1 A bill to be entitled
2 An act relating to managed care; amending s. 409.912,
3 F.S.; requiring health maintenance organizations to meet
4 certain standards before entering into a contract with the
5 Agency for Health Care Administration; requiring certain
6 provider service networks and minority physician networks
7 to comply with the surplus and financial requirements of
8 pt. I of ch. 641, F.S.; prohibiting the agency from
9 entering into contracts with managed care plans under
10 certain circumstances; providing exceptions; amending s.
11 409.91211, F.S.; requiring new applicants for provider
12 service network contracts to meet the financial
13 requirements of pt. I of ch. 641, F.S.; amending s.
14 641.225, F.S.; increasing the minimum surplus requirements
15 for new applicants for health maintenance organization
16 licensure; amending s. 641.2261, F.S.; providing
17 applicability of solvency requirements of pt. I of ch.
18 641, F.S.; providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Subsection (3), paragraph (d) of subsection
23 (4), and paragraph (a) of subsection (49) of section 409.912,
24 Florida Statutes, are amended, and subsection (53) is added to
25 that section, to read:
26 409.912 Cost-effective purchasing of health care.--The
27 agency shall purchase goods and services for Medicaid recipients
28 in the most cost-effective manner consistent with the delivery

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

57 particular drugs to prevent fraud, abuse, overuse, and possible
58 dangerous drug interactions. The Pharmaceutical and Therapeutics
59 Committee shall make recommendations to the agency on drugs for
60 which prior authorization is required. The agency shall inform
61 the Pharmaceutical and Therapeutics Committee of its decisions
62 regarding drugs subject to prior authorization. The agency is
63 authorized to limit the entities it contracts with or enrolls as
64 Medicaid providers by developing a provider network through
65 provider credentialing. The agency may competitively bid single-
66 source-provider contracts if procurement of goods or services
67 results in demonstrated cost savings to the state without
68 limiting access to care. The agency may limit its network based
69 on the assessment of beneficiary access to care, provider
70 availability, provider quality standards, time and distance
71 standards for access to care, the cultural competence of the
72 provider network, demographic characteristics of Medicaid
73 beneficiaries, practice and provider-to-beneficiary standards,
74 appointment wait times, beneficiary use of services, provider
75 turnover, provider profiling, provider licensure history,
76 previous program integrity investigations and findings, peer
77 review, provider Medicaid policy and billing compliance records,
78 clinical and medical record audits, and other factors. Providers
79 shall not be entitled to enrollment in the Medicaid provider
80 network. The agency shall determine instances in which allowing
81 Medicaid beneficiaries to purchase durable medical equipment and
82 other goods is less expensive to the Medicaid program than long-
83 term rental of the equipment or goods. The agency may establish
84 rules to facilitate purchases in lieu of long-term rentals in

85 order to protect against fraud and abuse in the Medicaid program
86 as defined in s. 409.913. The agency may seek federal waivers
87 necessary to administer these policies.
88 (3) The agency may contract with health maintenance
89 organizations certified pursuant to part I of chapter 641 for
90 the provision of services to recipients. As a condition of
91 approval for applications submitted after July 1, 2007, a health
92 maintenance organization shall demonstrate to the agency that it
93 has a record of success in providing comprehensive health
94 insurance coverage in this state for at least 3 years, has
95 contracted with this state or another state to provide
96 comprehensive Medicaid services on a prepaid capitated basis for
97 at least 3 years, or has been successful in providing
98 comprehensive prepaid services to state child health insurance
99 program members or Medicare members in this state or another
100 state for at least 3 years.
101 (4) The agency may contract with:
102 (d) A provider service network, which may be reimbursed on
103 a fee-for-service or prepaid basis.
104 1. A provider service network that ~~which~~ is reimbursed by
105 the agency on a prepaid basis shall be exempt from parts I and
106 III of chapter 641~~,~~ but must comply with the solvency
107 requirements in s. 641.2261(2) and meet appropriate financial
108 reserve, quality assurance, and patient rights requirements as
109 established by the agency.
110 2. A provider service network that is not operated by a
111 hospital and is approved for reimbursement pursuant to
112 subparagraph 1. after July 1, 2007, is not exempt from the

