By Senator Saunders

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A bill to be entitled

An act relating to Medicaid managed care programs; amending s. 409.9122, F.S.; revising criteria that the Agency for Health Care Administration is required to consider when assigning a Medicaid recipient to a managed care plan or MediPass provider; requiring the agency to consider a managed care plan's performance and compliance with network adequacy requirements and whether it meets certain needs; requiring the agency to establish, monitor, and evaluate network adequacy standards for managed care plans; expanding the basis for such standards to include patient access standards for specialty care providers and network adequacy standards established by contract, rule, and statute; requiring the agency to encourage the development of public and private partnerships to foster the growth of managed care plans rather than health maintenance organizations; authorizing the agency to enter into contracts with traditional providers of health care to low-income persons subject to a specific appropriation; requiring managed care plans and MediPass providers to demonstrate and document plans to ensure that Medicaid recipients receive health care service in a timely manner; authorizing the agency to extend eligibility for Medicaid recipients enrolled in contracted managed care plans rather than health maintenance organizations; requiring the agency to verify patient load certifications if the agency determines that access to primary care is being compromised; defining the term "Medicaid rate" or "Medicaid reimbursement rate"; requiring the agency to

include exemption payments and low-income pool payments in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate; amending s. 409.9124, F.S.; conforming provisions regarding managed care reimbursement to changes made by the act; amending s. 409.9128, F.S.; prohibiting a managed care plan or MediPass provider from withholding payment for emergency services and care; providing an effective date.

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

Section 1. Paragraphs (f) and (k) of subsection (2), paragraph (a) of subsection (3), subsection (8), paragraph (c) of subsection (9), and subsections (11), (12), and (14) of section 409.9122, Florida Statutes, are amended to read:

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

(2)

(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. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once this enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent

proportion, respectively. 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. The agency shall disproportionately assign Medicaid-eligible recipients who are required to but have failed to make a choice of managed care plan or MediPass, including children, and who are to be assigned to the MediPass program to children's networks as described in s. 409.912(4)(g), Children's Medical Services Network as defined in s. 391.021, exclusive provider organizations, provider service networks, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act, in such manner as the agency deems appropriate, until the agency has determined that the networks and programs have sufficient numbers to be economically operated. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes health maintenance organizations, exclusive provider organizations, provider service networks, minority physician networks, Children's Medical Services Network, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan maintains ~~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.

5. The managed care plan's performance and compliance with the network adequacy requirements, which the agency shall validate annually.

(k) 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, except in those counties in which there are fewer than two managed care plans accepting Medicaid enrollees, in which case assignment shall be to a managed care plan or a MediPass provider. Medicaid recipients in counties with fewer than two managed care plans accepting Medicaid enrollees who are subject to mandatory assignment but who fail to make a choice shall be assigned to managed care plans until an enrollment of 35 percent in MediPass and 65 percent in managed care plans, of all those eligible to choose managed care, is achieved. Once that enrollment is achieved, the assignments shall be divided in order to maintain an enrollment in MediPass and managed care plans which is in a 35 percent and 65 percent proportion, respectively. In service areas 1 and 6 of the Agency for Health Care Administration where the agency is contracting for the provision of comprehensive

behavioral health services through a capitated prepaid arrangement, recipients who fail to make a choice shall be assigned equally to MediPass or a managed care plan. For purposes of this paragraph, when referring to assignment, the term "managed care plans" includes exclusive provider organizations, provider service networks, Children's Medical Services Network, minority physician networks, and pediatric emergency department diversion programs authorized by this chapter or the General Appropriations Act. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the urgent, emergency, acute, and chronic needs ~~need~~ of its members and has consistently maintained compliance with the network adequacy requirements over the previous 12-month period.

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.

5. The agency shall ~~has authority to~~ make mandatory assignments based on quality of service and performance of managed care plans.

(3)(a) The agency shall establish quality-of-care and network adequacy standards for managed care plans, which the agency shall monitor quarterly and evaluate annually. These standards shall be based upon, but are not limited to:

1. Compliance with the accreditation requirements as provided in s. 641.512.

2. Compliance with Early and Periodic Screening, Diagnosis, and Treatment screening requirements.

3. The percentage of voluntary disenrollments.

4. Immunization rates.

5. Standards of the National Committee for Quality Assurance and other approved accrediting bodies.

6. Recommendations of other authoritative bodies.

7. Specific requirements of the Medicaid program and network adequacy~~, or~~ standards designed to specifically meet ~~assist~~ the unique needs of Medicaid recipients, including patient access standards for specialty care providers.

8. Compliance with the health quality improvement system as established by the agency, which incorporates standards and guidelines developed by the Medicaid Bureau of the Health Care Financing Administration as part of the quality assurance reform initiative.

9. Network adequacy as established by contract, rule, and statute for urgent, emergency, acute, and chronic care.

(8)(a) The agency shall encourage the development of public and private partnerships to foster the growth of managed care plans ~~health maintenance organizations~~ and prepaid health plans that will provide high-quality health care to Medicaid recipients.

(b) Subject to a specific appropriation ~~the availability of moneys~~ and any limitations established by the General Appropriations Act ~~or chapter 216~~, the agency is authorized to enter into contracts with traditional providers of health care to low-income persons to assist such providers with the technical aspects of cooperatively developing Medicaid prepaid health plans.

1. The agency may contract with disproportionate share hospitals, county health departments, federally initiated or federally funded community health centers, and counties that operate either a hospital or a community clinic.

