

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

1 A bill to be entitled

2 An act relating to Medicaid; amending s. 409.912, F.S.;

3 requiring the Agency for Health Care Administration to

4 implement federal waivers to administer an integrated,

5 fixed-payment delivery program for Medicaid recipients 60

6 years of age or older or dually eligible for Medicare and

7 Medicaid; providing for voluntary enrollment in the

8 program in specified locations, in accordance with certain

9 requirements; providing eligibility for managed care

10 entities to operate the program; providing for entities to

11 choose to serve certain enrollees; providing for the

12 establishment of informal and formal provider grievance

13 systems; requiring payment of certain nursing home claims

14 within a time certain; providing a timeframe for

15 evaluation of the program by the Office of Program Policy

16 Analysis and Government Accountability; extending the

17 deadline for submission of the evaluation report;

18 authorizing the agency to seek Medicaid state plan

19 amendments; requiring the agency to submit a report to the

20 Governor and the Legislature; amending s. 408.040, F.S.;

21 conforming terminology to changes made by the act;

22 amending s. 409.915, F.S.; requiring counties to

23 participate in Medicaid payments for certain nursing home

24 or intermediate facilities care for both health

25 maintenance members and fee-for-service beneficiaries;

26 providing an effective date.

27

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

ENROLLED
HB 7065, Engrossed 2

2007 Legislature

29

30 Section 1. Subsection (5) of section 409.912, Florida
31 Statutes, is amended to read:

32 409.912 Cost-effective purchasing of health care.--The
33 agency shall purchase goods and services for Medicaid recipients
34 in the most cost-effective manner consistent with the delivery
35 of quality medical care. To ensure that medical services are
36 effectively utilized, the agency may, in any case, require a
37 confirmation or second physician's opinion of the correct
38 diagnosis for purposes of authorizing future services under the
39 Medicaid program. This section does not restrict access to
40 emergency services or poststabilization care services as defined
41 in 42 C.F.R. part 438.114. Such confirmation or second opinion
42 shall be rendered in a manner approved by the agency. The agency
43 shall maximize the use of prepaid per capita and prepaid
44 aggregate fixed-sum basis services when appropriate and other
45 alternative service delivery and reimbursement methodologies,
46 including competitive bidding pursuant to s. 287.057, designed
47 to facilitate the cost-effective purchase of a case-managed
48 continuum of care. The agency shall also require providers to
49 minimize the exposure of recipients to the need for acute
50 inpatient, custodial, and other institutional care and the
51 inappropriate or unnecessary use of high-cost services. The
52 agency shall contract with a vendor to monitor and evaluate the
53 clinical practice patterns of providers in order to identify
54 trends that are outside the normal practice patterns of a
55 provider's professional peers or the national guidelines of a
56 provider's professional association. The vendor must be able to

Page 2 of 10

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

hb7065-03-er

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

57 | provide information and counseling to a provider whose practice
58 | patterns are outside the norms, in consultation with the agency,
59 | to improve patient care and reduce inappropriate utilization.
60 | The agency may mandate prior authorization, drug therapy
61 | management, or disease management participation for certain
62 | populations of Medicaid beneficiaries, certain drug classes, or
63 | particular drugs to prevent fraud, abuse, overuse, and possible
64 | dangerous drug interactions. The Pharmaceutical and Therapeutics
65 | Committee shall make recommendations to the agency on drugs for
66 | which prior authorization is required. The agency shall inform
67 | the Pharmaceutical and Therapeutics Committee of its decisions
68 | regarding drugs subject to prior authorization. The agency is
69 | authorized to limit the entities it contracts with or enrolls as
70 | Medicaid providers by developing a provider network through
71 | provider credentialing. The agency may competitively bid single-
72 | source-provider contracts if procurement of goods or services
73 | results in demonstrated cost savings to the state without
74 | limiting access to care. The agency may limit its network based
75 | on the assessment of beneficiary access to care, provider
76 | availability, provider quality standards, time and distance
77 | standards for access to care, the cultural competence of the
78 | provider network, demographic characteristics of Medicaid
79 | beneficiaries, practice and provider-to-beneficiary standards,
80 | appointment wait times, beneficiary use of services, provider
81 | turnover, provider profiling, provider licensure history,
82 | previous program integrity investigations and findings, peer
83 | review, provider Medicaid policy and billing compliance records,
84 | clinical and medical record audits, and other factors. Providers

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

85 shall not be entitled to enrollment in the Medicaid provider
86 network. The agency shall determine instances in which allowing
87 Medicaid beneficiaries to purchase durable medical equipment and
88 other goods is less expensive to the Medicaid program than long-
89 term rental of the equipment or goods. The agency may establish
90 rules to facilitate purchases in lieu of long-term rentals in
91 order to protect against fraud and abuse in the Medicaid program
92 as defined in s. 409.913. The agency may seek federal waivers
93 necessary to administer these policies.

