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CHAMBER ACTION

Senate . House

The Committee on Health Care (Saunders) recommended the following amendment:

Senate Amendment (with title amendment)

On page 56, line 14, through

page 64, line 9, delete those lines

and insert:

Section 2. Section 409.91211, Florida Statutes, is created to read:

409.91211 Medicaid managed care pilot program.--

(1)(a) The agency shall develop a pilot program to deliver health care services specified in ss. 409.905 and 409.906 through capitated managed care networks under the Medicaid program to persons in Medicaid fee-for-service or the MediPass program, contingent upon federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor, a methodology to allow the use of a portion of these funds to serve as risk pool for pilot sites, provisions to preserve the state's ability to use intergovernmental transfers, and

1 provisions to protect the disproportionate share program
2 authorized pursuant to this chapter.
3 (b) The agency may include, as part of the waiver
4 request, an alternative methodology for making additional
5 Medicaid payments to hospitals based on the level of Medicaid
6 or care provided to the uninsured. Any alternative
7 methodology, however, must provide the same level of federal
8 funding as the current upper payment limit and include a
9 reasonable growth factor. Absent federal approval of a
10 reasonable growth factor, the Agency for Health Care
11 Administration shall provide the Legislature, pursuant to the
12 implementation plan provided for in section 3 of this act, the
13 following:
14 1. Based on the historical growth and current federal
15 rules governing the upper-payment-limit funding, an estimate
16 of the projected growth of funding over the next 10 years and
17 an estimate of the loss of federal funding which can be
18 attributed to the implementation of any Medicaid waiver.
19 2. An analysis showing the amount of additional
20 upper-payment-limit-funds that this state would have received
21 if it had been granted the exceptions to the
22 upper-payment-limit cap provided to other states in 42 C.F.R.
23 s. 447.272 from the 2002 through 2009 state fiscal years.
24 3. An analysis with accompanying rationale supporting
25 the implementation of any waiver that would result in
26 hospitals in this state which provide safety net services
27 receiving less federal funds relative to the federal support
28 given to similar hospitals in other states.
29 (2) The Legislature intends for the capitated managed
30 care pilot program to:
31 (a) Provide recipients in Medicaid fee-for-service or

1 the MediPass program a comprehensive and coordinated capitated
2 managed care system for all medically necessary health care
3 services specified in ss. 409.905 and 409.906.
4 (b) Stabilize Medicaid expenditures under the pilot
5 program compared to Medicaid expenditures for the 3 years
6 before implementation of the pilot program.
7 (c) Provide an opportunity to evaluate the feasibility
8 of statewide implementation of capitated managed care networks
9 as a replacement for the current Medicaid fee-for-service and
10 MediPass systems.
11 (3) The agency shall have the following powers,
12 duties, and responsibilities with respect to the development
13 of a pilot program to deliver all health care services
14 specified in ss. 409.905 and 409.906 in the form of capitated
15 managed care networks under the Medicaid program to persons in
16 Medicaid fee-for-service or the MediPass program:
17 (a) To define and recommend the medical and financial
18 eligibility standards for capitated managed care networks in
19 the pilot program. This paragraph does not relieve an entity
20 that qualifies as a capitated managed care network under this
21 section from any other licensure or regulatory requirements
22 contained in state or federal law which would otherwise apply
23 to the entity.
24 (b) To include two geographic areas in the pilot
25 program and recommend Medicaid-eligibility categories, from
26 those specified in ss. 409.903 and 409.904, which shall be
27 included in the pilot program. One pilot program must include
28 only Broward County. A second pilot program must initially
29 include Duval County and may be expanded to Baker, Clay, and
30 Nassau Counties after the Duval County program has been
31 operating for at least 1 year. A Medicaid recipient may not be