113 surplus and other financial requirements of part I of chapter
114 641.
115 3. A provider service network that is not operated by a
116 hospital and is approved on or prior to July 1, 2007, shall be
117 required by the agency to comply with the surplus and other
118 financial requirements of part I of chapter 641 before July 1,
119 2010.
120
121 Medicaid recipients assigned to a provider service network shall
122 be chosen equally from those who would otherwise have been
123 assigned to prepaid plans and MediPass. The agency is authorized
124 to seek federal Medicaid waivers as necessary to implement the
125 provisions of this section. Any contract previously awarded to a
126 provider service network operated by a hospital pursuant to this
127 subsection shall remain in effect for a period of 3 years
128 following the current contract expiration date, regardless of
129 any contractual provisions to the contrary. A provider service
130 network is a network established or organized and operated by a
131 health care provider, or group of affiliated health care
132 providers, including minority physician networks and emergency
133 room diversion programs that meet the requirements of s.
134 409.91211, which provides a substantial proportion of the health
135 care items and services under a contract directly through the
136 provider or affiliated group of providers and may make
137 arrangements with physicians or other health care professionals,
138 health care institutions, or any combination of such individuals
139 or institutions to assume all or part of the financial risk on a
140 prospective basis for the provision of basic health services by

141 the physicians, by other health professionals, or through the
142 institutions. The health care providers must have a controlling
143 interest in the governing body of the provider service network
144 organization.
145 (49) The agency shall contract with established minority
146 physician networks that provide services to historically
147 underserved minority patients. The networks must provide cost-
148 effective Medicaid services, comply with the requirements to be
149 a MediPass provider, and provide their primary care physicians
150 with access to data and other management tools necessary to
151 assist them in ensuring the appropriate use of services,
152 including inpatient hospital services and pharmaceuticals.
153 (a) The agency shall provide for the development and
154 expansion of minority physician networks in each service area to
155 provide services to Medicaid recipients who are eligible to
156 participate under federal law and rules. The agency shall
157 require that each minority physician network that has been
158 approved for designation or expansion after July 1, 2007, comply
159 with the requirements of part I of chapter 641 as a condition of
160 such designation or expansion. Minority physician networks that
161 were approved on or prior to July 1, 2007, shall be required by
162 the agency to comply with the surplus and other financial
163 requirements of part I of chapter 641 before July 1, 2010.
164 (53)(a) The agency shall not enter into a contract with a
165 managed care plan eligible to receive assignment of Medicaid
166 recipients to be effective in any county when the contract would
167 cause the county to contain fewer than 35,000 recipients subject
168 to mandatory Medicaid managed care enrollment per each managed

169 care plan eligible to receive assignment of Medicaid recipients
170 residing in the county. For purposes of this subsection, the
171 term "mandatory Medicaid managed care enrollment" shall have the
172 same meaning as described in s. 409.9122, and the terms "managed
173 care plan" and "assignment" shall have the same meaning as
174 described in s. 409.9122(2)(f), except that "managed care plan"
175 shall not include a Children's Medical Services Network
176 contracted pursuant to paragraph (4)(i) or an entity contracted
177 to provide integrated long-term care services pursuant to
178 subsection (5).
179 (b) A contract in effect prior to July 1, 2007, shall not
180 be rendered invalid by the provisions of paragraph (a) and may
181 be renewed notwithstanding the provisions of paragraph (a).
182 However, the provisions of paragraph (a) shall apply if the
183 contract terminates or lapses after July 1, 2007.
184 (c) Paragraph (a) shall not apply in a county containing
185 no managed care plans eligible to receive assignment of Medicaid
186 recipients residing in the county.
187 Section 2. Paragraph (e) of subsection (3) of section
188 409.91211, Florida Statutes, is amended to read:
189 409.91211 Medicaid managed care pilot program.--
190 (3) The agency shall have the following powers, duties,
191 and responsibilities with respect to the pilot program:
192 (e) To implement policies and guidelines for phasing in
193 financial risk for approved provider service networks over a 3-
194 year period. These policies and guidelines must include an
195 option for a provider service network to be paid fee-for-service
196 rates. For any provider service network established in a managed