94 (5) ~~By December 1, 2005,~~ The Agency for Health Care
95 Administration, in partnership with the Department of Elderly
96 Affairs, shall create an integrated, fixed-payment delivery
97 program system for Medicaid recipients who are 60 years of age
98 or older or dually eligible for Medicare and Medicaid. The
99 Agency for Health Care Administration shall implement the
100 integrated program system initially on a pilot basis in two
101 areas of the state. The pilot areas shall be Area 7 and Area 11
102 of the Agency for Health Care Administration. In one of the
103 areas Enrollment in the pilot areas shall be on a voluntary
104 basis and in accordance with approved federal waivers and this
105 section. The agency and its program contractors and providers
106 shall not enroll any individual in the integrated program
107 because the individual or the person legally responsible for the
108 individual fails to choose to enroll in the integrated program.
109 Enrollment in the integrated program shall be exclusively by
110 affirmative choice of the eligible individual or by the person
111 legally responsible for the individual. The integrated program
112 must transfer all Medicaid services for eligible elderly

ENROLLED
 HB 7065, Engrossed 2

2007 Legislature

113 individuals who choose to participate into an integrated-care
 114 management model designed to serve Medicaid recipients in the
 115 community. The integrated program must combine all funding for
 116 Medicaid services provided to individuals who are 60 years of
 117 age or older or dually eligible for Medicare and Medicaid into
 118 the integrated program system, including funds for Medicaid home
 119 and community-based waiver services; all Medicaid services
 120 authorized in ss. 409.905 and 409.906, excluding funds for
 121 Medicaid nursing home services unless the agency is able to
 122 demonstrate how the integration of the funds will improve
 123 coordinated care for these services in a less costly manner; and
 124 Medicare coinsurance and deductibles for persons dually eligible
 125 for Medicaid and Medicare as prescribed in s. 409.908(13).

126 (a) Individuals who are 60 years of age or older or dually
 127 eligible for Medicare and Medicaid and enrolled in the
 128 developmental disabilities waiver program, the family and
 129 supported-living waiver program, the project AIDS care waiver
 130 program, the traumatic brain injury and spinal cord injury
 131 waiver program, the consumer-directed care waiver program, and
 132 the program of all-inclusive care for the elderly program, and
 133 residents of institutional care facilities for the
 134 developmentally disabled, must be excluded from the integrated
 135 program system.

136 (b) Managed care ~~The program must use a competitive~~
 137 ~~procurement process to select~~ entities who meet or exceed the
 138 agency's minimum standards are eligible to operate the
 139 integrated program system. Entities eligible to participate
 140 ~~submit bids~~ include managed care organizations licensed under

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

141 chapter 641, including entities eligible to participate in the
142 nursing home diversion program, other qualified providers as
143 defined in s. 430.703(7), community care for the elderly lead
144 agencies, and other state-certified community service networks
145 that meet comparable standards as defined by the agency, in
146 consultation with the Department of Elderly Affairs and the
147 Office of Insurance Regulation, to be financially solvent and
148 able to take on financial risk for managed care. Community
149 service networks that are certified pursuant to the comparable
150 standards defined by the agency are not required to be licensed
151 under chapter 641. Managed care entities who operate the
152 integrated program shall be subject to s. 408.7056. Eligible
153 entities shall choose to serve enrollees who are dually eligible
154 for Medicare and Medicaid, enrollees who are 60 years of age or
155 older, or both.

