A bill to be entitled

An act relating to Medicaid; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to implement federal waivers to administer an integrated, fixed-payment delivery program for Medicaid recipients 60 years of age or older; providing for voluntary enrollment in the program in specified locations, in accordance with certain requirements; requiring selection of managed care entities to operate the program; providing that such managed care entities shall be considered prepaid health plans; providing for the establishment of informal and formal provider grievance systems; requiring payment of certain nursing home claims within a time certain; providing a timeframe for evaluation of the program by the Office of Program Policy Analysis and Government Accountability; extending the deadline for submission of the evaluation report; authorizing the agency to seek Medicaid state plan amendments; requiring the agency to submit a report to the Legislature; amending s. 408.040, F.S.; conforming terminology to changes made by the act; amending s. 409.915, F.S.; requiring counties to participate in Medicaid payments for certain nursing home or intermediate facilities care for both health maintenance members and fee-for-service beneficiaries; providing an effective date.

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

Section 1. Subsection (5) of section 409.912, Florida Statutes, is amended 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. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. 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. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice

patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider

network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(5) ~~By December 1, 2005,~~ The Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, shall create an integrated, fixed-payment delivery program ~~system~~ for Medicaid recipients who are 60 years of age or older. The Agency for Health Care Administration shall implement the integrated program ~~system~~ initially on a pilot basis in two areas of the state. The pilot areas shall be Area 7 and Area 11 of the Agency for Health Care Administration. ~~In one of the areas~~ Enrollment in the pilot areas shall be on a voluntary basis and in accordance with approved federal waivers and this section. The agency and its program contractors and providers shall not enroll any individual in the integrated program because the individual or the person legally responsible for the individual fails to choose to enroll in the integrated program. Enrollment in the integrated program shall be exclusively by affirmative choice of the eligible individual or by the person legally responsible for the individual. The integrated program must transfer all Medicaid services for eligible elderly individuals who choose to participate into an integrated-care management model designed to serve Medicaid

recipients in the community. The integrated program must combine all funding for Medicaid services provided to individuals 60 years of age or older into the integrated program ~~system~~, including funds for Medicaid home and community-based waiver services; all Medicaid services authorized in ss. 409.905 and 409.906, excluding funds for Medicaid nursing home services unless the agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner; and Medicare coinsurance and deductibles for persons dually eligible for Medicaid and Medicare as prescribed in s. 409.908(13).

(a) Individuals who are 60 years of age or older and enrolled in the developmental disabilities waiver program, the family and supported-living waiver program, the project AIDS care waiver program, the traumatic brain injury and spinal cord injury waiver program, the consumer-directed care waiver program, and the program of all-inclusive care for the elderly program, and residents of institutional care facilities for the developmentally disabled, must be excluded from the integrated program ~~system~~.

(b) The integrated program shall ~~must use a competitive procurement process to~~ select managed care entities who meet or exceed the agency's minimum standards to operate the integrated program ~~system~~. For the purpose of this section, managed care entities shall be considered prepaid health plans as provided in s. 408.7056(1)(e). Entities eligible to submit bids include managed care organizations licensed under chapter 641, including entities eligible to participate in the nursing home diversion

program, other qualified providers as defined in s. 430.703(7), community care for the elderly lead agencies, and other state-certified community service networks that meet comparable standards as defined by the agency, in consultation with the Department of Elderly Affairs and the Office of Insurance Regulation, to be financially solvent and able to take on financial risk for managed care. Community service networks that are certified pursuant to the comparable standards defined by the agency are not required to be licensed under chapter 641.