197 care pilot area, the option to be paid fee-for-service rates
198 shall include a savings-settlement mechanism that is consistent
199 with s. 409.912(44). This model shall be converted to a risk-
200 adjusted capitated rate no later than the beginning of the
201 fourth year of operation, and may be converted earlier at the
202 option of the provider service network. For a provider service
203 network not operated by a hospital that is approved by the
204 agency for designation after July 1, 2007, the applicant shall
205 meet the initial surplus and other financial requirements of
206 part I of chapter 641. Provider service networks not operated by
207 a hospital that were approved on or prior to July 1, 2007, shall
208 be required by the agency to comply with the surplus and other
209 financial requirements of part I of chapter 641 before July 1,
210 2010. Federally qualified health centers may be offered an
211 opportunity to accept or decline a contract to participate in
212 any provider network for prepaid primary care services.
213 Section 3. Subsections (1) and (2) and paragraph (a) of
214 subsection (6) of section 641.225, Florida Statutes, are amended
215 to read:
216 641.225 Surplus requirements.--
217 (1)(a) Prior to July 1, 2010, each health maintenance
218 organization receiving a certificate of authority on or prior to
219 July 1, 2007, shall at all times maintain a minimum surplus in
220 an amount that is equal to $1.5 million ~~the greater of~~
221 ~~$1,500,000~~, ~~or~~ 10 percent of total liabilities, or 2 percent of
222 total annualized premium, whichever is greatest.
223 (b) After June 30, 2010, each health maintenance
224 organization receiving a certificate of authority on or prior to

225 July 1, 2007, shall at all times maintain a minimum surplus in
226 an amount that is equal to $5 million, 10 percent of total
227 liabilities, or 2 percent of total annualized premium, whichever
228 is greatest.
229 (c) Each health maintenance organization receiving a
230 certificate of authority after July 1, 2007, shall at all times
231 maintain a minimum surplus in an amount that is equal to $5
232 million, 10 percent of total liabilities, or 2 percent of total
233 annualized premium, whichever is greatest.
234 (2) The office shall not issue a certificate of authority,
235 except as provided in subsection (3), unless the health
236 maintenance organization has a minimum surplus in an amount
237 which is the greatest ~~greater~~ of:
238 (a) Ten percent of its ~~their~~ total liabilities based on
239 its ~~their~~ startup projection as set forth in this part;
240 (b) Two percent of its ~~their~~ total projected premiums
241 based on its ~~their~~ startup projection as set forth in this part;
242 or
243 (c) Five million dollars ~~$1,500,000~~, plus all startup
244 losses, excluding profits, projected to be incurred on its ~~their~~
245 startup projection until the projection reflects statutory net
246 profits for 12 consecutive months.
247 (6) In lieu of having any minimum surplus, the health
248 maintenance organization may provide a written guarantee to
249 assure payment of covered subscriber claims and all other
250 liabilities of the health maintenance organization, provided
251 that the written guarantee is made by a guaranteeing
252 organization which:

253 (a) Has been in operation for 5 years or more and has a
254 surplus, not including land, buildings, and equipment, of the
255 greater of $5 ~~$2~~ million or 2 times the minimum surplus
256 requirements of the health maintenance organization. In any
257 determination of the financial condition of the guaranteeing
258 organization, the definitions of assets, liabilities, and
259 surplus set forth in this part shall apply, except that
260 investments in or loans to any organizations guaranteed by the
261 guaranteeing organization shall be excluded from surplus. If the
262 guaranteeing organization is sponsoring more than one
263 organization, the surplus requirement shall be increased by a
264 multiple equal to the number of such organizations.
265 Section 4. Subsection (2) of section 641.2261, Florida
266 Statutes, is amended to read:
267 641.2261 Application of solvency requirements to provider-
268 sponsored organizations and Medicaid provider service
269 networks.--
270 (2) The solvency requirements of this part apply to a
271 Medicaid provider service network that is not operated by a
272 hospital licensed under chapter 395 if the network was approved
273 for designation as a provider service network under chapter 409
274 after July 1, 2007. The solvency requirements of this part shall
275 be applied on or prior to July 1, 2010, to provider service
276 networks that are not operated by a hospital and that were
277 approved for designation on or prior to July 1, 2007. If at any
278 time the solvency requirements in 42 C.F.R. s. 422.350, subpart
279 H, and the solvency requirements established in approved federal
280 waivers pursuant to chapter 409 exceed the requirements of this

281 part, the federal requirements shall apply to provider service
282 networks not operated by a hospital licensed under chapter 395.
283 The solvency requirements in 42 C.F.R. s. 422.350, subpart H,
284 and the solvency requirements established in approved federal
285 waivers pursuant to chapter 409, rather than the solvency
286 requirements of this part, apply to a Medicaid provider service
287 network operated by a hospital licensed under chapter 395 ~~rather~~
288 ~~than the solvency requirements of this part~~.
289 Section 5. This act shall take effect July 1, 2007.