1 enrolled in or assigned to a capitated managed care plan
2 unless the capitated managed care plan has complied with the
3 standards and credentialing requirements specified in
4 paragraph (e).
5 (c) To determine and recommend how to design the
6 managed care delivery system in order to take maximum
7 advantage of all available state and federal funds, including
8 those obtained through intergovernmental transfers, the
9 upper-payment-level funding systems, and the disproportionate
10 share program.
11 (d) To determine and recommend actuarially sound,
12 risk-adjusted capitation rates for Medicaid recipients in the
13 pilot program which can be separated to cover comprehensive
14 care, enhanced services, and catastrophic care.
15 (e) To determine and recommend policies and guidelines
16 for phasing in financial risk for approved provider service
17 networks over a 3-year period. These shall include an option
18 to pay fee-for-service rates that may include a
19 savings-settlement option for at least 2 years. This model may
20 be converted to a risk adjusted capitated rate in the third
21 year of operation.
22 (f) To determine and recommend provisions related to
23 stop-loss requirements and the transfer of excess cost to
24 catastrophic coverage that accommodates the risks associated
25 with the development of the pilot projects.
26 (g) To determine and recommend a process to be used by
27 the Social Services Estimating Conference to determine and
28 validate the rate of growth of the per-member costs of
29 providing Medicaid services under the managed care initiative.
30 (h) To determine and recommend descriptions of the
31 eligibility assignment processes that will be used to

1 facilitate client choice while ensuring pilot projects of
2 adequate enrollment levels. These processes shall ensure that
3 pilot sites have sufficient levels of enrollment to conduct a
4 valid test of the managed care pilot project model within a
5 2-year timeframe.
6 (i) To determine and recommend program standards and
7 credentialing requirements for capitated managed care networks
8 to participate in the pilot program, including those related
9 to fiscal solvency, quality of care, and adequacy of access to
10 health care providers. This paragraph does not relieve an
11 entity that qualifies as a capitated managed care network
12 under this section from any other licensure or regulatory
13 requirements contained in state or federal law that would
14 otherwise apply to the entity. These standards must address,
15 but are not limited to:
16 1. Compliance with the accreditation requirements as
17 provided in s. 641.512.
18 2. Compliance with early and periodic screening,
19 diagnosis, and treatment screening requirements under federal
20 law.
21 3. The percentage of voluntary disenrollments.
22 4. Immunization rates.
23 5. Standards of the National Committee for Quality
24 Assurance and other approved accrediting bodies.
25 6. Recommendations of other authoritative bodies.
26 7. Specific requirements of the Medicaid program, or
27 standards designed to specifically meet the unique needs of
28 Medicaid recipients.
29 8. Compliance with the health quality improvement
30 system as established by the agency, which incorporates
31 standards and guidelines developed by the Centers for Medicare

1 and Medicaid Services as part of the quality assurance reform
2 initiative.
3 (j) To develop and recommend a mechanism for providing
4 information to Medicaid recipients for the purpose of
5 selecting a capitated managed care plan. Examples of such
6 mechanisms may include, but need not be limited to,
7 interactive information systems, mailings, and mass-marketing
8 materials. Capitated managed care plans, their
9 representatives, and providers employed by or contracted with
10 the capitated managed care plans may not provide inducements
11 to Medicaid recipients to select their plans and may not
12 prejudice Medicaid recipients against other capitated managed
13 care plans.
14 (k) To develop and recommend a system to monitor the
15 provision of health care services in the pilot program,
16 including utilization and quality of health care services for
17 the purpose of ensuring access to medically necessary
18 services. This system may include an encounter
19 data-information system that collects and reports utilization
20 information. The system shall include a method for verifying
21 data integrity within the database and within the provider's
22 medical records.
23 (l) To recommend a grievance-resolution process for
24 Medicaid recipients enrolled in a capitated managed care
25 network under the pilot program modeled after the subscriber
26 assistance panel, as created in s. 408.7056. This process
27 shall include a mechanism for an expedited review of no
28 greater than 24 hours after notification of a grievance if the
29 life of a Medicaid recipient is in imminent and emergent
30 jeopardy.
31 (m) To recommend a grievance-resolution process for

1 health care providers employed by or contracted with a
2 capitated managed care network under the pilot program in
3 order to settle disputes among the provider and the managed
4 care network or the provider and the agency.
5 (n) To develop and recommend criteria to designate
6 health care providers as eligible to participate in the pilot
7 program. The agency and capitated managed care networks must
8 follow national guidelines for selecting health care
9 providers, whenever available. These criteria must include at
10 a minimum those criteria specified in s. 409.907.
11 (o) To develop and recommend health care provider
12 agreements for participation in the pilot program.
13 (p) To require that all health care providers under
14 contract with the pilot program be duly licensed in the state,
15 if such licensure is available, and meet other criteria as may
16 be established by the agency. These criteria shall include at
17 a minimum those criteria specified in s. 409.907.
18 (q) To develop and recommend agreements with other
19 state or local governmental programs or institutions for the
20 coordination of health care to eligible individuals receiving
21 services from such programs or institutions.
22 (r) To develop and recommend a system to oversee the
23 activities of pilot program participants, health care
24 providers, capitated managed care networks, and their
25 representatives in order to prevent fraud or abuse,
26 overutilization or duplicative utilization, underutilization
27 or inappropriate denial of services, and neglect of
28 participants and to recover overpayments as appropriate. For
29 the purposes of this paragraph, the terms "abuse" and "fraud"
30 have the meanings as provided in s. 409.913. The agency must
31 refer incidents of suspected fraud, abuse, overutilization and