(c) The agency must ensure that the capitation-rate-setting methodology for the integrated program ~~system~~ is actuarially sound and reflects the intent to provide quality care in the least restrictive setting. The agency must also require integrated-program ~~integrated system~~ providers to develop a credentialing system for service providers and to contract with all Gold Seal nursing homes, where feasible, and exclude, where feasible, chronically poor-performing facilities and providers as defined by the agency. The integrated program must develop and maintain an informal provider grievance system that addresses provider payment and contract problems. The agency shall also establish a formal grievance system to address those issues that were not resolved through the informal grievance system. The integrated program ~~system~~ must provide that if the recipient resides in a noncontracted residential facility licensed under chapter 400 or chapter 429 at the time of enrollment in the integrated program ~~system is initiated~~, the recipient must be permitted to continue to reside in the noncontracted facility as long as the recipient desires. The

integrated program ~~system~~ must also provide that, in the absence of a contract between the integrated-program ~~integrated-system~~ provider and the residential facility licensed under chapter 400 or chapter 429, current Medicaid rates must prevail. The integrated-program provider must ensure that electronic nursing home claims that contain sufficient information for processing are paid within 10 business days after receipt. Alternately, the integrated-program provider may establish a capitated payment mechanism to prospectively pay nursing homes at the beginning of each month. The agency and the Department of Elderly Affairs must jointly develop procedures to manage the services provided through the integrated program ~~system~~ in order to ensure quality and recipient choice.

(d) ~~Within 24 months after implementation,~~ The Office of Program Policy Analysis and Government Accountability, in consultation with the Auditor General, shall comprehensively evaluate the pilot project for the integrated, fixed-payment delivery program ~~system~~ for Medicaid recipients created under this subsection ~~who are 60 years of age or older~~. The evaluation shall begin as soon as Medicaid recipients are enrolled in the managed care pilot program plans and shall continue for 24 months thereafter. The evaluation must include assessments of each managed care plan in the integrated program with regard to cost savings; consumer education, choice, and access to services; coordination of care; and quality of care. The evaluation must describe administrative or legal barriers to the implementation and operation of the pilot program and include recommendations regarding statewide expansion of the pilot

program. The office shall submit its ~~an~~ evaluation report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2009 ~~June 30, 2008~~.

(e) The agency may seek federal waivers or Medicaid state plan amendments and adopt rules as necessary to administer the integrated program ~~system~~. The agency may implement the approved federal waivers and other provisions as specified in this subsection ~~must receive specific authorization from the Legislature prior to implementing the waiver for the integrated system~~.

(f) No later than December 31, 2007, the agency shall provide a report to the President of the Senate and the Speaker of the House of Representatives containing an analysis of the merits and challenges of seeking a waiver to implement a voluntary program that integrates payments and services for dually enrolled Medicare and Medicaid recipients who are 65 years of age or older.

Section 2. Paragraph (d) of subsection (1) of section 408.040, Florida Statutes, is amended to read:

408.040 Conditions and monitoring.--

(1)

(d) If a nursing home is located in a county in which a long-term care community diversion pilot project has been implemented under s. 430.705 or in a county in which an integrated, fixed-payment delivery program ~~system~~ for Medicaid recipients who are 60 years of age or older has been implemented under s. 409.912(5), the nursing home may request a reduction in

the percentage of annual patient days used by residents who are eligible for care under Title XIX of the Social Security Act, which is a condition of the nursing home's certificate of need. The agency shall automatically grant the nursing home's request if the reduction is not more than 15 percent of the nursing home's annual Medicaid-patient-days condition. A nursing home may submit only one request every 2 years for an automatic reduction. A requesting nursing home must notify the agency in writing at least 60 days in advance of its intent to reduce its annual Medicaid-patient-days condition by not more than 15 percent. The agency must acknowledge the request in writing and must change its records to reflect the revised certificate-of-need condition. This paragraph expires June 30, 2011.

Section 3. Paragraph (b) of subsection (1) of section 409.915, Florida Statutes, is amended to read:

409.915 County contributions to Medicaid.--Although the state is responsible for the full portion of the state share of the matching funds required for the Medicaid program, in order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section.

(1) Each county shall participate in the following items of care and service:

(b) For both health maintenance members and fee-for-service beneficiaries, payments for nursing home or intermediate facilities care in excess of $170 per month, with the exception of skilled nursing care for children under age 21.

Section 4. This act shall take effect July 1, 2007.