) of section 409.9122, Florida Statutes, is amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.--

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid

recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Health Care Financing Administration.

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 236.0812 and 409.908(21) shall be reimbursed by Medicaid, subject to the limitations of s. 236.0812(1) and (2), for a Medicaid-eligible child participating in the services as authorized in s. 236.0812, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts and county health departments regarding the coordinated provision of services authorized under s.

236.0812. To ensure continuity of care for Medicaid patients, the agency and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 236.0812 and 409.9071.

(b) A Medicaid recipient shall not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(c) Medicaid recipients shall have a choice of managed care plans or MediPass. The Agency for Health Care Administration, the Department of Health ~~and Rehabilitative Services~~, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care, including MediPass.

2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their own managed care plans or MediPass. However, if a recipient does not choose a managed care plan or MediPass, the

agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.

(d) The agency shall develop a mechanism for providing information to Medicaid recipients for the purpose of making a managed care plan or MediPass selection. Examples of such mechanisms may include, but not be limited to, interactive information systems, mailings, and mass marketing materials. Managed care plans and MediPass providers are prohibited from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans or MediPass providers.

(e) Prior to requesting a Medicaid recipient who is subject to mandatory managed care enrollment to make a choice between a managed care plan or MediPass, the agency shall contact and provide choice counseling to the recipient. Medicaid recipients who are already enrolled in a managed care plan or MediPass shall be offered the opportunity to change managed care plans or MediPass providers on a staggered basis, as defined by the agency. All Medicaid recipients shall have 90 days in which to make a choice of managed care plans or MediPass providers. Those Medicaid recipients who do not make a choice shall be assigned to a managed care plan or MediPass in accordance with paragraph (f). To facilitate continuity of care, for a Medicaid recipient who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan or MediPass, the agency shall determine whether the SSI recipient has an ongoing

relationship with a MediPass provider or managed care plan, and if so, the agency shall assign the SSI recipient to that MediPass provider or managed care plan. Those SSI recipients who do not have such a provider relationship shall be assigned to a managed care plan or MediPass provider in accordance with paragraph (f).

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. In the first period that assignment begins, the assignments shall be divided equally between the MediPass program and managed care plans. Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(i) After a recipient has made a selection or has been enrolled in a managed care plan or MediPass, the recipient shall have 90 ~~60~~ days in which to voluntarily disenroll and select another managed care plan or MediPass provider. After 90 ~~60~~ days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of cause, except in cases in which immediate

risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

(j) The agency shall apply for a federal waiver from the Health Care Financing Administration to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

~~(k) In order to provide increased access to managed care, the agency may request from the Health Care Financing Administration a waiver of the regulation requiring health maintenance organizations to have one commercial enrollee for each three Medicaid enrollees.~~

Section 4. Subsection (18) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.--

(18) A recipient or his or her legal representative or any person representing, or acting as agent for, a recipient or the recipient's legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (6)(d), or who has actual knowledge of the department's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the department the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid <u>within 30 days after settlement</u>, or to place the full amount of the third-party benefits in <u>an interest-bearing</u> ~~a~~ trust account for the benefit of the department pending judicial or administrative determination of the department's right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the department the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial or administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for

payments received from social security, insurance, or other sources, pursuant to s. 414.39(4)(b), and acted with the intent set forth in s. 812.014(1).

(a) The department is authorized to investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Attorney General, or to any state attorney. Pursuant to s. 409.913, the Attorney General has primary responsibility to investigate and control Medicaid fraud.

(b) In carrying out duties and responsibilities related to Medicaid fraud control, the department may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(c) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from s. 119.07(1):

1. Until such time as the department takes final agency action;

2. Until such time as the Attorney General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

Section 5. Subsection (1) of section 414.28, Florida Statutes, is amended to read:

414.28 Public assistance payments to constitute debt of recipient.--

(1) CLAIMS.--The acceptance of public assistance creates a debt of the person accepting assistance, which debt is enforceable only after the death of the recipient. The debt thereby created is enforceable only by claim filed against the estate of the recipient after his or her death or by suit to set aside a fraudulent conveyance, as defined in subsection (3). After the death of the recipient and within the time prescribed by law, the department may file a claim against the estate of the recipient for the total amount of public assistance paid to or for the benefit of such recipient, reimbursement for which has not been made. Claims so filed shall take priority as <u>class 3</u> ~~class 7~~ claims as provided by s. 733.707(1)(g).

Section 6. Section 198.30, Florida Statutes, is amended to read:

198.30 Circuit judge to furnish department with names of decedents, etc.--Each circuit judge of this state shall, on or before the 10th day of every month, notify the department of the names of all decedents; the names and addresses of the respective personal representatives, administrators, or curators appointed; the amount of the bonds, if any, required by the court; and the probable value of the estates, in all estates of decedents whose wills have been probated or propounded for probate before the circuit judge or upon which letters testamentary or upon whose estates letters of administration or curatorship have been sought or granted,

during the preceding month; and such report shall contain any other information which the circuit judge may have concerning the estates of such decedents. In addition, a copy of this report shall be provided to the Agency for Health Care Administration.A circuit judge shall also furnish forthwith such further information, from the records and files of the circuit court in regard to such estates, as the department may from time to time require.

Section 7. Subsection (3) of section 733.212, Florida Statutes, is amended to read:

733.212 Notice of administration; filing of objections and claims.--

(3) The personal representative shall serve a copy of the notice on the following persons who are known to the personal representative:

(a) The decedent's surviving spouse;

(b) Beneficiaries; ~~and~~

(c) The trustee of any trust described in s. 733.707(3), of which the decedent was grantor; and

(d) The Agency for Health Care Administration

in the manner provided for service of formal notice, unless served under s. 733.2123. The personal representative may similarly serve a copy of the notice on any devisees under a known prior will or heirs.

Section 8. This act shall take effect July 1, 1998.

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SENATE SUMMARY

Requires that the Agency for Health Care Administration establish a methodology for reimbursing providers under the Medicaid program. Provides certain limitations on the amount of payment that may be made for a Medicare service on behalf of a person who is also eligible for Medicaid. Authorizes the agency to competitively negotiate the purchase of home health services for Medicaid recipients. Provides that a Medicaid recipient has 90 days rather than 60 days within which to select another managed care plan or MediPass provider after voluntarily disenrolling from a managed care plan or MediPass. Requires that third-party benefits received by a Medicaid recipient must be remitted to the agency within 30 days after settlement. Provides for public assistance payments to take priority in recovery against the estate of a deceased person as a class 3 claim rather than as a class 7 claim. Requires circuit judges and personal representatives to notify the Agency for Health Care Administration on the administration of estates. (See bill for details.)