156 (c) The agency must ensure that the capitation-rate-
157 setting methodology for the integrated program ~~system~~ is
158 actuarially sound and reflects the intent to provide quality
159 care in the least restrictive setting. The agency must also
160 require integrated-program ~~integrated-system~~ providers to
161 develop a credentialing system for service providers and to
162 contract with all Gold Seal nursing homes, where feasible, and
163 exclude, where feasible, chronically poor-performing facilities
164 and providers as defined by the agency. The integrated program
165 must develop and maintain an informal provider grievance system
166 that addresses provider payment and contract problems. The
167 agency shall also establish a formal grievance system to address
168 those issues that were not resolved through the informal

ENROLLED
 HB 7065, Engrossed 2

2007 Legislature

169 grievance system. The integrated program ~~system~~ must provide
 170 that if the recipient resides in a noncontracted residential
 171 facility licensed under chapter 400 or chapter 429 at the time
 172 of enrollment in the integrated program ~~system is initiated,~~ the
 173 recipient must be permitted to continue to reside in the
 174 noncontracted facility as long as the recipient desires. The
 175 integrated program ~~system~~ must also provide that, in the absence
 176 of a contract between the integrated-program ~~integrated-system~~
 177 provider and the residential facility licensed under chapter 400
 178 or chapter 429, current Medicaid rates must prevail. The
 179 integrated-program provider must ensure that electronic nursing
 180 home claims that contain sufficient information for processing
 181 are paid within 10 business days after receipt. Alternately, the
 182 integrated-program provider may establish a capitated payment
 183 mechanism to prospectively pay nursing homes at the beginning of
 184 each month. The agency and the Department of Elderly Affairs
 185 must jointly develop procedures to manage the services provided
 186 through the integrated program ~~system~~ in order to ensure quality
 187 and recipient choice.

188 (d) ~~Within 24 months after implementation,~~ The Office of
 189 Program Policy Analysis and Government Accountability, in
 190 consultation with the Auditor General, shall comprehensively
 191 evaluate the pilot project for the integrated, fixed-payment
 192 delivery program ~~system~~ for Medicaid recipients created under
 193 this subsection who are 60 years of age or older. The evaluation
 194 shall begin as soon as Medicaid recipients are enrolled in the
 195 managed care pilot program plans and shall continue for 24
 196 months thereafter. The evaluation must include assessments of

ENROLLED
 HB 7065, Engrossed 2

2007 Legislature

197 each managed care plan in the integrated program with regard to
 198 cost savings; consumer education, choice, and access to
 199 services; coordination of care; and quality of care. The
 200 evaluation must describe administrative or legal barriers to the
 201 implementation and operation of the pilot program and include
 202 recommendations regarding statewide expansion of the pilot
 203 program. The office shall submit its ~~an~~ evaluation report to the
 204 Governor, the President of the Senate, and the Speaker of the
 205 House of Representatives no later than December 31, 2009 ~~June~~
 206 ~~30, 2008.~~

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

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

221 Section 2. Paragraph (d) of subsection (1) of section
 222 408.040, Florida Statutes, is amended to read:

223 408.040 Conditions and monitoring.--
 224 (1)

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

225 (d) If a nursing home is located in a county in which a
226 long-term care community diversion pilot project has been
227 implemented under s. 430.705 or in a county in which an
228 integrated, fixed-payment delivery program ~~system~~ for Medicaid
229 recipients who are 60 years of age or older or dually eligible
230 for Medicare and Medicaid has been implemented under s.
231 409.912(5), the nursing home may request a reduction in the
232 percentage of annual patient days used by residents who are
233 eligible for care under Title XIX of the Social Security Act,
234 which is a condition of the nursing home's certificate of need.
235 The agency shall automatically grant the nursing home's request
236 if the reduction is not more than 15 percent of the nursing
237 home's annual Medicaid-patient-days condition. A nursing home
238 may submit only one request every 2 years for an automatic
239 reduction. A requesting nursing home must notify the agency in
240 writing at least 60 days in advance of its intent to reduce its
241 annual Medicaid-patient-days condition by not more than 15
242 percent. The agency must acknowledge the request in writing and
243 must change its records to reflect the revised certificate-of-
244 need condition. This paragraph expires June 30, 2011.

245 Section 3. Paragraph (b) of subsection (1) of section
246 409.915, Florida Statutes, is amended to read:

247 409.915 County contributions to Medicaid.--Although the
248 state is responsible for the full portion of the state share of
249 the matching funds required for the Medicaid program, in order
250 to acquire a certain portion of these funds, the state shall
251 charge the counties for certain items of care and service as
252 provided in this section.

ENROLLED

HB 7065, Engrossed 2

2007 Legislature

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

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

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