1 duplicative utilization, and underutilization or inappropriate
2 denial of services to the appropriate regulatory agency.
3 (s) To develop and provide actuarial and benefit
4 design analyses that indicate the effect on capitation rates
5 and benefits offered in the pilot program over a prospective
6 5-year period based on the following assumptions:
7 1. Growth in capitation rates which is limited to the
8 estimated growth rate in general revenue.
9 2. Growth in capitation rates which is limited to the
10 average growth rate over the last 3 years in per-recipient
11 Medicaid expenditures.
12 3. Growth in capitation rates which is limited to the
13 growth rate of aggregate Medicaid expenditures between the
14 2003-2004 fiscal year and the 2004-2005 fiscal year.
15 (t) To develop a system whereby school districts
16 participating in the certified school match program pursuant
17 to ss. 409.908(21) and 1011.70 shall be reimbursed by
18 Medicaid, subject to the limitations of s. 1011.70(1), for a
19 Medicaid-eligible child participating in the services as
20 authorized in s. 1011.70, as provided for in s. 409.9071,
21 regardless of whether the child is enrolled in a capitated
22 managed care network. Capitated managed care networks must
23 make a good-faith effort to execute agreements with school
24 districts regarding the coordinated provision of services
25 authorized under s. 1011.70. County health departments
26 delivering school-based services pursuant to ss. 381.0056 and
27 381.0057 must be reimbursed by Medicaid for the federal share
28 for a Medicaid-eligible child who receives Medicaid-covered
29 services in a school setting, regardless of whether the child
30 is enrolled in a capitated managed care network. Capitated
31 managed care networks must make a good-faith effort to execute

1 agreements with county health departments regarding the
2 coordinated provision of services to a Medicaid-eligible
3 child. To ensure continuity of care for Medicaid patients, the
4 agency, the Department of Health, and the Department of
5 Education shall develop procedures for ensuring that a
6 student's capitated managed care network provider receives
7 information relating to services provided in accordance with
8 ss. 381.0056, 381.0057, 409.9071, and 1011.70.
9 (u) To develop and recommend a mechanism whereby
10 Medicaid recipients who are already enrolled in a managed care
11 plan or the MediPass program in the pilot areas shall be
12 offered the opportunity to change to capitated managed care
13 plans on a staggered basis, as defined by the agency. All
14 Medicaid recipients shall have 30 days in which to make a
15 choice of capitated managed care plans. Those Medicaid
16 recipients who do not make a choice shall be assigned to a
17 capitated managed care plan in accordance with paragraph
18 (4)(a). To facilitate continuity of care for a Medicaid
19 recipient who is also a recipient of Supplemental Security
20 Income (SSI), prior to assigning the SSI recipient to a
21 capitated managed care plan, the agency shall determine
22 whether the SSI recipient has an ongoing relationship with a
23 provider or capitated managed care plan, and if so, the agency
24 shall assign the SSI recipient to that provider or capitated
25 managed care plan where feasible. Those SSI recipients who do
26 not have such a provider relationship shall be assigned to a
27 capitated managed care plan provider in accordance with
28 paragraph (4)(a).
29 (v) To develop and recommend a service delivery
30 alternative for children having chronic medical conditions
31 which establishes a medical home project to provide primary