2. A contract may not be for more than $100,000 per year, and no contract may be extended with any particular provider for more than 2 years. The contract is intended only as seed or development funding and requires a commitment from the interested party.

3. A contract must require participation by at least one community health clinic and one disproportionate share hospital.

(9)

(c) The agency shall require managed care plans and MediPass providers to demonstrate and document plans and activities, as defined by rule, including outreach and followup, undertaken to ensure that Medicaid recipients receive the health care service to which they are entitled in a timely manner.

(11) The agency may extend eligibility for Medicaid recipients enrolled in contracted managed care plans ~~licensed and accredited health maintenance organizations~~ for the duration of the enrollment period or for 6 months, whichever is earlier,

provided the agency certifies that such an offer will not increase state expenditures.

(12) A managed care plan that has a Medicaid contract shall at least annually review each primary care physician's active patient load and shall ensure that additional Medicaid recipients are not assigned to physicians who have a total active patient load of more than 3,000 patients. As used in this subsection, the term "active patient" means a patient who is seen by the same primary care physician, or by a physician assistant or advanced registered nurse practitioner under the supervision of the primary care physician, at least three times within a calendar year. Each primary care physician shall annually certify to the managed care plan whether or not his or her patient load exceeds the limits established under this subsection and the managed care plan shall accept such certification on face value as compliance with this subsection. The agency shall accept the managed care plan's representations that it is in compliance with this subsection based on the certification of its primary care physicians, unless the agency has an objective indication that access to primary care is being compromised, such as <u>failure to maintain network adequacy or</u> receiving complaints or grievances relating to access to care. If the agency determines that an objective indication exists that access to primary care is being compromised, it <u>shall</u> ~~may~~ verify the patient load certifications submitted by the managed care plan's primary care physicians and that the managed care plan is not assigning Medicaid recipients to primary care physicians who have an active patient load of more than 3,000 patients.

(14) As used in this section and ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), the term "Medicaid rate" or "Medicaid reimbursement rate" is equivalent to the amount paid directly to a hospital by the agency for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis. The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including, but not limited to, upper payment limit, exemption payments, low-income pool payments, or disproportionate share hospital payments~~,~~ made to qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendments ~~amendment~~ as needed to implement this adjustment.

Section 2. Subsection (6) of section 409.9124, Florida Statutes, is amended to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(6) As used in this section and ss. 409.912(19), 409.9128(5)(d), and 641.513(6)(d), the term "Medicaid rate" or "Medicaid reimbursement rate" is equivalent to the amount paid directly to a hospital by the agency for providing inpatient or outpatient services to a Medicaid recipient on a fee-for-service basis. The agency shall include in its calculation of the hospital inpatient component of a Medicaid health maintenance organization's capitation rate any special payments, including, but not limited to, upper payment limit, exemption payments, low-income pool, or disproportionate share hospital payments made to

qualifying hospitals through the fee-for-service program. The agency may seek federal waiver approval or state plan amendments as needed to implement this adjustment. ~~For the 2005-2006 fiscal year only, the agency shall make an additional adjustment in calculating the capitation payments to prepaid health plans, excluding prepaid mental health plans. This adjustment must result in an increase of 2.8 percent in the average per-member, per-month rate paid to prepaid health plans, excluding prepaid mental health plans, which are funded from Specific Appropriations 225 and 226 in the 2005-2006 General Appropriations Act.~~

Section 3. Paragraph (d) of subsection (1), paragraph (b) of subsection (3), and subsection (5) of section 409.9128, Florida Statutes, are amended to read:

409.9128 Requirements for providing emergency services and care.--

(1) In providing for emergency services and care as a covered service, neither a managed care plan nor the MediPass program may:

(d) Deny or withhold payment based on the enrollee's or the hospital's failure to notify the managed care plan or MediPass primary care provider in advance or within a certain period of time after the care is given.

(3)

(b) If a determination has been made that an emergency medical condition exists and the enrollee has notified the hospital, or the hospital emergency personnel otherwise has knowledge that the patient is an enrollee of the managed care plan or the MediPass program, the hospital must make a reasonable

attempt to notify the enrollee's primary care physician, if known, or the managed care plan, if the managed care plan had previously requested in writing that the notification be made directly to the managed care plan, of the existence of the emergency medical condition. If the primary care physician is not known, or has not been contacted, the hospital must:

1. Notify the managed care plan or the MediPass provider as soon as possible prior to discharge of the enrollee from the emergency care area; or

2. Notify the managed care plan or the MediPass provider within 24 hours or on the next business day after admission of the enrollee as an inpatient to the hospital.

If notification required by this paragraph is not accomplished, the hospital must document its attempts to notify the managed care plan or the MediPass provider or the circumstances that precluded attempts to notify the managed care plan or the MediPass provider. Neither a managed care plan nor the Medicaid program on behalf of MediPass patients may deny or withhold payment for emergency services and care based on a hospital's failure to comply with the notification requirements of this paragraph.

(5) Reimbursement for services provided to an enrollee of a managed care plan under this section by a provider who does not have a contract with the managed care plan shall be the lesser of:

(a) The provider's billed charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided;

(c) The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

(d) The Medicaid rate defined as equivalent to the amount paid directly to a hospital by the agency for providing inpatient and outpatient services to a Medicaid recipient on a fee-for-service basis.

Section 4. This act shall take effect July 1, 2008.