1 care services to this population. The project shall provide
2 community-based primary care services that are integrated with
3 other subspecialties to meet the medical, developmental, and
4 emotional needs for children and their families. This project
5 shall include an evaluation component to determine impacts on
6 hospitalizations, length of stays, emergency room visits,
7 costs, and access to care, including specialty care and
8 patient, and family satisfaction.
9 (4)(a) A Medicaid recipient in the pilot area who is
10 not currently enrolled in a capitated managed care plan upon
11 implementation is not eligible for services as specified in
12 ss. 409.905 and 409.906, for the amount of time that the
13 recipient does not enroll in a capitated managed care network.
14 If a Medicaid recipient has not enrolled in a capitated
15 managed care plan within 30 days after eligibility, the agency
16 shall assign the Medicaid recipient to a capitated managed
17 care plan based on the assessed needs of the recipient as
18 determined by the agency. When making assignments, the agency
19 shall take into account the following criteria:
20 1. A capitated managed care network has sufficient
21 network capacity to meet the need of members.
22 2. The capitated managed care network has previously
23 enrolled the recipient as a member, or one of the capitated
24 managed care network's primary care providers has previously
25 provided health care to the recipient.
26 3. The agency has knowledge that the member has
27 previously expressed a preference for a particular capitated
28 managed care network as indicated by Medicaid fee-for-service
29 claims data, but has failed to make a choice.
30 4. The capitated managed care network's primary care
31 providers are geographically accessible to the recipient's

1 residence.
2 (b) When more than one capitated managed care network
3 provider meets the criteria specified in paragraph (3)(j), the
4 agency shall make recipient assignments consecutively by
5 family unit.
6 (c) The agency may not engage in practices that are
7 designed to favor one capitated managed care plan over another
8 or that are designed to influence Medicaid recipients to
9 enroll in a particular capitated managed care network in order
10 to strengthen its particular fiscal viability.
11 (d) After a recipient has made a selection or has been
12 enrolled in a capitated managed care network, the recipient
13 shall have 90 days in which to voluntarily disenroll and
14 select another capitated managed care network. After 90 days,
15 no further changes may be made except for cause. Cause shall
16 include, but not be limited to, poor quality of care, lack of
17 access to necessary specialty services, an unreasonable delay
18 or denial of service, inordinate or inappropriate changes of
19 primary care providers, service access impairments due to
20 significant changes in the geographic location of services, or
21 fraudulent enrollment. The agency may
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23
24 =============== T I T L E A M E N D M E N T ==============
25 And the title is amended as follows:
26 On page 1, line 12, through
27 page 2, line 28, delete those lines
28
29 and insert:
30 equipment; providing that a contract awarded to
31 a provider service network remains in effect

1 for a certain period; defining a provider
2 service network; providing health care
3 providers with a controlling interest in the
4 governing body of the provider service network
5 organization; requiring that the agency, in
6 partnership with the Department of Elderly
7 Affairs, develop an integrated, fixed-payment
8 delivery system for Medicaid recipients age 60
9 and older; deleting an obsolete provision
10 requiring the agency to develop a plan for
11 implementing emergency and crisis care;
12 requiring the agency to develop a system where
13 health care vendors may provide data
14 demonstrating that higher reimbursement for a
15 good or service will be offset by cost savings
16 in other goods or services; requiring the
17 Comprehensive Assessment and Review for
18 Long-Term Care Services (CARES) teams to
19 consult with any person making a determination
20 that a nursing home resident funded by Medicare
21 is not making progress toward rehabilitation
22 and assist in any appeals of the decision;
23 requiring the agency to contract with an entity
24 to design a clinical-utilization information
25 database or electronic medical record for
26 Medicaid providers; requiring that the agency
27 develop a plan to expand disease-management
28 programs; requiring the agency to coordinate
29 with other entities to create emergency room
30 diversion programs for Medicaid recipients;
31 revising the Medicaid prescription drug

1 spending control program to reduce costs and
2 improve Medicaid recipient safety; requiring
3 that the agency implement a Medicaid
4 prescription drug management system; allowing
5 the agency to require age-related prior
6 authorizations for certain prescription drugs;
7 requiring the agency to determine the extent
8 that prescription drugs are returned and reused
9 in institutional settings and whether this
10 program could be expanded; requiring the agency
11 to develop an in-home, all-inclusive program of
12 services for Medicaid children with
13 life-threatening illnesses; authorizing the
14 agency to pay for emergency mental health
15 services provided through licensed crisis
16 stabilization centers; creating s. 409.91211,
17 F.S.; requiring that the agency develop a pilot
18 program for capitated managed care networks to
19 deliver Medicaid health care services for all
20 eligible Medicaid recipients in Medicaid
21 fee-for-service or the MediPass program;
22 authorizing the agency to include an
23 alternative methodology for making additional
24 Medicaid payments to hospitals;
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